State of Alabama
STATE EMPLOYEES’ INSURANCE BOARD

Request for Proposals
Medical and Dental
Administrative Services Only
Released: March 24, 2016

Health Care Benefits:
State Employees’ Health Insurance Program
“RFP: 2016 SEHIP ASO-01”

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www.alseib.org
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1.00 GENERAL INFORMATION

1.01 Introduction
The State Employees’ Insurance Board (SEIB) requests proposals for the procurement of medical and dental Administrative Services Only (ASO) described herein.

The SEIB is empowered by Title 36, Chapter 29 of the Code of Alabama (as amended) to provide health and dental benefits to employees and retirees of state agencies through the State Employees’ Health Insurance Plan (SEHIP). The SEIB also offers supplemental coverage, workers’ compensation benefits and inmate hospital services, as described later in this RFP. The program is overseen by an 11 member Board of Directors.

Currently, about 51,000 employees of state agencies are covered. The plan is self-insured with administrative services currently being provided by Blue Cross and Blue Shield of Alabama (BCBS).

BCBS provides comprehensive claims administrative services for the plan. Services include providing networks with hospitals, physicians, and dental providers; providing medical services that include inpatient hospital precertification, concurrent review, case management, disease management, and outpatient certification of selected ambulatory surgical and diagnostic procedures.

BCBS also administers the SEIB dental plan, supplemental coverage, workers’ compensation benefits and inmate hospital services.

For additional information go to the SEIB website: www.alseib.org.

1.02 Purpose
The SEIB is seeking an experienced Vendor that can provide comprehensive administrative services in the following areas:

- Claims Adjudication;
- Provider Network Management;
- Medical Services;
- Utilization Management; and
- Dental Services.

The Scope of Work is described in Section 3 of the RFP.

1.03 Terminology
Throughout this RFP, the terms “State”, “SEIB” and “Board” shall refer to the State Employees’ Insurance Board.

Throughout this RFP, the terms Proposer, Vendor, Contractor, or Claims Administrator may be used interchangeably.
Throughout this RFP, the terms “SEHIP” and “Plan” shall refer to the State Employees’ Health Insurance Plan.

Other Contract Terms and Conditions are described in Section 4 of the RFP.

1.04 Eligible Employees
The term “employee” as used throughout this RFP is defined as those employees, former employees, and retired employees who are enrolled in the SEIB programs. It also includes individuals determined by the SEIB to be eligible for benefits offered to prison inmates.

Exhibit 1 displays the historical number of covered employees and retirees by month for the State Employees’ Health Insurance Plan, Supplemental Plan and the prison inmates. Exhibit 2 displays enrollment by ZIP Codes.

1.05 Summary of Benefits
The plan documents for the respective medical plans to be administered are included in this RFP as Exhibit 3. The successful Proposer will be expected to administer these benefit structures without deviation.

1.06 Claims Transaction Volumes
The claim counts are provided in Exhibit 4. Historical claim counts are provided for information only. The SEIB makes no representation whatsoever that these volumes are indicative of future activity.

1.07 Procurement Timetable
The following timetable is anticipated:

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for Proposal Released</td>
<td>March 24, 2016</td>
</tr>
<tr>
<td>Intent to Quote and Minimum Qualifications Due</td>
<td>March 31, 2016</td>
</tr>
<tr>
<td>Last Date to Submit Written Questions</td>
<td>April 5, 2016</td>
</tr>
<tr>
<td>Proposal Deadline</td>
<td>April 29, 2016</td>
</tr>
<tr>
<td>Notification of Finalist(s)</td>
<td>month of May, 2016</td>
</tr>
<tr>
<td>On-site Review of Finalists (If necessary)</td>
<td>month of June, 2016</td>
</tr>
<tr>
<td>Award Contract</td>
<td>Summer, 2016</td>
</tr>
<tr>
<td>Contract Effective Date</td>
<td>January 1, 2017</td>
</tr>
</tbody>
</table>

Note: The Board reserves the right to adjust this schedule as it deems necessary.

1.08 Proposal Submission
The Vendors interested in submitting a proposal should follow the “Instructions to Vendors” in Section 5 and submit the proposal according to the “Proposal Format and Content” in Section 6 of the RFP.
1.09 Proposal Evaluation

Vendors, whose proposals are received by the deadline and meet the Vendor Minimum Qualifications listed in Section 2.00, will be evaluated further. Each proposal may receive up to 100 maximum points (45 possible technical points, 40 possible price points, 10 possible finalist presentation points, and 5 possible onsite points). The evaluation will be conducted in up to three phases for those bidders meeting minimum qualifications:

a. Phase I - Evaluation of Technical Proposal. The following criteria will be used in the technical evaluation:
   i. Response to Confirmation in Section 6.02.03;
   ii. Response to Questionnaire in Section 6.02.04; and
   iii. Analysis of Network Access and Disruption in Appendices B and C.

b. Phase II - Evaluation of Price Proposal. Points will be awarded based on a Mercer “NetPic” network analysis of relative claims cost amounts plus proposed administrative fees. The lowest total three year claims plus administration cost (“Cost”) proposal will receive the maximum allowable 40 points. Points will be awarded to higher cost proposals based on a formula to allocate the percentage difference in the three year Cost for the lowest bidder and each higher bidder.

Medical/dental and pharmacy proposals (whether “carve-in” or “carve-out” pharmacy proposals) will be evaluated separately, based on combined Technical and Price Proposal scores for each medical/dental or pharmacy proposal.

c. Phase III – Presentations/Onsite of the Successful Proposal(s). However, at any time during the evaluation phases, the State may, at the State’s discretion, contact a Vendor to: (1) provide further or missing information or clarification of their Proposal, (2) provide an oral presentation of their Proposal, (3) obtain the opportunity to interview the proposed key personnel, or (4) conduct an onsite visit of the vendor’s facilities. Reference checks may also be made at this time. However, there is no guarantee that the State will look for information or clarification outside of the submitted written Proposal, nor conduct any finalist or onsite meetings. Therefore, it is important that the Proposer ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information. A “Phase III Presentation/Onsite” score will be determined based on the State’s evaluation of any Phase III activity.

The evaluation team will review the Proposal scores in making its recommendations of the successful Proposal(s) for award consideration. If any optional Phase III evaluation is conducted by the
State, a Proposer’s total score will be the sum of the final scores (reflecting any information obtained in Phase III) received for the Technical Proposal, Price Proposal and Presentation/Onsite Visit. The State may also submit a list of detailed comments, questions, and concerns to one or more Proposers after the initial evaluation. This may include requesting one or more Proposers’ “Best and Final” offers on price or technical requirements, or both. The total scores for those Proposers selected to submit additional information may be revised as a result of the new information.

The evaluation team will make its final or conditional recommendation based on the above-described evaluation process. The final award decision will be made by the SEIB.

1.10 Single Point of Contact

From the date this RFP is released until a Vendor is selected and announced by the SEIB, all communication must be directed to:

Slate Taylor (Consultant)
Mercer Health & Benefits
3560 Lenox Road, Suite 2400
Atlanta, GA 30326
(404) 442 3520
Slate.taylor@Mercer.com

Subsequent to the opening of the sealed proposals, discussions for the purpose of clarification to assure full understanding of and responsiveness to the solicitation requirements may be conducted by the Consultant on behalf of the SEIB with responsible Vendors who submit proposals determined to have reasonable expectations of being selected for an award.

In conducting any such discussion, there shall be no disclosure of any information derived from proposals submitted by competing Vendors, including the name of a potential Vendor.

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc., will be posted to the SEIB website at www.alseib.org.
2.00 VENDOR MINIMUM QUALIFICATIONS

The Proposer must meet all of the Vendor Minimum Qualifications to submit a valid proposal. The Minimum Qualifications are as follows:

A. The Proposer must be rated by at least one of the following rating agencies and must meet the minimum rating requirements outlined below for the most recent rating. Provide the SEIB all agencies, corresponding ratings, and date of rating for your organization.

Acceptable ratings for this feature are as follows:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM Best</td>
<td>A++, A+, A, A-, B++, B+</td>
</tr>
<tr>
<td>Duff &amp; Phelps</td>
<td>AAA, AA+, AA, AA-, A+, A, A-</td>
</tr>
<tr>
<td>Standard &amp; Poor’s</td>
<td>AAA, AA+, AA, AA-, A+, A, A-</td>
</tr>
<tr>
<td>Moody’s</td>
<td>Aaa, Aa1, Aa2, Aa3, A1, A2, A3</td>
</tr>
</tbody>
</table>

B. The SEIB account must not result in more than a (25%) twenty-five percent increase in total business or forty percent (40%) increase in the Proposer’s current Alabama business, as measured by the number of covered contracts in existing medical claims administration accounts for services similar to those required in this RFP. Provide the SEIB your organization’s current, as of December, 2015, number of covered contracts in existing medical claims administration accounts.

C. The Proposer must have experience adjudicating and paying health and dental claims for Alabama-based companies with 1,500 or more Plan participating employees. For your organization’s book of business, provide all Alabama based companies, corresponding number of participating employees and date the account was effective.

D. The Proposer must have experience adjudicating and paying health and dental claims for at least three clients (Alabama or National) with 10,000 or more Plan participating employees for a minimum of five (5) years. For your organization’s book of business, provide all companies, corresponding number of participating employees, and date the account was effective.

E. The Proposer must have been licensed to transact and provide health insurance benefits for at least the past five (5) years in the state of Alabama. Provide the SEIB the date your organization was licensed to transact medical claim administration services in the state of Alabama.

F. The Proposer must not be on probation with the Alabama Department of Insurance. Provide a written confirmation statement as to such.
2.01 Vendor Minimum Qualifications Form

State of Alabama
State Employees’ Insurance Board

PLEASE ENSURE THAT ALL REQUIRED SIGNATURE BLOCKS ARE COMPLETE. FAILURE TO SIGN THIS FORM WILL RENDER YOUR CERTIFICATION INVALID.

It is understood and agreed that my organization must meet all of the Vendor Minimum Qualifications in Section 2.00 to submit a valid proposal. Failure to meet all Vendor Qualifications will render the proposal invalid. All validating information is submitted behind this Vendor Minimum Qualifications Form.

SIGNATURE AND CERTIFICATION
(Vendor must sign and return with Intent to Quote Form)

I certify that my organization meets all of the Vendor Minimum Qualifications in Section 2.00 in order to submit a valid proposal. I agree to abide by all conditions of the proposal and certify that I am authorized to sign this form for the proposer.

_________________________   _____________         ____________
Authorized Signature      Corporate Seal    Date
3.00 SCOPE OF WORK

The successful Proposer must demonstrate that it has the ability to perform the required services stated in this RFP.

3.01 General Requirements

The successful Proposer will be an organization with extensive experience in handling large group medical plans and a sophisticated claims adjudication system. Any proposing organization should have the size and resources to take over an account the size of the SEIB without perceptible upset of service to this or other clients.

If financial losses have been experienced during one (1) or both of the Proposer’s last two (2) fiscal years, the ratio of assets to liabilities must reflect sound financial conditions.

The Vendor must be licensed in the State of Alabama to conduct health and accident insurance business, or be a non-profit health care corporation licensed to transact business in Alabama, or be licensed to conduct the business of paying health claims on behalf of a self-insured health plan in Alabama. The Vendor must have been licensed to transact health claims processing business for a minimum of five (5) years.

The Vendor must agree to set up a separate claims processing unit which will be dedicated exclusively to provide services to the SEIB.

The Vendor’s total organization must be committed to leadership and support of excellent service to the SEIB during the period of the contract for rapid change in benefits issues, and in the context of national health care reform. This commitment must be demonstrated through proactive and timely effective actions of the following:

- To promote and enhance quality to members and measure service;
- To stay current with ever-changing Medicare coordination issues and requirements;
- To provide proper response to possible health system reform;
- To identify new initiatives for cost management; and
- To commit the people, systems, and financial resources necessary to be in the forefront of the medical benefits industry.
3.02 Claims Processing – General

The Vendor must adjudicate claims and pay benefits to the employee or provider according to SEIB approved benefit schedules in Exhibit 3.

Any claim payments or adjustments that the Vendor interprets as not in compliance with the approved plan or that require a policy decision shall be made only upon written authorization from SEIB management or as delegated in writing to authorized personnel by the SEIB.

The Vendor should minimize the number of persons handling a claim during the processing cycle. This goal for handling claims must not, however, conflict with accepted standards for internal control by the separation of various functions.

All information, including but not limited to claims and Explanation of Benefits (EOB), must be identified as to date and time received, a permanent record made, and reviewed for completeness. Incomplete claims must be returned with the appropriate request for information.

All claims must be coded and entered for type of service, place of service, provider, and all other information required for accurate claims processing according to the approved benefit plan and for analysis of utilization and pricing.

The Vendor must inspect the claim for other carrier information.

The Vendor must inspect claims to determine if Medicare is or may be the primary payer.

The Vendor must review and research EOBs which are received separately from claims. If the EOB dates of service and amounts match a pended or denied claim, the Vendor must appropriately adjudicate the claim. If the EOB does not match a pended claim, the Vendor must correspond with the employee.

The Vendor must inspect claims to determine if a third-party, such as automobile or other casualty insurance, may have primary responsibility for paying the claim. If further information is needed to accurately complete the claims adjudication process, the Vendor must correspond with the employee or provider, as appropriate.

Upon determination that the claim is a valid claim under the benefit plan, the Vendor must issue a draft for the eligible benefits to the member or the provider according to appropriate contractual arrangements with providers and SEIB regulations, and mail to the payee’s home address via first class postage or the member can opt to obtain the EOB online from the vendor.

The Vendor must identify the reason for a returned draft. If the address is incorrect, the Vendor must resubmit the draft to the correct address; if the draft is returned for another reason (i.e., wrong payee, duplicate payment, incorrect amount), the Vendor must void the draft and re-issue or otherwise correct the payment.
The Vendor’s Information Technology (IT) system must produce an EOB to the employee that clearly identifies how the claim was processed and paid and what the employee’s liability may be, even if the employee’s liability is zero.

3.02.01 Claims Processing – Coordination of Benefits (COB)
Members of plans offered by the SEIB frequently have other group coverage for the spouse, stepchildren, natural children, and themselves through other employer groups. Some employees have active coverage through two (2) employers, simultaneously. Members may have other group coverage through the spouse.

The SEIB will attempt to identify if new enrollees and their dependents have primary coverage through another group health plan and will forward new or revised information as it is received. However, responsibility for the determination of primary and secondary coverage is placed with the Vendor. During the claims processing or adjustment cycle, the Vendor must verify and re-verify information about other coverage as specified in this RFP.

The “other carrier” coverage information must be interfaced with the claims system for proper claims adjudication. The IT system must have the capability of maintaining separate COB information for each individual under the employee’s contract (employee, spouse, and each dependent) with claim adjudication defaulting to the family (employee) COB information if no dependent specific COB information is on file. The IT system must have the capability of calculating when the dependent children are primary/secondary in accordance with the birthday rules of the NAIC. The IT system must be capable of querying members regarding divorce decree requirements and custodial relationships and storing information received to be used in claims processing.

When a claim for a spouse or dependent is filed, the Vendor must edit the other coverage file to determine if a plan offered by the SEIB is the secondary payer. COB information must be elicited and updated upon receipt of a claim for the spouse or dependent child when the IT file indicates that “no other coverage” was present at least six (6) months prior to such claim receipt.

The IT system must generate correspondence to the employee if the claim and COB information conflict in any way.

The Vendor must update information received from the employee (completed EOB or COB update) and automatically complete processing of any pending claims.
3.02.02 Claims Processing – Other Third-Party Liability
The plans offered by the SEIB have non-duplication clauses for third-party liability claims. In addition, the SEIB incorporates a subrogation right for all third-party liability claims.

The Vendor must be able to identify, and the IT system must have the capability to distinguish between various types of coordination with third parties.

The Vendor must identify possible third-party liability claims through proper query procedures. When third-party liability is involved, the Vendor must correspond with the member, establish the State’s right of subrogation, and/or coordinate payment with the liable entity (or provider) as appropriate.

3.02.03 Claims Processing – Medicare
Where appropriate, plans offered by the SEIB include Medicare subrogation provisions when the patient is entitled to Medicare. The State and the Vendor exchange information via acceptable electronic media regarding enrollment for Part A, Part B and Part D. Data for identifying Medicare Part A, Part B and Part D enrollment, the effective dates of each option, an indicator that the member has group coverage other than Medicare, and a flag indicating that automatic reduction (without further correspondence) of benefits are shared between the SEIB and Medicare.

The IT system must be capable of maintaining historical records for effective dates of enrollment in Medicare; identifying when the SEIB plan is the primary payer (this is necessary because of grandfathering retirees without Medicare or in those situations where the State has determined that the retiree/spouse is not entitled to Medicare); identifying and paying primary benefits for the entire month in which the employee/dependent attains age 65 and automatically reducing benefits beginning the month following the employee/dependent’s 65th birthday; and identifying conflicts between claim information and Medicare information supplied by the State of Alabama.

In cases where conflicts in information arise, the Vendor must correspond with the employee. During the time when the information is to be perfected, the claim should be suspended although follow-up within a reasonable number of days is required.

The Vendor must maintain knowledge about Medicare processing and coverage. The SEIB requires that the Vendor obtain itemized claim information for all Medicare related claims. The Medicare EOMB without itemized information must be returned to obtain complete information when Medicare is the primary payer.
3.02.04 Claims Processing – Supplemental Coverage
The Vendor must administer SEIB supplemental coverage. The SEIB offers supplemental benefits to eligible state employees and non-Medicare retirees who are able to obtain group health coverage through a plan maintained by another employer.

Members participating in this plan are electing not to participate in the State Employees’ Health Insurance Plan. Participants in the State Employees’ Supplemental Coverage Plan are eligible for benefits that supplement coverage under their primary plan. Only after benefits have been determined under the primary plan, will this plan determine the level of supplemental benefits that are due to be paid.

If a participant has no primary dental plan, he or she may elect to participate in the SEIB Preferred Dental Program as the primary dental plan. The supplemental provisions of the State Employees’ Supplemental Coverage Plan will not apply to dental benefits if the participant elects the SEIB Preferred Dental Program.

3.02.05 Claims Processing – Inmate Hospital Services
The Vendor must administer the Alabama Department of Corrections (ADOC) inmate hospital services. The SEIB has an Interagency Agreement with the ADOC to enable the ADOC to receive the same network discounts, as available to the SEHIP, for its inmates receiving hospital services. The SEIB will be billed for the cost of all inmate hospital claims processed by the Vendor. All claims outside the Vendor’s hospital network will be processed by the ADOC or its TPA.

3.02.06 Claims Processing – Workers’ Compensation
The Vendor must administer SEHIP workers’ compensation services. The SEIB provides discounted medical benefits for the treatment of work-related injuries and illnesses for members of the SEHIP through the same contractual agreements the Claims Administrator has with the SEHIP. Benefits will not be subject to any deductibles, coinsurance, co-payments or maximums normally included as part of the SEHIP. The Vendor should be capable of providing case management, cost control programs, and return-to-work programs if requested by the SEIB.

3.02.07 Claims Processing – Document Controls
The Vendor must establish a method of tracking claims from date of receipt until date paid or date of final disposition. A process must be maintained that will allow the Vendor to control and report to the SEIB the claims inventory by each step (manual and computer) of the adjudication process. The control process must also differentiate between the types of claims received (i.e., electronic and paper).

Documents should be numbered, or otherwise uniquely identified, when received and that identifier must be used throughout the processing cycle. The document must be retrievable using this identifier.

Document controls must also be established for correspondence, EOBs, adjustments and any other items used in the claim process.
3.02.08 Claims Processing – Electronic Data Interchange (EDI)
The Vendor is to use a system of electronic data interchange for hospitals or other providers of medical service. Such system must be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). The SEIB must approve any EDI activity for its account. If the Vendor uses EDI claims entry for other clients, SEIB data must be protected from access, including “read only” capability or entry upon request from the SEIB. Proper controls must be implemented to require some types of claims to be submitted by paper only (e.g., transplant claims).

The Vendor must install security safeguards for any provider having access to the Vendor’s computerized system to assure that only valid claims are entered.

Additionally, the IT system supporting such delegated claims entry must include safeguards against entry of claims for providers other than for the provider of the medical services and proper input controls for receipt of any other application for electronic submission.

The Vendor shall train provider staff in the proper use of the computerized system. The Vendor will train provider staff in the coding structures used for the SEIB account. Training of provider staff must be completed prior to use of the computerized system.

The use of a delegated system of claims entry does not remove the requirement that permanent records be kept as described elsewhere in this RFP. The Vendor must maintain contracts with these entities for maintenance of supporting documentation (paper or electronic record) for proper audit trails, including documents to substantiate the patient’s authorization for assignment. The Vendor must receive and forward copies of claim forms or other requested documents to the SEIB within twenty-one (21) days of request.

The ability of a provider to perform claims entry must be revocable through the Vendor’s software without physical access to the provider’s office.

3.03 Information Technology (IT) Systems – General
The IT environment, the physical and data security features and the internal controls used by the Vendor must meet the standards outlined by the American Institute of Certified Public Accountants.

The Vendor must use an IT environment that fully supports the requirements of this RFP. The IT environment must be covered by a disaster recovery plan that facilitates the restoration of the application software and data as well as the rapid replacement of hardware through reinstallation or use of an alternate site.

3.03.01 IT Systems – Facility and Physical Security
The Vendor must be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for
Economic and Clinical Health Act (HITECH). The Vendor must: (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic Protected Health Information (ePHI) that it creates, receives, maintains, or transmits on behalf of the SEIB as required by HIPAA and HITECH; and (2) Ensure that any agent, including a Sub-vendor, to whom the Vendor provides such ePHI agrees to implement reasonable and appropriate safeguards to protect it. These administrative, physical, and technical safeguards should include, but not be limited to:

- Physical security requirements that shall at a minimum consist of a data center with access limited to authorized personnel;

- All processing of and access to SEIB data must be through a system of security features that protect against invasion of privacy and unauthorized access; and

- Devices may not be permitted access to SEIB data without specific authorization from the SEIB. Such access must be immediately revoked upon SEIB request.

3.03.02 IT Systems – Data Storage and Access Control
Data security requirements shall, at a minimum, consist of fully operational internal controls. All processing of and access to the SEIB data must be through a system of security features that protect against invasion of privacy and unauthorized access.

3.03.03 IT Systems – Inputs, Outputs, and Processing
The IT hardware and software environment must be capable of accurately adjudicating 3 million claims each year for this account in addition to the Vendor’s regular business. The IT system must:

- Be “on-line” or “real-time” with a proper balance of on-line and batch processing applications;

- Have been in operation adjudicating and paying health and dental claims for at least three clients having at least 10,000 employees for a minimum of five (5) years;

- Use the employee’s contract number (assigned by SEIB) as the unique employee identifier. Access to information about an employee, dependents or their claims must be available through use of the assigned contract number;

- Be capable of waiving office visit copayment or hospital deductible for patients’ compliance with SEIB wellness programs (i.e., Physician referral form, Maternity program);

- Accept directly keyed and remotely keyed claims and must accept claims transmitted from authorized providers using electronic interchange/exchange techniques;
Be capable of accepting information from a Sub-vendor(s) and appropriately adjudicate claims as a result of compliance/non-compliance with policies of the plan;

Accept membership/eligibility information for members and dependents from the SEIB on a daily basis. The records maintained by the SEIB are the official records of eligibility and the Vendor must accept our data transmissions as accurate, overriding existing eligibility edits;

Provide for automated Coordination of Benefits with other carriers;

Provide for automatic suspension and referral of potential workers’ compensation and other third-party liability claims;

Accept, process, store, and report claims data using the coding conventions;

Provide for the adjudication on a Usual, Customary, and Reasonable (UCR) and fee schedule basis. UCR-based adjudication of claims should be based on ZIP Code areas, including services provided outside the State of Alabama;

Have the ability to automatically complete processing a claim if it is previously suspended for any reason, such as awaiting the arrival of coordination information or dependent eligibility data;

Have the ability to process certain claims on a case-by-case basis, as in the case of transplants;

Be able to retain and display claim information in detail for a period of 24 months from date of claim filing. The system must be able to retain and display claim information in a pdf or electronic image for a minimum of an additional five (5) years;

Design all screens and reports to be “user-friendly” and “user-readable”;

Use of on-line help screens and user manuals to increase the number of questions/problems that can be resolved on-line and reduce the need to refer to printed documents and manuals;

Generate a notice to the employee to explain the reason for delay when a claim is not paid within fifteen work days after receipt;

Allow the SEIB access to the Vendor’s system for assistance in responding to members’ inquiries about claims and coverage; and

Be capable of displaying sufficient information on claims, members, UCR, other coverage, Medicare information, providers, deductibles, and lifetime maximum benefits paid. Claim information must be accessible by patient, contract, summary, detail, date of service, and provider/date of service.
3.03.04 IT Systems – Provider Files
The IT system must maintain a subsystem for identifying licensed and approved providers under the plans offered by the SEIB. The system must be integrated with the claims adjudication system in such a manner to maximize efficiency in entry and minimize payments to the wrong provider. Recognizing that many provider group names are similar, the Vendor must utilize a tax identification number as the major identifier (unless the Vendor can demonstrate to the SEIB that another identifier is equally as good).

The provider subsystem must incorporate appropriate methods of cross-referencing individual providers with group practices, individual providers with multiple offices, and providers associated with more than one group practice.

The Vendor’s IT system must have the capability of storing the type of provider (e.g., acute care hospital, psychiatric hospital, outpatient substance abuse facility), and specialty/subspecialty of the physician. The SEIB maintains specific contracts (e.g., mental health networks) that may conflict with the Vendor’s contracts. In such cases, the IT system used for State processing must incorporate methods of handling “SEIB-only” providers.

The Vendor’s IT system must provide the capability of validating “SEIB-only” provider contracted discounts, per diems, and a combination of payment methods, along with the effective dates of the contract and/or cancellation dates of the contract.

The current Vendor utilizes an in-house coding scheme for provider numbers. The Vendor must retain this coding scheme, convert the current Vendor’s provider references on its history files to the Vendor’s references or must provide a cross-reference to check for duplicate claim payments.

3.03.05 IT Systems – Eligibility Information
The Vendor’s IT system must include a subsystem (or other reference file) for processing, editing, and storing eligibility information for the member and each dependent. The initial file of all covered lives must be created using information electronically transferred from the SEIB to the Vendor. The file will utilize the same format as that used for on-going eligibility updates.

The Vendor’s IT system updates must incorporate basic data validity edits for submitted membership/eligibility transactions. The validity edits must be sufficient to assure proper updating of the eligibility records.

In addition to the automated updates to eligibility records, the Vendor must have the capability of accepting from authorized staff of the SEIB either verbal or written information for use in updating eligibility records. This method of updating the Vendor’s membership/eligibility system may be used for complex eligibility transactions, or to submit eligibility information to allow immediate claim processing.
The Vendor’s IT system must have the capability to provide an electronic file of all active members and dependents to compare and validate the Vendor’s membership information against that maintained by the SEIB.

The Vendor’s IT system must have the capability of linking any COB information for a member to the member’s eligibility records. The IT system must also be capable of linking all dependent information, and any COB information for each dependent, to the member’s eligibility records.

The Vendor’s system must be capable of editing any claim filed for a dependent first against the coverage history for the member to verify that family coverage is in effect for the service date; and second against the coverage history for the dependent to verify that coverage for the specific dependent is in effect for the claim service date. When the member or dependent coverage history does not support payment of a claim for the service date, the Vendor’s system must have the capability of automatically generating correspondence tailored to the State’s needs to inform the member of the eligibility requirements.

3.04 Medical Management – General
The Vendor must maintain an adequate number of medically trained staff in a unit dedicated to service this account. The dedicated unit will perform a variety of functions including provider credentialing support, network management, medical policy research, utilization management support, review of claims for abusive or excessive filings, specialized claim review, and appeals resolutions.

3.04.01 Medical Management – Provider Credentialing Staff
The Vendor must have available support staff to participate in on-site assessments of various facilities or providers. It is desirable that this staff have experience in provider credentialing and relations as well as hospital and medical audit experience.

3.04.02 Medical Management – Network Management
The Vendor must have established contracted provider networks that provide SEIB members with broad statewide access. The proposed network must have at least one general practice provider within a 35 mile radius of any ZIP Code in which eligible member resides. The networks must also involve comprehensive chiropractic, lab, and dental provider arrangements, again throughout the state. In addition, the SEIB has contracted independently with selected providers of mental health and chemical dependency services.

In all cases, the resulting fee arrangements must represent substantial discounts from normally applicable “retail” charges. The successful Proposer(s) would be expected to duplicate or exceed current arrangements and be prepared to document prospectively how these commitments will be met with network providers currently contracted within the State of Alabama.

This RFP is based on a serious good faith effort to consider competitive alternatives to the present arrangements. To be competitive, your organizational response to the RFP must fully address provider access and favorable pricing. The Vendor
should have comprehensive established networks in Alabama for the following provider types:

- Hospital;
- Physician;
- Mental Health/Substance Abuse;
- Dental;
- Lab Services;
- Durable Medical Equipment; and
- Telemedicine.

3.04.03 Medical Management – Medical Policy
The Vendor must maintain detailed medical policy guidelines for determining specific medical coverage issues. Such policy guidelines shall be updated and the SEIB furnished with copies of recommended decisions as well as back-up documentation, which support the policy recommendation. This documentation shall cite the credentials of the review panel and the basis on which coverage recommendations have been made.

In addition, the Vendor must periodically review and assess new technologies and provide policy and coverage recommendations to the plan.

Recognizing that such information may be proprietary, it is desirable for the Vendor to have basic knowledge of other large Group Plans’ (Medicare, SEIB, and private groups) coverage guidelines.

The SEIB must approve changes in policy for its plans.

3.04.04 Medical Management – Medical Necessity/Utilization Management
The plans offered by the SEIB include “medical necessity” requirements for reimbursement of medical and surgical expenses. The Vendor’s IT system should identify suspect claims because of an excessive number of units, visits, days, or the like and suspend these claims for further review. The Vendor must also review claims for nursing services, durable medical equipment and other similar services for statements of medical necessity. The review must include checking for reasonableness and customary practices. The Vendor must provide utilization management services that include the following:

- Precertification;
- Concurrent review;
- Discharge planning;
- Case Management;
- Disease management; and
- Gaps in Care.
For more information on the Utilization Management programs see the SPD at www.alseib.org.

3.04.05 Medical Management – Unbundling and Upcoding Software
The Vendor must have a fully automated claims auditing system in place that is clinically-oriented and designed to analyze coded claims data to ensure that CPT codes are correctly identified and reimbursed. The editing capability should also include:

- The determination of (and re-pricing where appropriate) procedure unbundling;
- Separate billing for incidental services;
- Simultaneous billing of mutually-exclusive procedures;
- Identification and management of incorrect use of CPT coding rules;
- Additional non-incidental surgical procedures;
- The denial of payment for same day care by physicians with same specialty;
- The denial of payment for surgical follow-up care within a reasonably short follow-up period;
- Age and sex appropriateness;
- Cosmetic procedures; and
- Assistant surgeon claims.

3.04.06 Medical Management – Specialized Claims Review
The Vendor must have on staff (and be accessible to SEIB personnel) an adequate number of medically trained personnel, whose primary duties include: assistance in evaluating claims for medical necessity and for conditions which may fall under the cosmetic procedure limitations of the plan, medical policy re-pricing, daily UR contact and bill verification, approval of DME, and applying specialized reimbursement guidelines on surgical claims.

The Vendor must have reasonable access to a physician advisor and in addition maintain contractual relationships with peer review organizations (medical, chiropractic, and dental) for determining (upon SEIB request) medical necessity or price variances.

The Vendor must have the ability to provide some of these services on a prospective basis when necessary.

3.04.07 Medical Management – Administer Appeals
The Vendor must provide for the fair and timely hearing of member grievances to denied services. Each appeal should:

- Ensure proper instruction from customer service;
- Maintain health care professionals who have appropriate expertise; and
Ensure fair, proper and consistent adjudication of the claim.

3.05 Dental Benefit Management
The Vendor must be able to administer the dental benefits outlined in Exhibit 3. The Vendor will be required to provide a comprehensive network of dental providers throughout the state. The Vendor will receive dental information electronically at the time of service, perform applicable review services, and subsequently provide claims adjudication services.

3.06 Financial Management – General
The Vendor’s IT system must be satisfactorily interfaced and integrated to minimize manual controls and transactions between the financial cash payment, reconcilement, and cash receivables systems.

The Vendor must establish acceptable internal controls and separation of duties (according to generally accepted accounting practices) for issuing drafts, controlling cash disbursement, canceling accounts receivable (claim refunds), voiding of drafts and reconciling bank statements.

The Vendor must have the capability of controlling adjustments to claim payments, such as returned drafts, voided drafts, and forged drafts. The Vendor must maintain documentation detailing the status and disposition of returned drafts. Voiding, re-issuing or other corrections to drafts must be made without changing the original claim data. Transactions for claim adjustments must be processed by:

- Reversing the previous reimbursement amounts and units of service in an exact image of the paid claim; and
- Processing a positive record of adjustment to the claim, if any, indicating the same information as if the adjustment were an original claim.

The Vendor must have the capability of transmitting a daily and quarterly electronic media and paper reports of these adjustments to the SEIB. Such adjustments must be reconcilable to the SEIB’s financial records.

The Vendor must have the capability of transmitting, on a monthly basis, paper reports, and electronic media; as outlined in the report section, in order for the SEIB to balance financial records and reconcile all differences in payments, receivables and outstanding drafts.

The Vendor must prepare and submit reports to satisfy the Federal Government requirements for payments to providers and/or members.

3.06.01 Financial Management – Data Management
The Vendor must stay current with industry standards and use the latest version of Current Procedural Terminology codes for procedures (CPT and HCPCS).
The Vendor must use conventions acceptable by the health insurance industry when coding and storing the hospital claim information, including revenue code, discharge status and continued confinement.

The Vendor should use already established unique codes for identifying items of durable medical equipment, home care, hyper alimentation, and other similar types of care.

The Vendor must be prepared to actively cooperate with other Sub-vendors and provide data to the claims analysis Vendor in furtherance of its efforts to reduce and control costs of the SEIB.

3.06.02 Financial Management – Claim Refunds and Adjustments

Claim overpayments may be identified by the Vendor or the SEIB. The Vendor shall be responsible for collecting all claim overpayments. The Vendor shall initiate the request for refund from the payee, or from the member if the provider has refunded the overpayment to the member. The SEIB desires the Vendor’s IT system to have the capability of reducing future benefit payments on behalf of the member by the amount of the overpayment.

The Vendor must adjust the member’s claim history and all maximum and deductible accumulators to reflect the refund by:

- Reversing the previous reimbursement amounts and units of service in an exact image of the paid claim; and
- Processing a positive record of adjustment (with explanation) to a claim, if any, indicating the same information as if the adjustment were an original claim.

The Vendor must have established internal controls over returned drafts.

The Vendor’s IT financial subsystem must have the capability to establish accounts receivable for requested claim refunds, record collection amounts, maintain balances, and control the claim history adjustment for unsolicited repayments. Reports (paper, electronic media, and tape) on the accounts receivable, collection activity, and claims history adjustment are outlined in this RFP.

3.06.03 Financial Management – Audit Procedures

The Vendor awarded the contract must supply the SEIB with documentation of the IT system to meet the standards as outlined in this section for performing audits. Prior to implementing any subsequent system modification requested by the SEIB and agreed to by the Vendor, the Vendor must document the modification and confirm the appropriateness of the design modification with the SEIB. The system modification must be tested through acceptable user testing processes prior to installation. The system documentation provided to the SEIB must be updated within thirty (30) days after implementation of the modification.

The Vendor must demonstrate the capability to control various approval levels based on staff assigned security codes.
The Vendor must maintain a structured internal review process using sampling techniques and conducted by supervisory staff for work performed by each claims adjudicator.

The Vendor must utilize its internal auditors to conduct a structured review of the work performed by each claims adjudicator. The Vendor will have completed by October 1 of each year an IT systems audit by an independent auditing firm which has had prior IT auditing experience with other fiscal agents. An independent auditing firm means an organization other than the CPA firm engaged as the Vendor’s corporate auditor. The selection of, and contract with, the independent auditor shall be subject to the approval of the SEIB. Since such audits are not intended to fully satisfy all auditing requirements of the SEIB, the SEIB reserves the right to fully and completely audit at his/her discretion the operation of the SEIB – including all aspects of the Vendor’s operation which have effect upon the SEIB – either on an interim audit basis or at the end of the SEIB fiscal year.

The independent auditing firm will simultaneously deliver identical reports of its findings and recommendations to the Vendor and to the SEIB within one (1) month after the close of each review period.

This audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for electronic data processing audits as defined in the publications of the American Institute of Certified Public Accounts entitled Statements on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. In addition to the usual and customary scope of this electronic data processing system audit, which includes the production of a report on both the design of the system, and also specific compliance tests that are directed to specific objectives of internal accounting control, the audit program for the audit must address all of the required features, but not limited to, the provisions for the operating system outlined in this RFP. The SEIB will use the findings and recommendations of each such report as part of its ongoing SEIB monitoring process.

The Vendor must respond to the audit findings and recommendations within 30 days of receipt of the audit and submit an acceptable proposed corrective action plan to the SEIB. The Vendor must implement the corrective action plan within 40 days of its approval by the SEIB.

The Vendor shall audit any organization utilizing EDI on a periodic basis and shall furnish the SEIB with a copy of the results of such audit. The Vendor agrees to audit any hospital provider and large multi-specialty physician group on a scheduled and structured basis no less frequently than every two (2) years or at the request of the SEIB. EDI claims entry must be conducted by an organizational unit independent of the Vendor’s dedicated unit processing claims for SEIB. Audits may be performed by the Vendor’s Corporate Internal Audit function or by an independent auditing firm.
3.06.04 Financial Management – Fraud and Abuse Controls

The Vendor must reimburse the SEIB for all losses and judgments due to error, fraud, misuse, and abuse of the EDI claims entry system by the provider or provider’s staff.

The Vendor must demonstrate through internal audits or other internal monitoring processes that processing controls are present and that the level of accuracy meets minimum standards. The Vendor must dedicate staff for detecting and documenting fraud and overutilization of benefits.

The Vendor must maintain medically trained staff to service this account.

The staff should be trained to look for signs of fraud including:

- hospital bills submitted directly by an employee;
- claim forms or medical bills with alterations (e.g., erasures, strikeouts or whiteouts);
- repeat accident claims of similar nature;
- no assignment of benefits to provider for large amounts; and
- post office box address where payment is to be sent.

The SEIB must have timely access to a full-time physician medical director in the employment of the Vendor. The Vendor must also maintain contractual relationships with peer review organizations (medical, chiropractic, and dental) for determining (upon request) medical necessity or price variances.

The Vendor must perform analyses on claim patterns and physician practice patterns to determine fraudulent and abusive filings. The Vendor must have the capability of performing statistical analyses of physician charges to look for potential areas of abuse. The Vendor must support the fact finding efforts by researching claim histories, corresponding with providers and employees, and performing analysis of the findings. If the SEIB pursues any legal action, the Vendor must assist the SEIB and, if required, testify in such proceedings. The Vendor’s obligations include information gathering, testifying, and analysis of findings.

It is desirable that the Vendor be a member of the National Health Care Anti-Fraud Association (NHCAA).

In addition to these basic elements, the Vendor must be able to satisfy the following cost control design requirements:

- The automated ability to “flag” individual service providers’ and/or employees’ records so as to suspend all claims for cases potentially involving fraudulent and/or abusive filings based on internally detected patterns of behavior or based on notification from the State of Alabama; and,

- The Vendor will cooperate with the SEIB’s independent claims auditing process.
3.06.05 Financial Management – Reports
The Vendor must submit raw claims data and standardized reports to the SEIB. The SEIB requires extensive reporting in the areas of cash, finance, claims statistics, types of claims cost/service utilization, areas of benefit payments, claims inventory, work statistics and every aspect of the claims processing/adjudication and financial systems. Reporting may be monthly, quarterly, semi-annually, annually or as required by the SEIB. The reports may be on paper, or acceptable electronic media.

3.06.06 Financial Management – Contract Termination
Upon termination or other expiration of the contract as a result of this RFP, all data, records, files and the like along with the appropriate guides, instructions, manuals, etc. that are held for the purpose of performance under the contract, shall be surrendered in a current and updated form to the SEIB. With the exception of the foregoing, each party shall forthwith return any copyrighted or proprietary documents, documentation, or other materials of the other held by each for the purpose of performance under the contract.

The Vendor and the SEIB will assist the other in the orderly termination of the contract and the transfer of all aspects hereof, tangible and intangible, as may be necessary for the orderly, non-disruptive business continuation of each party.

3.06.07 Financial Management – Performance Standards
The Vendor must hire, train, and retain staff to service the SEIB account in a manner that meets or exceeds the contracted performance requirements. Vendor performance shall be assessed by an independent auditor. Vendor must be prepared to provide the following performance standards:

A. Medical and Dental Performance Requirements Claims Processing Timeliness – During each year, 95% of all Claims received by the Claims Administrator during such year shall be processed within 14 calendar days of the receipt; provided that the Claims Administrator shall not be deemed to have failed to process any Claim if its failure to process such Claim within 14 calendar days of the receipt was the direct result of the SEIB’s failure, or the failure of any third party providing services for or on behalf of the SEIB or its Members, to furnish required information in a timely manner. If this standard is not met for the year, the SEIB shall be entitled to a credit equal to the following:

- Less than 95% but greater than or equal to 94%: 3% of the annual Administrative Fees;
- Less than 94% but greater than or equal to 93%: 4% of the annual Administrative Fees; or
- Less than 93%: 5% of the annual Administrative Fees.

B. Medical and Dental Claims Payment Accuracy – During each year, processing accuracy for claims processed during the year shall be at least 97%. The Processing accuracy rate for a year shall be determined by dividing the number
of correct claims by the total number of claims processed. If this standard is not met for the year, the SEIB shall be entitled to a credit equal to the following:

- Less than 97% but greater than or equal to 96%: 2% of the annual Administrative Fees; or
- Less than 96%: 3% of the annual Administrative Fees.

C. Medical and Dental Financial Accuracy – During each year, financial accuracy for claims processed during the year shall be at least 99%. Financial accuracy rate for a year shall be determined by dividing the actual amount of monies paid correctly by the total amount of monies that should have been paid. If this standard is not met for the year, the SEIB shall be entitled to a credit equal to the following:

- Less than 99% but greater than or equal to 98%: 3% of the annual Administrative Fees;
- Less than 98% but greater than or equal to 97%: 4% of the annual Administrative Fees; or
- Less than 97%: 5% of the annual Administrative Fees.

D. Member Satisfaction – A customer satisfaction survey must be developed and approved by the SEIB which will be administered quarterly. The results will be provided to the Chief Executive Officer of the SEIB. If an acceptable customer satisfaction survey is not approved and administered, the SEIB will be credited 5% of the quarterly Administrative Fees until an acceptable customer satisfaction survey is approved and administered.

E. Customer Service – All telephone calls will be answered with an average of 30 seconds or less wait time. If this standard is not met for the year, the SEIB will be credited 3% of the annual Administrative Fees.

The abandonment rate for all telephone calls received will be no greater than 2%. If this standard is not met for the year, the SEIB will be credited 3% of the annual Administrative Fees.

F. Report Production – A mutually agreed upon standard report package and data must be provided within 45 days after the end of each month. If such reports are not provided within 45 days after the end of each month, the SEIB will be credited 3% of the quarterly Administrative Fees.

3.07 Customer Service and Staffing

The Vendor must demonstrate commitments to quality services through customer feedback surveys, focus groups, provider groups, or other appropriate means. Internally, the Vendor must demonstrate how teamwork is fostered, monitored and rewarded. The Vendor must demonstrate commitment to and willingness to continuous improvement to enhance customer service and effectiveness.
The Vendor must provide a customer service unit dedicated to the SEIB between the hours of 8 a.m. to 5 p.m. Central Time.

The Vendor must maintain a cadre of staff trained in computer sciences to support ongoing IT maintenance as it relates to all software and hardware used to service this account.

The Vendor must maintain a dedicated unit of staff to perform claims adjudication and payment processes and support staff (if not included in the dedicated unit) to update membership, record transactions, control cash disbursement and reconciliation, produce the necessary reports and control records for refund collection.

The Vendor must designate an account executive who has authority to respond to the SEIB’s needs in a timely manner. This account executive must be able to make decisions or report to a person who can make decisions to add staff or make processing changes as required to service this account.

The Vendor must provide a full-time customer service representative at the SEIB office in Montgomery, Alabama

3.08 Benefit Books and Identification Cards

The Vendor must prepare and mail benefit books on an annual basis, make SPDs available, and identification cards as needed. All costs of printing and postage must be included in fees so no ad hoc costs are invoiced.

3.09 Other Services

The Vendor must provide SEIB staff with access to all files and data related to the SEIB in a timely manner.

The Vendor must provide drafts to be used for benefit payments.

The Vendor must provide claims forms and other forms required for the adjudication of claims.

The Vendor’s fee must include the cost of postage for services described in this RFP.

3.10 Services Under Consideration

The SEIB is considering the following added value services:

3.10.01 Telemedicine

The SEIB is considering adding a telemedicine benefit that provides members with 24/7/365 on-demand access to board-certified physicians to resolve common medical issues. Members could use the program for the following:

Non-emergency medical care;
When their primary doctor is not available;

When urgent care is not available;

After normal office hours;

When on vacation; and

Refills of recurring prescription.

3.10.02 Near-Site Clinics

The SEIB is considering expanding its preventive care and wellness program to include “near-site clinics”. The Board is looking to establish 10 to 12 clinics in various localities around the state. The clinics could provide members with access to local physicians for primary medical services, plus basic preventive and wellness services that compliments the SEHIP wellness program. The clinics also offer basic lab and x-ray services. The SEIB would like to provide the near-site clinic services to members with $0 copayment per visit. The clinics would be paid on a PEPM basis.

3.11 Implementation

The Vendor awarded the contract must designate an implementation team of the Vendor’s experienced staff in the areas of IT, finance, and claims adjudication. During the transition period, a minimum of two (2) team members trained in health claim data processing must be on-site at the SEIB offices a minimum of three (3) days per week, or as required at the discretion of the SEIB.

In order to assure full performance of all obligations imposed on a Vendor contracting with the SEIB, the Vendor will be required to provide a performance guarantee in the amount of $100,000.00. The performance guarantee must be submitted by the Vendor at least ten (10) calendar days prior to the contract start date. The form of performance guarantee shall be one of the following: (1) An irrevocable letter of credit or (2) Surety bond issued by a company authorized to do business within the State of Alabama. This performance guarantee shall be in force from the contract effective date through the term of the administrative services contract and ninety (90) calendar days beyond and shall be conditioned on faithful performance of all contractual obligations. Failure of the Vendor to perform satisfactorily shall cause the performance guarantee to become due and payable to the SEIB. The Chief Executive Officer of the SEIB or his designee shall be the custodian of the performance guarantee.
4.00 CONTRACT TERMS AND CONDITIONS
The successful Vendor who is awarded the contract is expected to agree to the following contract terms and conditions.

4.01 General
This RFP and the Vendor’s response thereto shall be incorporated into a contract by the execution of a formal agreement. The contract shall include the following:
1. Executed contract;
2. RFP, attachments, and any amendments thereto; and
3. Contractor’s response to the RFP.

4.02 Compliance with State and Federal Regulations
The Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. The SEIB retains full operational and administrative authority and responsibility over the SEHIP, as the same may be amended from time to time.

4.03 Term of Contract
The initial contract term shall be for three years effective January 1, 2017, through December 31, 2019. The SEIB shall have two, one-year options for extending the contract. The Vendor will provide pricing for each year of the contract, including any extensions.

The Vendor acknowledges and understands that this contract is not effective until it has received all requisite state government approvals and the Vendor shall not begin performing work under this contract until notified to do so by the SEIB. The Vendor is entitled to no compensation for work performed prior to the effective date of this contract.

4.04 Contract Amendments
No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

The contract shall be deemed to include all applicable provisions of the SEHIP and all state and federal laws and regulations applicable to the SEIB Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affect the operation of the SEIB or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.
4.05 Confidentiality
The Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract.

The Contractor shall ensure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the successful Contractor shall sign and comply with the terms of a Business Associate Agreement with the SEIB.

4.06 Security and Release of Information
The Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. The Contractor shall not release any data or other information relating to the SEHIP without prior written consent of the SEIB. This provision covers both general summary data as well as detailed, specific data. The Contractor shall not be entitled to the use of SEIB data in its other business dealings without prior written consent of the SEIB.

4.07 Contract a Public Record
Upon signing of the contract by all parties, the terms of the contract become available to the public pursuant to Alabama law. The Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of the Contractor's refusal to comply with this provision shall constitute a material breach of contract.

4.08 Termination for Bankruptcy
The filing of a petition for voluntary or involuntary bankruptcy of a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of the SEIB, constitute default by the Contractor effective the date of such filing. The Contractor shall inform the SEIB in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. The SEIB may, at its option, declare default and notify the Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from the Contractor.

4.09 Termination for Default
The SEIB may, by written notice, terminate performance under the contract, in whole or in part, for failure of the Contractor to perform any of the contract provisions. In the event the Contractor defaults in the performance of any of the
Contractor’s material duties and obligations, written notice shall be given to the Contractor specifying default. The Contractor shall have 10 calendar days, or such additional time as agreed to in writing by the SEIB, after the mailing of such notice to cure any default. In the event the Contractor does not cure a default within 10 calendar days, or such additional time allowed by the SEIB, the SEIB may, at its option, notify the Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from the Contractor.

4.10 Termination for Unavailability of Funds
Performance by the SEIB of any of its obligations under the contract is subject to and contingent upon the availability of monies lawfully applicable for such purposes. If the SEIB, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, the SEIB shall promptly notify the Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to the SEIB or the State of Alabama.

4.11 Proration of Funds
In the event of proration of the funds from which payment under this contract is to be made, this contract will be subject to termination.

4.12 Termination for Convenience
The SEIB may terminate performance of work under the Contract in whole or in part whenever, for any reason, the SEIB, in its sole discretion determines that such termination is in the best interest of the State. In the event that the SEIB elects to terminate the contract pursuant to this provision, it shall so notify the Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, the Contractor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

4.13 Employment of State Staff
The Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of the SEIB during the previous twenty-four (24) months without the written consent of the SEIB. Certain SEIB employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq., Code of Alabama 1975.

4.14 Immigration Compliance
The Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. The Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986.
and the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (Ala. Act 2012-491 and any amendments thereto) and certify its compliance.

4.15 Novation
In the event of a change in the corporate or company ownership of the Contractor, the SEIB shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and SEIB execution of the novation agreement, a valid contract shall continue to exist between the SEIB and the original Contractor. When, to the SEIB’s satisfaction, sufficient evidence has been presented of the new owner’s ability to perform under the terms of the contract, the SEIB may approve the new owner and a novation agreement shall be executed.

4.16 Employment Basis
It is expressly understood and agreed that the SEIB enters into this agreement with the Contractor and any subcontractor as authorized under the provisions of this contract as an independent contractor on a purchase of service basis and not on an employer-employee basis and not subject to Alabama State Merit System law.

4.17 Disputes and Litigation
Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of the Contractor and the RFP shall be controlled by the provisions of the RFP. Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Chief Executive Officer of the SEIB.

The Contractor’s sole remedy for the settlement of any and all disputes arising under the terms of this contract shall be limited to the filing of a claim with the Board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Contractor must proceed diligently with the performance of the contract in accordance with the disputed decision.

4.18 Records Retention and Storage
The Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the SEIB Program for a period of three years from the date of the final payment made by the SEIB to the Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the SEIB has begun but is not completed at the end of the three-year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution.

4.19 Inspection of Records
The Contractor agrees that representatives of the SEIB and their authorized representatives shall have the right during business hours to inspect and copy the Contractor’s books and records pertaining to contract performance and costs thereof. The Contractor shall cooperate fully with any such requests and shall
furnish free of charge copies of all requested records. The Contractor may require that a receipt be given for any original record removed from the Contractor's premises.

4.20 Payment
The Contractor shall submit to the SEIB a detailed monthly invoice for compensation for the deliverable and/or work performed. Invoices should be submitted to the Chief Executive Officer or his designee. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

4.21 Notices to Parties
Any notice to the SEIB under the contract shall be sufficient when mailed to the Chief Executive Officer. Any notice to the Contractor shall be sufficient when mailed to the Contractor at the address given on the return receipt from this RFP or on the contract after signing. Notice shall be given by certified mail, return receipt requested.

4.22 Disclosure Statement
The successful Vendor shall be required to complete a financial disclosure statement with the executed contract.

4.23 Not to Constitute a Debt of the State
Under no circumstances shall any commitments by the SEIB constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this Contract, be enacted, then that conflicting provision in the contract shall be deemed null and void.

4.24 Choice of Law
The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of law provisions. In the event any provision of this contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.
5.00 INSTRUCTIONS TO VENDORS

5.01 RFP Documentation
All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc., will be posted to the SEIB website at www.alseib.org.

5.02 Single Point of Contact
From the date this RFP is released until a Vendor is selected and announced by the SEIB, all communication must be directed to:

Slate Taylor (Consultant)  
Mercer Health & Benefits  
3560 Lenox Road, Suite 2400  
Atlanta, GA 30326  
(404) 442 3520  
Slate.taylor@Mercer.com

Subsequent to the opening of the sealed proposals, discussions for the purpose of clarification to assure full understanding of and responsiveness to the solicitation requirements may be conducted by the Consultant on behalf of the SEIB with responsible Vendors who submit proposals determined to have reasonable expectations of being selected for an award.

In conducting any such discussion, there shall be no disclosure of any information derived from proposals submitted by competing Vendors, including the name of a potential Vendor.

5.03 Restrictions on Communication with Staff
From the issue date of this RFP until a Vendor is selected and the selection is announced, the Proposers are not allowed to communicate concerning this RFP with any SEIB member or employee except as provided by existing work agreements. For violation of this provision, the State reserves the right to reject the proposal of the violator.

5.04 Intent to Quote and Vendor Minimum Qualifications Form
All potential proposers must indicate their intention to quote in writing and submit the Vendor Minimum Qualifications Form by March 31, 2016 at 5:00 PM Central Time. Regardless of cause, late submissions will not be accepted and the Vendor will automatically be disqualified from further consideration. It shall be the Vendor's sole responsibility to assure delivery to the Consultant by the designated deadline. Only those Vendors that submit an “Intent to Quote” form (Appendix A) and a “Vendor Minimum Qualifications Form” (Section 2.01) indicating that they intend to quote and certifying that they meet the minimum qualifications will receive copies of responses to questions, changes and updates. Your intent to quote should indicate your organization's primary contact, direct telephone number of contact, and e-mail
address. The “Intent to Quote” notification and the “Vendor Minimum Qualifications Form” should be sent to the Consultant.

5.05 RFP Amendments
The State reserves the right to amend the RFP prior to the date the proposals are due to be submitted. Amendments will be sent to all Vendors who return an “Intent to Quote” form located in Appendix A.

5.06 Submitting Questions
Vendors with questions regarding clarification or interpretation of any section within this RFP must submit them to the Consultant via email by April 5, 2016 at 5:00 P.M. Central Time. All questions and answers will be posted on the SEIB website.

5.07 Proposal Submission
All proposals must be submitted by April 29, 2016 at 5:00 P.M. Central Time. Proposals received after the 5:00 P.M. deadline will be rejected. Please note that individual exceptions to the deadline will not be made; if the Vendor relies on “overnight” delivery, this should be taken into consideration.

Proposals should be submitted to the Consultant at the address stated in section 5.02.

5.08 Copies Required
The Vendor must submit copies of proposal as follows:
- three hard copies of the Price Proposal;
- three hard copies of the Technical Proposal in binder form; and
- two electronic (Word format) copies of the Technical Proposal:
  - one complete version of the Vendor’s response; and
  - one version that redacts any information asserted as confidential or proprietary.

5.09 Late Proposals
Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Vendor’s sole responsibility to assure delivery to the Consultant by the designated deadline.

5.10 Proposal Offer and Withdrawal
A proposal may not be modified, withdrawn or canceled by the Vendor for a 180-day period following the deadline for proposal submission as defined in the Procurement Timetable, or receipt of best and final offer, if required, and the Vendor so agrees in submitting the proposal.

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting to the Consultant a written request for withdrawal which is signed by the Vendor.
5.11 Cost of Preparing Proposal
Cost for developing the proposal is solely the responsibility of the Vendor. The State will not provide reimbursement for such cost.

5.12 Right of Negotiation
Discussions, negotiations and requests for additional information regarding price and other matters may be conducted with the Vendor(s) who submit proposal(s) determined to be reasonably susceptible of being selected for award, but proposal(s) may be accepted without such discussions.

The Board reserves the right to further clarify and/or negotiate with the proposer(s) on any matter submitted. The Board may ask for best and final offers. The Board also reserves the right to move to the next best proposer(s) if negotiations do not lead to a final contract with the best proposer(s).

5.13 Price
The SEIB shall pay to the Vendor, on a monthly basis, the administrative fee set forth in the Price Proposal (Appendix D) submitted by the Vendor. The administrative fee per employee for each calendar year set out in the Schedule shall be fixed for each contract year. The fee must include all costs associated with servicing this account, including the costs of network administration and the interfaces with any Sub-vendor.

5.14 Order of Precedence
In the event of inconsistencies or contradictions between language contained in the RFP and a Vendor’s response, the language contained in the RFP will prevail. Should the State issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Vendor's proposal in the event of an inconsistency, ambiguity, or conflict.

5.15 State’s Rights Reserved
While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:
- Cancel or terminate this RFP;
- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);
- Negotiate with any Vendor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Vendor’s proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the SEIB website);
- Release a new RFP for the same or revised services;
- Not award any contract.

5.16 Use of Subcontractors/Joint Proposal/Separate Proposals
In the event a proposal is jointly submitted by more than one (1) organization, one (1) of the organizations must be designated as the prime Contractor. This prime Contractor must perform not less than eighty percent (80%) of the work to be proposed (as measured by price). All other participants in such proposal shall be designated as subcontractors.

5.17 Disclosure of Proposal Contents
Proposals and supporting documents are kept confidential until the evaluation process is complete and a Vendor has been selected. The Vendor should be aware that any information in a proposal may be subject to disclosure and/or reproduction under Alabama law. Designation as proprietary or confidential may not protect any materials included within the proposal from disclosure if required by law. The Vendor should mark or otherwise designate any material that it feels is proprietary or otherwise confidential by labeling the page as “CONFIDENTIAL” on the bottom of the page. The Vendor must also state any legal authority as to why that material should not be subject to public disclosure under Alabama open records law and is marked as Proprietary Information. By way of illustration but not limitation, “Proprietary Information” may include trade secrets, inventions, mask works, ideas, processes, formulas, source and object codes, data, programs, other works of authorship, know-how, improvements, discoveries, developments, designs and techniques.

Information contained in the Pricing Section may not be marked confidential. It is the sole responsibility of the Vendor to indicate information that is to remain confidential. The SEIB assumes no liability for the disclosure of information not identified by the Vendor as confidential. If the Vendor identifies its entire proposal as confidential, the SEIB may deem the proposal as non-compliant and may reject it.
6.00 PROPOSAL FORMAT AND CONTENT

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to “RFP: 2016 SEHIP ASO-01”. This section describes the format and requirements for submission of the proposal. Proposals that do not meet requirements listed below will be rejected. Each Vendor shall submit the proposal content as follows in two (2) separate parts:

6.01 Price Proposal

The first part must contain the documents as described below and be marked “Price Proposal” on the outside cover. Three (3) bound copies must be submitted.

The price proposal (s) shall present a firm, fixed fee per employee per month, as well as a percentage of paid claims for Calendar year 2017 and for each of the subsequent four (4) full Calendar years. The fee should include the total services as shown in this RFP. The Vendor must follow the instructions and complete the Price Schedule, as described in Appendix D, by entering the fees for all services proposed.

6.02 Technical Proposal

The second part shall be in 2 steps:

Step 1 - Provide separate:

- The signed, single document titled “Instructions for Medical TPA RFP Questionnaire”.

Step 2 - Provide the following sections together:

- The signed Proposal Certification and Vendor Minimum Qualifications Form in Sections 6.02.01 and 2.01, respectively, with supporting documentation;
- The Transmittal Letter in Section 6.02.02;
- Answers to Confirmations in Section 6.02.03; and
- Answers to Questionnaire in Section 6.02.04

Three hard copies of the Technical Proposal must be submitted. In addition, two electronic (Word format) copies (one complete version and one redacted version) must be submitted as well.

Note: The Vendor’s proposal document will become the property of the SEIB and will not be returned to the Vendor.
6.02.01 Proposal Certification

State of Alabama
State Employees’ Insurance Board

PLEASE ENSURE THAT ALL REQUIRED SIGNATURE BLOCKS ARE COMPLETE. FAILURE TO SIGN THIS FORM WILL RENDER YOUR PROPOSAL INVALID.

Proposal

We propose to furnish and deliver the deliverables and services named in the attached Request for Proposal for which prices have been set. It is understood and agreed that this proposal shall be valid and held open for a period of 180 days from proposal due date.

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

It is understood and agreed that we have read the State’s specifications shown or referenced in the RFP and that this proposal is made in accordance with the provisions of such specifications. By our written signature on this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications. We further agree, if awarded a contract, to deliver services which meet or exceed the specifications.

PROPOSAL SIGNATURE AND CERTIFICATION
(Proposer must sign and return with proposal)

I certify that this proposal is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a proposal for the same 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 award. I agree to abide by all conditions of the proposal and certify that I am authorized to sign this proposal for the proposer.

_________________________   _____________         ____________
Authorized Signature      Corporate Seal    Date
6.02.02 Transmittal Letter
The Proposer is required to submit a transmittal letter, which shall be in the form of a standard business letter on the Proposer’s letterhead and shall be signed by an individual authorized to legally bind the Proposer. It shall include:

A. A statement indicating that the Proposer has been licensed to insure health and accident insurance or to transact business as a health benefit Claims Administrator for at least five (5) years and is licensed in the State of Alabama as a corporation to conduct health and accident insurance business or is licensed as a non-profit health care corporation or is licensed to conduct the business of paying health claims on behalf of a self-insured health plan in Alabama. All Sub-vendors should be identified, and a statement included indicating the exact amount of work to be done by the prime Vendor (not less than 80%) and each Sub-vendor, as measured by price.

B. A statement that the Proposer does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability.

C. A statement that the person signing the proposal certifies that he/she is the person in the Proposer’s organization responsible for, or authorized to make, decisions as to the prices quoted and that he/she has not participated, and will not participate, in any action contrary to the above.

D. If the proposal deviates from the detailed requirements of this RFP, the transmittal letter should identify and explain these deviations, including deviations from current plan design. The SEIB reserves the right to reject any proposal containing such deviations or to require modifications before acceptance.

E. If the use of Sub-vendor(s) is proposed, a statement from each Sub-vendor must be appended to the transmittal letter signed by an individual authorized to legally bind the Sub-vendor and stating:
   1. The general scope of work to be performed by the Sub-vendor;
   2. The Sub-vendor’s willingness to perform the work indicated; and
   3. That they do not discriminate in their employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability.

F. The name and phone number of the individual(s) who can be contacted from 8:00 a.m. to 5:00 p.m. during business days for questions regarding your proposal.
6.02.03 Confirmations
Where indicated, state “AGREE” or “DISAGREE”. If you disagree, please provide an explanation.

A. The Proposer can meet or exceed the Scope of Work outlined in Section 3 and listed below:

- General Requirements
- Claims Processing – General
- Claims Processing – Coordination of Benefits
- Claims Processing – Other Third-Party Liability
- Claims Processing – Medicare
- Claims Processing – Supplemental Coverage
- Claims Processing – Inmate Hospital Services
- Claims Processing – Workers’ Compensation
- Claims Processing – Document Controls
- Claims Processing – Electronic Data Interchange
- Information Technology (IT) Systems – General
- IT Systems – Facility and Physical Security
- IT Systems – Data Storage and Access Control
- IT Systems – Inputs, Outputs, and Processing
- IT Systems – Provider Files
- IT Systems – Eligibility Information
- Medical Management – General
- Medical Management – Provider Credentialing Staff
- Medical Management – Network Management
- Medical Management – Medical Policy
- Medical Management – Medical Necessity/UM
- Medical Management – Unbundling & Upcoding
- Medical Management – Specialized Claims Review
- Medical Management – Administer Appeals
- Dental Benefit Management
- Financial Management – General
- Financial Management – Data Management
- Financial Management – Claim Refunds, & Adj.
- Financial Management – Audit Procedures
- Financial Management – Fraud and Abuse Controls
- Financial Management – Reports
- Financial Management – Contract Termination
- Financial Management – Performance Standards
- Customer Service and Staffing
- Benefit Books and Identification Cards
- Other Services
- Services Under Consideration
B. The Proposer accepts the Contract Terms and Conditions described in Section 4 and listed below:

- General
- Compliance with State and Federal Regulations
- Term of Contract
- Contract Amendments
- Confidentiality
- Security and Release of Information
- Contract a Public Record
- Termination for Bankruptcy
- Termination for Default
- Termination for Unavailability of Funds
- Proration of Funds
- Termination for Convenience
- Employment of State Staff
- Immigration Compliance
- Novation
- Employment Basis
- Disputes and Litigation
- Records Retention and Storage
- Inspection of Records
- Payment
- Notice to Parties
- Disclosure Statement
- Not to Constitute a Debt of the State
- Choice of Law

C. The Proposer accepts the additional conditions listed below:

1. The Proposer agrees that the account will have no minimum participation requirements. ________________

2. The Proposer guarantees the administrative fees for three (3) years and the option to renew for two (2) one-year agreements. ________________

3. The Proposer agrees that no commissions or overrides are to be payable to any agent or representative. ________________

4. The Proposer accepts subscribers and dependent eligibility definitions as defined by the SEIB. ________________
5. The Proposer agrees to accept IT enrollee eligibility and coverage data file on a daily basis. 

6. The Proposer agrees to, and will facilitate, on-site audits whereby the SEIB or other designated staff will periodically perform assessment and evaluation of performance.

7. The Proposer agrees to execute the final Administrative Services Agreement, within sixty (60) days of its receipt, if its proposal is determined to be the apparent winner.

8. The Proposer agrees the technical proposal will become an integral part of the Administrative Services Agreement.

9. The Proposer must use the employee’s contract number (assigned by the SEIB) as the unique employee identifier.

10. The Proposer agrees to provide monthly paid claims “raw” data in such detail and format as approved by the SEIB to the SEIB’s claims analysis Vendor.

11. The Proposer agrees to allow those prison inmates designated by the SEIB to have access to its hospital networks and receive the same discounted hospital services as offered to other members of SEIB plans.

12. The Proposer agrees to allow those employees covered under the State Employee Injury Compensation Trust Fund (Section 36-29A-1, et seq, Code of Alabama) to have access to its medical networks and receive the same discounted services as offered to other members of the SEIB plans.

13. The Proposer agrees to administer the current benefit structures without deviation.

14. The Proposer agrees to provide a full-time customer service representative at the SEIB office.
6.02.04 Questionnaire

**Important:** Please make sure you have read and completed the separate document entitled “Instructions for Medical TPA RFP Questionnaire.pdf” prior to preparing your responses.

In preparing your response to any RFP question or request for information, you should repeat each question followed by your response (an electronic copy of the RFP in MS Word is included with the RFP). Questions and answers should be in the same order as found in the RFP. The information contained in your response to this RFP will be used by the Board in determining whether or not you will be selected. “Will discuss” and “will consider” are not preferred answers. **If the Proposer is unable to answer a question, please indicate why the Proposer cannot.** If a particular question is not applicable please so indicate for each question. If the Proposer is unwilling to disclose particular information asked in a question, please indicate why not. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information which fails to answer the question.

The proposal the Board selects will be a working document. As such, the Board will consider the technical proposal an integral part of the contract and will expect that all representations made in the proposal will be honored. Please provide complete answers and explain all issues in a concise, direct manner. If you have additional information you would like to provide, include it as an appendix to your response. You must indicate in your written response to the questions the location of any additional material referenced in your response. All documentation submitted in response to this RFP and any subsequent requests for information pertaining to this RFP, shall become the property of the Board and will not be returned to the Vendor.

**FAILURE TO PROVIDE ALL REQUESTED INFORMATION MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.**

Questions outlined in this Section are asked in terms of the proposed implementation for the SEIB account. In responding to the questions, please indicate whether or not the Proposer can and is currently performing in the manner described, to what extent any development activity is required to meet the requirement, or if the Proposer cannot meet the requirement.

Make sure that:

- All appendices, exhibits, attachments, or enclosures are numbered;
- The exhibits show cross-references to the printed material; and
- The page number where the response is contained is shown on the exhibit.
A. Corporate Background & Experience
1. Indicate the total number and dollar amount of health benefit claims processed in Alabama and the total number and dollar amount of health benefit claims processed in the entire corporation in calendar year 2015.

2. Provide a list of the ten (10) largest organizations for which the Proposer currently provides self-insured health benefit claims processing and adjudication services. Indicate for each of these organizations the number of employees covered, the types of services being provided, the date upon which each contract began, the number of health benefit claims processed in 2015 and the amount of benefit dollars these claims represented. Provide the name, address and phone number of a person in each organization who can be contacted as an informed reference.

3. Provide audited financial statements for the organization for each of the last two (2) fiscal years.

4. Provide the most recent copy of an SAS70 report.

5. When was the company licensed in Alabama to conduct health and accident insurance business, to be a non-profit health care corporation, or to conduct the business of paying health claims on behalf of a self-insured health plan?

B. Location of Administrative and Servicing Functions
6. What is the address of the location from which administrative functions are provided?

7. What is the address of the location from which servicing functions are provided?

C. Legal and Liability
8. Provide proof of professional and comprehensive general liability insurance coverage, including stated amounts and limits. Would you be willing to list the Board as an additional insured?

9. Has your organization ever been involved in a lawsuit involving any area covered by this RFP? If yes, provide details including dates and outcomes.

10. During the past five years, has your organization, related entities, principals or officers ever been a party in any criminal litigation, whether directly related to this RFP or not? If so, provide details including dates and outcomes.

11. Do you require all providers to maintain professional liability coverage? If so, at what levels?

12. Has the Proposer ever been denied a state license, qualification or certificate of authority? If yes, please describe why.
D. **Claims Processing and IT System**

13. Describe how the Proposer will insure that all payments are in accordance with the approved benefit design or have written authorization by the SEIB.

14. To what degree will the Proposer tailor the various standard correspondence, including those generated through IT interfaces, to meet the State’s needs and style of communication?

15. Describe the general process of inspection for Medicare coverage.

16. Describe the methodology for assessing a claimant’s medical necessity. Include IT edits to identify questionable medical necessity (i.e., quantity by service).

17. Are COB records stored for each employee or each individual covered under the employee’s contract? Is Medicare considered COB? How many occurrences of COB information may be stored on the IT system simultaneously?

18. Provide a flow chart for handling COB claims. Describe any correspondence to the other carrier and employee during the process. Include information as to the level of automation used in the COB process. Also include information as to the wait time between steps and how other claims that may be filed will be affected during the wait time.

19. What does the Proposer do when there is a “no” response to other coverage on the claim and the IT file conflicts with the “no” other coverage?

20. Describe how the Proposer will identify enrollment in Medicare when a person reaches age 65.

21. Describe how the IT system identifies if a claim for a person over age 65 should be processed for secondary payment to Medicare.

22. Describe how a claim showing Medicare information on the claim will be processed.

23. What information is required when processing a claim in which Medicare is involved? Include information on whether or not the EOMB is sufficient without attached detailed claim information.

24. What coding structure is currently being used by the Proposer’s claims processing system to identify and record medical diagnoses? If a secondary diagnosis is present on a claim, is it coded and entered into the processing system? If a tertiary diagnosis is present on a claim, is it coded and entered into the processing system?
25. Does the processing system provide for entry, storage and retrieval of discharge status and continued confinement information from hospital claims?

26. What is the method of tracking, controlling, and retrieving other documents (EOBs, DCIs, etc.) used in the claims adjudication process?

27. Describe the Proposer’s policy for the SEIB’s access to records maintained on behalf of this account.

28. Does the Proposer delegate claims entry to providers? If yes, answer questions a. through i., below:

   a. What guidelines or policies are used in approving delegated claims entry to providers? Describe how the IT system will control the delegation to the provider.

   b. Describe the procedures and control of assigning passwords and user IDs to provider corporations. Include the confidential nature of assignment, how the passwords (IDs) are monitored for provider staff turnover, and how often the passwords are changed.

   c. Are providers provided VPN/Web access to SEIB data? Describe how the Proposer will conform to the access protection.

   d. Describe what controls, in addition to those installed for the on-site Proposer’s staff, will be installed in the Proposer’s IT system to safeguard against unauthorized access to SEIB data for on-line adjudication.

   e. How often will the Proposer perform an internal audit of any provider having delegated claims entry? Who will perform the audit? When will the SEIB receive a copy of the audit findings as such relates to the SEIB account?

   f. Outline the training that will be provided to the provider’s staff that will be performing the delegated claims entry. Include an outline of the content, frequency of training, and policy regarding requirements for training prior to claims entry.

   g. Describe how the Proposer will monitor the quality of work and adherence to policies regarding passwords, IDs, and training. What recourse will be taken for non-compliance with the policies?

   h. On what basis will the Proposer reimburse the SEIB for all losses and judgments due to error, fraud, misuse, and abuse of the delegated claims entry system?

   i. Describe the procedure for revocation of delegated claims entry.

29. Are you HIPAA and HITECH compliant?
30. What physical and logistical provisions will you make to separate SEIB data from that of other clients, or regular business accounts?

31. Explain how unauthorized attempts to access SEIB files will be monitored and controlled.

32. Do you have intrusion detection and monitoring tools, and are you conducting penetration testing and vulnerability scans?

33. Do you have a dedicated team to assess and respond to security vulnerabilities reported in your IT systems?

34. Do you have an incident response plan for network intrusions and virus incidents?

35. Do you have a business continuity plan and a disaster recovery plan?

36. Will you defend, indemnify, and hold harmless the SEIB, and, at your expense, notify our members and mitigate any harmful effects, in the event you or one of your business associates uses or discloses PHI in violation of HIPAA, the HITECH Act, or any applicable regulations?

37. Describe the application software to be used in the claims adjudication process. Provide the date the software was first installed on hardware of the Proposer, the current release number of the software, the name of the company that developed the software, and the programming language used in developing the application software. If the Proposer did not develop the software, what contractual provisions have been made to maintain and modify the system?

38. Describe the levels or identifiers at which claim expense can be reported and summarized.

39. What are the data and logical edits for identifying duplicate claims?

40. What claims data are edited against the eligibility file to verify coverage for the claimant?

41. What claims data are edited against the provider file to verify that charges are from a valid provider?

42. Generally, how is other group coverage identified?

43. How does the software assure that dollar or unit maximums for calendar year, benefit categories, deductibles, co-payments or stop-loss are not exceeded? Explain how the maximums are updated and maintained.

44. Explain how the benefit files will permit waiver of deductibles or payment at a higher percentage when certified by the SEHIP.
45. Describe how SEIB approved benefit parameters will be input, updated, and stored. Explain how claims will edit for the specific benefits approved based upon the date of service. How many different benefit time periods will the IT software support?

46. Provide a copy of the Explanation of Benefits (EOB).

47. Are multiple claims listed on the same EOB?

48. Does the employee receive an EOB for each claim payment made to a provider?

49. When is the EOB produced and mailed or emailed to the employee?

50. Explain how the Proposer notifies the employee and/or provider of claim payment delay. Include time, reason and type of correspondence.

51. Describe how the provider file is used in claims processing.

52. What is the coding convention used for the unique provider identifier? Describe how the IT system checks for separate billing offices, (i.e. a clinic versus individual).

53. Describe how the Proposer will establish cross-reference to the currently used provider references in the claim records in order to edit for duplicate payments.

54. List the employee data elements maintained in the Proposer’s IT system.

55. List the dependent data elements maintained in the Proposer’s IT system.

56. Describe or list the manual or computer edits for validating that the claim is filed for an eligible employee and an eligible dependent.

57. Will the Proposer’s computer system accept daily information transmitted via secure file transfer protocol (secure FTP)? If variable inputs present difficulty, describe maximum flexibility in updating information.

58. How many days are required to update the eligibility/membership records? Include the process to match the State and the Proposer’s eligibility files for discrepancies.

59. Describe how the IT system is affected when retroactive updates are processed and when prospective actions are processed.

60. How are dependent records linked to the employee records?

61. How often will the Proposer accept secure FTP transmitted information of the current membership/eligibility file and match against the Proposer’s eligibility
file for discrepancies? Describe or provide a copy of the discrepancy report that will be transmitted to the SEIB.

62. Outline the IT system edits to control the level of monetary benefit approvals by staff members. List the dollar thresholds and the basis (experience, position) for the approval levels. Indicate the positions and organizational placement of the reviewers.

63. Describe the Proposer’s quality control procedures for assuring accurate claims payment. Include an explanation of sampling techniques used by the supervisory staff for internal review of the work processed by each claims adjudicator. Also include the frequency and sampling techniques used by staff external to the assigned unit who performs quality control reviews.

E. Provider Network Management

64. Describe, in detail, your proposal to provide statewide networks with hospitals, physicians, and other health service providers (e.g., dental, lab, chiropractic, home health, DME). Include a complete discussion of:
   a. Your approach to provider selection;
   b. Your approach to provider credentialing, initially and ongoing;
   c. Your approach to provider contracting and payment;
   d. How you will protect SEIB members from balance billing by participating providers; and
   e. Your approach to network quality assurance and management.

65. Provide in an Excel spreadsheet format a listing of the hospitals, physicians, and dental providers with which your organization contracts in Alabama, including (for physicians) the practice specialty as required in Appendix C. Include the provider’s name and office zip code.

66. Provide network information as described on the Network Provider Form in Appendix B.

67. State any guarantees your organization is prepared to offer with respect to year-over-year savings with respect to network costs escalation. Be very specific and detailed in your response.

68. Are contracted network providers precluded from balance billing patients for amounts over and above the negotiated reimbursement amount i.e., the patient is held harmless?

69. Provide a list showing the status (e.g., Excellent, Commendable, Accredited, Provisional Accreditation, Denial, Expired, etc.) of the accreditation review by the National Committee for Quality Assurance (NCQA) of all PPO networks within your health plan which would be serving the SEIB.
70. How do you propose to resolve disputes between plan participants and providers? Describe your grievance procedures in detail, including your average time schedule for resolution.

71. What standards of provider performance are monitored and what are the targets? If the answer varies from network-to-network, provide a separate answer for each network.

72. What is the process for improving provider performance that does not meet standards? If the answer varies from network-to-network, provide a separate answer for each network.

73. Please describe how you are working with your contracted providers to help promote transparency as it relates to provider cost and quality metrics.

74. Please describe your current and future planned capabilities for Value-Based Care (VBC) programs. Will any provider payments for SEHIP be “variable payments” covered by VBC agreements? This includes any payments that are based on performance (cost, quality, patient satisfaction) or member attribution. This may include care coordination fees, shared savings agreements, performance guarantees, or other types of fees that are generated on a performance basis not covered through a fee-for-service arrangement. If yes, please describe.

75. List all the SEIB locations where you lease, rather than own, the network(s). Indicate the name(s) of the leased network you utilize in each location.

76. For out-of-network claims, please describe your reasonable and customary fee profile. How often is it updated? What percentile is used?

77. Briefly describe the process that allows the SEIB and its participants to recommend a physician for addition to the network.

78. Confirm you will notify the SEIB prior to any hospital leaving the network.

79. Will there be significant changes in the service area boundaries for the network offered to the SEIB on or after the plan’s effective date?

80. Are there any large physician groups in the network your organization is proposing for the SEIB that will expire in the next six months?

81. Are there any hospital contracts in this network that will expire in the next six months?

82. Describe in detail your Telemedicine program, including participation levels, average member cost of a visit and whether telephonic visits are available.
83. Do your provider networks include “near-site clinics” that provide for minor conditions, plus basic preventive and wellness services? If yes, please describe in detail.

F. Medical Management

84. Complete the following staffing levels for calendar year 2015:

<table>
<thead>
<tr>
<th>Staffing – Full-time equivalent employees</th>
<th>Utilization Management Services</th>
<th>Mental Health</th>
<th>Case Management</th>
<th>Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time equivalent RNs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time equivalent MDs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time MDs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

85. Provide the total number of MDs employed by your organization to provide utilization management services. Break out the number by physician's specialty.

86. Describe the medical expertise to be used in evaluating medical necessity. Outline the relationship of this expertise (i.e., Sub-vendor, peer review committee, staff) with the Proposer. Indicate where in the Proposer’s organization this staff is assigned. If medical expertise is on staff, specify the level of medical training (i.e., LPN, RN, MD).

87. Provide the number and types of new staff you would need to hire to implement and administer the contract.

88. Are any portions of the review processes subcontracted to other organizations? If so, please describe the sub-contracted arrangement.

89. What are your days and hours of operation for utilization management services? Please use central time zone.

90. Are you URAC, NCQA or JCAHO accredited? If yes, full or provisional? If no, please submit your quality improvement work plan for year 2015.

91. Indicate the specific medical/surgical criteria and/or guidelines used to conduct utilization review in both the inpatient and outpatient areas utilizing the format below. Check all appropriate areas:
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Inpatient</th>
<th></th>
<th>Outpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milliman</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>InterQual</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Internally developed</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Other: (indicate specific criteria)</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

92. If you use internally developed clinical criteria, are they cross-matched to other published medical criteria such as Milliman or InterQual? If so, what is the frequency of this process?

93. Please describe your process for updating clinical protocols including the frequency of updates.

94. What is your average turnaround time from receipt of complete clinical information to the rendering of a certification decision?

95. While performing concurrent review, if it is determined that continued stay is not medically necessary, what is your procedure for notifying the member and the provider(s)?

96. Is there a formal panel of physician specialists to review cases? If yes, how many physicians are on the panel? How many physician specialties are represented? Are the physicians board certified?

97. Describe the processes followed when a planned medical or surgical admission fails to meet the medical necessity criteria used by your medical review staff. At what stage of the review does physician-to-physician communication initiate?

98. What is the time frame from the patient/provider initiating an appeal to your response to them?

99. How are the patient and provider notified of the outcome of their appeal?

100. Please complete the following table for business handled during 2015.

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of cases authorized</th>
<th>Number of cases non-authorized</th>
<th>Number of cases appealed</th>
<th>Number of cases overturned on appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
101. What percentage of admissions was referred to the case management program during 2015?

102. Do case managers utilize an automated system for documentation? If yes, indicate which of the following components of the case are documented in the system:

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date referred / identified</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Date accepted</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Case management assessment and problem identification</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Case management dates of monitoring / communication with patient, family and providers</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Case management evaluation / goal-specific outcomes monitoring</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Date of closure and reason code</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Reporting / cost savings analysis</td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

103. Which diagnoses are managed within your disease management programs?

104. Please identify the total number of members managed within the disease management programs by diagnosis for calendar year 2015.

105. For the various diagnoses managed, please provide a description of how you identify members potentially at risk.

106. Is your disease management program an opt-in or an opt-out program?

107. Describe your review program that handles transplant request. Do you survey provider satisfaction? If so, please provide the results of your latest survey.

108. Explain how you handle out-of-area emergency and non-emergency care.

109. List all of the health education programs and prevention programs you provide and attach examples of each.

110. What is the annual turnover rate for your primary care providers?

111. Please provide the following utilization statistics: Hospital days / 1,000, outpatient physician visits / 1,000, emergency room visits / 1,000, and ambulatory surgery visits / 1,000 for calendar year 2015; specifically, we are requesting Alabama’s active book of business data only – without any Medicare, SEIB or CHIP information. Additionally, please specify the average age of this population.

112. Please describe specific procedures and programs that assure a member is not “under treated.”
113. Describe in detail the quality control procedures and staffing to detect fraud, abuse and over-utilization, including the use of peer review committees. Include the types of medically trained personnel on staff for performance of these functions.

114. Describe in detail your Gaps in Care program.

G. Financial Management

115. Demonstrate standard data reporting capabilities as follows:
   a. Specify 10-key reports recommended for this account;
   b. Provide an example of each key report;
   c. Indicate the reporting cycle of each key report;
   d. Explain the purpose of each key report and what it will monitor; and
   e. Describe the usefulness of each key report and how it can be used to pinpoint problems.

116. Describe the claim funding process and address the following points:
   a. Payment options;
   b. Billing frequency;
   c. Due dates;
   d. Grace period;
   e. Late payment procedures;
   f. Interest penalties;
   g. Automated Clearing House (ACH) payments and/or wire transfer requirements; and
   h. Advance deposit requirements.

117. Describe the administration fee billing process and address the following points:
   a. Payment options;
   b. Billing frequency;
   c. Due dates;
   d. Grace period;
   e. Late payment procedures; and
   f. Interest penalties.
118. Provide Alabama book-of-business actual health care expenses per member per month (PMPM). The term “member” includes all active employees and their covered dependents net of any membership enrolled in Medicare, SEI B and CHIP.

<table>
<thead>
<tr>
<th>Category</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services: Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services: Specialty Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Average Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Contract Size</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

119. Provide a sample copy of your employer’s invoice of claims paid and an explanation of payment terms.

120. Describe the proposed cash system. Include any proposed bank to be used, the method of accepting the drafts issued, and the proposed method of satisfying the bank for service costs.

121. Describe internal cash controls. Include control of spoiled drafts, balancing (batched cash totals), and signature from the time of approval of payment to time the draft is in the mail.

122. Describe the proposed cash control system for handling adjustments for claims, returned drafts, voided drafts, and stale dated drafts.

123. Outline the Proposer’s capability to transmit electronically showing drafts cleared, outstanding drafts at month end, and outstanding accounts receivable at month end.

124. Describe the proposed system for collecting claim overpayments. Include the method used to adjust claims history for a requested refund or repayment when not requested.

125. Describe any IT system capability for collecting overpayments through reducing future benefits.

126. Other than the performance standards outlined in this RFP, describe any other performance standards to which your organization is prepared to commit.
127. Describe the service that is included in this proposal that the Vendor will provide for analyzing claim patterns, fact finding, information gathering, and analysis of findings.

128. Describe the IT system edits for flagging individual provider or employee records to isolate aberrant claim filings.

H. **Customer Service and Staffing**

129. Describe the telephone system proposed for customer service. Include the location of the system, monitoring and reporting capabilities, and automated messages provided to callers.

130. Specify the days and hours of normal customer service access.

131. Describe how telephone calls are documented.

132. Describe the experience requirements for your customer service representatives.

133. Describe your training program for customer service representatives.

134. Describe your quality assurance program for customer service representatives.

135. Describe how claim problems can be resolved during a call. What types of problems do the customer service representatives have authority to resolve "on the spot?"

136. How are telephonic responses to telephonic inquiries documented?

137. What has been your enrollee satisfaction rating each year over the last two years?

138. Provide an organizational chart of the proposed dedicated unit for the SEIB contract account.

139. Describe the staff unit that will be assigned to support the IT requirements of the SEIB account. Identify the number of staff assigned by organizational placement, physical location, job title, and programming experience.

140. Describe the types and levels of other support staff, such as in the areas of eligibility/membership, cash disbursement, etc. Provide the number and location of support staff by function to be assigned to this account.

141. Provide the name and qualifications of the individuals who will be directly involved in the daily administration of this contract.

142. What authority will the dedicated account executive be given for making changes to processing and to assigning additional resources?
143. Who will have authority to add resources over and above that budgeted for this contract?

144. What is the staffing turnover (terminations of all kinds and promotions out of the area) percentage in the claims processing areas during the last two (2) 12-month periods?

I. Implementation

145. Prepare a work plan for completing the transition and implementing the contract as a result of this RFP. The work plan should include any critical tasks or dates. Include for each task a “start” and “finish” date with respective responsibilities (SEIB, Current Vendor or Proposer). Specify any assumptions made for SEIB staff responsibilities or requirements and the associated time required.

146. Identify the number of people by area of expertise to be assigned to the transition team. Indicate by area of expertise the number of full-time team members, part-time members and “as needed” team members.

147. Describe how the Proposer will convert the current Vendor’s claim payment records and claim histories. Specifically describe how the Proposer will handle conversion of the current Vendor’s coding structure to that used by the Proposer. Specifically describe how the Proposer will identify specific claims and how this unique claim identifier will be cross-referenced to the current Vendor’s unique claim identifier.

J. Health Care Reform

148. Detail your process for providing briefings on changes due to PPACA. Specifically detail how it will be communicated and the timing associated with the briefing.

149. How often are preventive care requirements due to PPACA updated to ensure compliance? Detail the communication method as well as timing of the update. Please confirm there is at least 30 days’ notice of any changes due to PPACA.

150. Confirm that you will administer the plan to comply with the cost sharing limits applicable to large employer plans pursuant to Section 2707(b) of the PHSA and Section 1302(c) of PPACA. Specifically, describe whether you have system capabilities to embed a member out of pocket maximum for members in dependent coverage inside an aggregate out of pocket maximum.

151. Describe the assistance provided in 1094-C and 1095-C reporting which is used to report to the IRS summary information for each employer. Detail the type of support you can provide including data files provide to the SEHIP.
152. Describe the type of support you will provide to SEHIP as it relates to the minimum essential coverage of the plan. Confirm you will attest to the minimum essential coverage for the plan.

153. Describe the type of support you will provide to SEHIP as it relates to the creditable coverage in relation to Medicare part D of the plan. Confirm you will attest to the creditable coverage as it relates to Medicare Part D of all plans.

154. Please confirm that you will assist SEHIP in the event that it has to appeal any Code Section 4890H shared responsibility penalty that may be assessed against SEHIP based upon coverage during the plan year.

155. Please confirm that you will provide such assistance as to permit SEHIP to meet all applicable deadlines and other requirements of the shared responsibility penalty appeals process as they may be set forth by regulators.

156. Confirm that you will make a reasonable determination as to which benefits are considered Essential Health Benefits (EHBs), and administer the plan so as to remove all annual dollar limits on those benefits as required by Section 2711 of the PHSA.

157. Confirm that you will continue to revise your definition of EHBs to comply with any new guidance that may be issued and that you will alert SEHIP as to those revisions and prepare a communication to participants if necessary.

158. Will you make a good faith, reasonable effort to comply with Section 2709 of the PHSA, which mandates coverage for clinical trials, in accordance with FAQ XIV, Q/A 3 (issued Apr. 23, 2013)?

159. Confirm that you will comply with any future guidance that is issued concerning the implementation of the coverage mandate for clinical trial coverage.

160. Will you make a good faith, reasonable effort to comply with Section 2706 of the PHSA, which prohibits discrimination against health care providers, in accordance with FAQ XIV, Q/A 2 (issued Apr. 23, 2013)?

161. Confirm that you will comply with any future guidance that is issued concerning the prohibition of discrimination against health care providers.

162. Confirm that you will provide SEHIP with any information required to meet its reporting obligations under the Affordable Care Act.

163. What will be the method for communicating with SEHIP about ACA changes?

164. Confirm that you will support SEHIP’s compliance with the W-2 reporting requirement for the cost of employees’ health coverage, in accordance with applicable IRS guidance, for example by providing information upon request.
165. Confirm that you will prepare new uniform summaries of benefit coverage (SBCs) that comply with applicable government regulations in advance of open enrollment.

166. Confirm that you will agree to provide draft of SBC no later than August 1 (or within 5 business days of final plan design decisions being communicated to you).

167. Confirm that you will work with SEHIP in the days following delivery of the draft SBC to revise the SBC as may be necessary in a timely manner.

168. If you are not going to prepare new uniform summaries of benefit coverage (SBCs), how do you support employers in the preparation of their SBCs? Confirm that you will review and confirm the accuracy of the SBC as prepared by SEHIP, and provide the results of your review on a timely basis.

169. For requests made by a member directly to your organization, will you provide the SBC to the participant within seven business days of the participant’s request?

170. Confirm that you will reissue the SBCs (or provide some other notice of the change as may comply with the final rules) at least 60 days in advance of any mid-year change to the SBC content.

171. Confirm that you will complete all necessary state and local filings wherever possible under applicable laws and regulations, and where not possible, you will provide assistance to SEHIP as needed. Confirm that you will notify SEHIP if you will not be conducting a specific filing.

172. Confirm that you will support SEHIP with the reporting required by Code Section 6055.

173. Is there any assistance that you intend to provide to employers with respect to the Code Section 6055 reporting? If yes, describe.

174. Confirm that you will support SEHIP in submitting its IRS filing under Code Sections 6056.

175. Is there any assistance that you intend to provide to employers with respect to the Code Section 6056 reporting? If yes, describe.

176. Confirm that you will comply with any additional guidance concerning the reporting obligations under Sections 6055 and 6056.

177. Will you be making reasonable efforts to obtain the necessary taxpayer ID numbers (TINs) for all covered individuals as described in Treas. Reg. 1.6055? If not, what assistance, if any, can you provide to SEHIP in its efforts to obtain the necessary TINs?
178. Will you provide any assistance to employers who want to electronically furnish the reporting pursuant to Sections 6055/6056? Will you require any assistance from SEHIP?

179. Confirm that you have the capability to calculate the PCORI fee for SEHIP, including calculating the number of covered lives according to applicable regulations. If not, confirm that you will support SEHIP by providing necessary data and assistance if needed for SEHIP to calculate the PCORI fee.

180. Confirm that you will support SEHIP by providing data and assistance (as needed) for SEHIP to pay the PCORI fee via a Form 720.

181. Please confirm that you will comply with any future guidance concerning collection of these fees.

K. Data Security

<table>
<thead>
<tr>
<th>Policy or Procedure</th>
<th>Yes/No</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Code of Conduct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Account Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Passwords</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Data Classification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Third Party Information Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Mobile Computing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Use of Cryptography (for data in motion and at rest)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Operational Management (e.g. including but not limited to change management and software development, incident and breach response, vulnerability and patch management, network security including firewalls and intrusion detection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Disaster Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Data Secure Disposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Email and Internet Appropriate Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Privacy Policy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Exhibit 1. Enrollment History

<table>
<thead>
<tr>
<th>TIME PERIOD</th>
<th>SEHIP</th>
<th>SUPPLEMENTAL</th>
<th>INMATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2014</td>
<td>51,021</td>
<td>1,616</td>
<td>27,310</td>
</tr>
<tr>
<td>Feb 2014</td>
<td>50,956</td>
<td>1,612</td>
<td>27,199</td>
</tr>
<tr>
<td>Mar 2014</td>
<td>50,920</td>
<td>1,613</td>
<td>27,027</td>
</tr>
<tr>
<td>Apr 2014</td>
<td>51,024</td>
<td>1,632</td>
<td>26,936</td>
</tr>
<tr>
<td>May 2014</td>
<td>51,073</td>
<td>1,633</td>
<td>26,795</td>
</tr>
<tr>
<td>Jun 2014</td>
<td>51,093</td>
<td>1,630</td>
<td>26,895</td>
</tr>
<tr>
<td>Jul 2014</td>
<td>51,168</td>
<td>1,621</td>
<td>26,673</td>
</tr>
<tr>
<td>Aug 2014</td>
<td>51,195</td>
<td>1,621</td>
<td>26,643</td>
</tr>
<tr>
<td>Sep 2014</td>
<td>51,245</td>
<td>1,616</td>
<td>26,702</td>
</tr>
<tr>
<td>Oct 2014</td>
<td>51,197</td>
<td>1,615</td>
<td>26,663</td>
</tr>
<tr>
<td>Nov 2014</td>
<td>51,155</td>
<td>1,607</td>
<td>26,638</td>
</tr>
<tr>
<td>Dec 2014</td>
<td>51,222</td>
<td>1,602</td>
<td>26,625</td>
</tr>
<tr>
<td>Jan 2015</td>
<td>51,435</td>
<td>1,600</td>
<td>26,424</td>
</tr>
<tr>
<td>Feb 2015</td>
<td>51,385</td>
<td>1,610</td>
<td>26,306</td>
</tr>
<tr>
<td>Mar 2015</td>
<td>51,419</td>
<td>1,622</td>
<td>26,145</td>
</tr>
<tr>
<td>Apr 2015</td>
<td>51,464</td>
<td>1,629</td>
<td>26,238</td>
</tr>
<tr>
<td>May 2015</td>
<td>51,411</td>
<td>1,606</td>
<td>26,024</td>
</tr>
<tr>
<td>Jun 2015</td>
<td>51,348</td>
<td>1,611</td>
<td>26,079</td>
</tr>
<tr>
<td>Jul 2015</td>
<td>51,343</td>
<td>1,600</td>
<td>25,863</td>
</tr>
<tr>
<td>Aug 2015</td>
<td>51,342</td>
<td>1,591</td>
<td>25,930</td>
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<tr>
<td>Sep 2015</td>
<td>51,250</td>
<td>1,580</td>
<td>25,695</td>
</tr>
<tr>
<td>Oct 2015</td>
<td>51,172</td>
<td>1,573</td>
<td>25,661</td>
</tr>
<tr>
<td>Nov 2015</td>
<td>51,036</td>
<td>1,574</td>
<td>25,648</td>
</tr>
<tr>
<td>Dec 2015</td>
<td>51,026</td>
<td>1,573</td>
<td>25,802</td>
</tr>
</tbody>
</table>
Exhibit 2. Employee Count by ZIP Code

(See Excel file)
Exhibit 3. Summary Plan Descriptions

See PDF files for:

State Employees’ Health Insurance Plan
Supplemental Health Insurance Plan

For additional detail, please visit the SEIB website:
www.alseib.org
Exhibit 4. Claims Payment Summary

**2015 Calendar Year Claim Counts**

<table>
<thead>
<tr>
<th>Subset</th>
<th>State</th>
<th>Supplemental</th>
<th>Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees Avg</td>
<td>51,330.9</td>
<td>1,606.1</td>
<td>26,219.2</td>
</tr>
<tr>
<td>Members Avg</td>
<td>88,781.1</td>
<td>4,802.2</td>
<td>26,219.2</td>
</tr>
<tr>
<td>Family Size Avg</td>
<td>1.7</td>
<td>3.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Admits Acute</td>
<td>8,385</td>
<td>171</td>
<td>1,372</td>
</tr>
<tr>
<td>Days Admit Acute</td>
<td>43,800</td>
<td>727</td>
<td>4,259</td>
</tr>
<tr>
<td>Days LOS Admit Acute</td>
<td>5.22</td>
<td>4.25</td>
<td>3.10</td>
</tr>
<tr>
<td>Svcs Med</td>
<td>4,073,007</td>
<td>94,026</td>
<td>201,679</td>
</tr>
<tr>
<td>Svcs OP Lab</td>
<td>846,463</td>
<td>16,223</td>
<td>22,786</td>
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<tr>
<td>Svcs OP Med</td>
<td>3,456,203</td>
<td>84,743</td>
<td>123,647</td>
</tr>
<tr>
<td>Svcs OP Rad</td>
<td>300,311</td>
<td>4,648</td>
<td>28,070</td>
</tr>
<tr>
<td>Visits ER</td>
<td>29,050</td>
<td>887</td>
<td>1,489</td>
</tr>
<tr>
<td>Visits Office Med</td>
<td>783,941</td>
<td>28,697</td>
<td>0</td>
</tr>
<tr>
<td>Visits OP Fac Med</td>
<td>246,520</td>
<td>3,432</td>
<td>14,828</td>
</tr>
<tr>
<td>Visits OP Prof Med</td>
<td>1,128,838</td>
<td>33,859</td>
<td>41,706</td>
</tr>
<tr>
<td>Scripts Rx</td>
<td>2,057,281</td>
<td>120</td>
<td>0</td>
</tr>
<tr>
<td>Net Pay Med</td>
<td>$260,046,270.40</td>
<td>$2,199,659.46</td>
<td>$36,958,935.75</td>
</tr>
<tr>
<td>Net Pay Rx</td>
<td>$131,964,525.49</td>
<td>$873,069.75</td>
<td>$-</td>
</tr>
<tr>
<td>Net Pay Dental</td>
<td>$16,863,705.94</td>
<td>$571,230.80</td>
<td>$-</td>
</tr>
<tr>
<td>Net Payment</td>
<td>$408,874,501.83</td>
<td>$3,643,960.01</td>
<td>$36,958,935.75</td>
</tr>
</tbody>
</table>
Appendix A. Intent to Quote Form

Return by: 5:00PM, CDT, March 31, 2016

State Employees’ Insurance Board
Request for Proposal
Medical and Dental Benefits Administration
Release Date: 03/24/2016

We have received the invitation to respond to the State Employees’ Insurance Board RFP for Medical and Dental Benefits Administration, and have the following intentions:

Check below:

☑   We decline to bid at this time.
☑   We intend to submit a proposal.

Company Name: ______________________________________

Contact Person: ________________________________________

Address: ______________________________________________

Phone: ________________________________________________

Email: _________________________________________________

Authorization:

______________________________  _______________________
Name and Title                      Date
Appendix B. Network Provider Form

Provide the organization that owns the medical networks you’re proposing to utilize, each county in which the network is present, and number of unique physicians and hospitals by county in which the network is present.

<table>
<thead>
<tr>
<th>County</th>
<th>Network / Owner</th>
<th>Number of Physicians</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autauga</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baldwin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calhoun</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elmore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etowah</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Houston</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jefferson</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montgomery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morgan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pike</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Clair</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Talladega</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tallapoosa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuscaloosa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remaining Counties</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B. Network Provider Form (continued)

For the network you are proposing, please respond to all questions for the following Major Service Areas (MSAs):

**MSAs**
- Birmingham, AL
- Huntsville, AL
- Mobile, AL
- Montgomery, AL
- Tuscaloosa, AL

Please provide the total number of *unique* contracted providers in the key MSA locations for the service types listed below.

<table>
<thead>
<tr>
<th>Type</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatricians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Please ensure that each provider is only counted once. For example, if a PCP is board certified to do annual exams, he/she shouldn’t be counted twice (as both an Internist and Gynecologist) on your network panel.
Appendix B. Network Provider Form (continued)

To enable the SEIB to accurately compare the accessibility of each Vendor’s network, we are requesting network accessibility reports from each Vendor. The required access standards are described below. Note that access must be based on the employee’s home ZIP Code.

Census data for the SEIB is included in Exhibit 2. The failure to include all employees in the analysis will require your organization to redo the reports. Please include the following locations in your analysis:

**MSAs**
Birmingham, AL  
Mobile, AL  
Huntsville, AL  
Montgomery, AL  
Tuscaloosa, AL

**Counties**

Autauga  Baldwin  Calhoun  
Dallas  Elmore  Etowah  
Houston  Jefferson  Lee  
Montgomery  Madison  Mobile  
Morgan  Pike  St. Clair  
Talladega  Tallapoosa  Tuscaloosa  
Remaining Counties

To ensure quality and consistency in the comparison of networks, the preferred method of measuring the mile radius from a network provider is the program developed for the GeoNetworks™ system. If GeoNetworks™ is not used, then the method used to measure mile radius must be CLEARLY defined.

For each location/proposed network, provide a GeoNetworks analysis that includes:

- 2 PCPs within 15 miles
- 2 OB/GYNs within 15 miles
- 2 Pediatricians within 15 miles
- 1 Hospital within 20 miles
- 1 Pharmacist within 15 miles
- 1 Dentist within 15 miles

For each measurement criteria, summarize the results of the network analysis and report the number of employees who have access based upon each employee’s home ZIP Code. The following table should be completed for the specific MSAs and counties listed above.
## Appendix B. Network Provider Form (continued)

<table>
<thead>
<tr>
<th>MSA and County</th>
<th>Total</th>
<th># of Employees</th>
<th>Employees WITH Desired Access</th>
<th>Employees WITHOUT Desired Access</th>
<th>Avg. Distance to 1 Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>2 Adult PCPs within 15 miles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 OB/GYNs within 15 miles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Pediatricians within 15 miles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Hospital within 20 miles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Dentist within 15 miles</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Your response should be one report file with the following report sections repeated for each provider type:

- Title Page
- Accessibility Summary, Employees with Access
- Accessibility Detail, Employees with Access, summarized by MSA
- Accessibility Detail, Employees with Access, summarized by County
- Accessibility Summary, Employees without Access
- Accessibility Detail, Employees without Access, summarized by MSA
- Accessibility Detail, Employees without Access, summarized by County

Please provide detailed electronic Excel files via secure email, diskette, or CD ROM.
Appendix C. Provider Disruption and Listing

Instructions
The supplemental Excel file, labelled as “Appendix C - CY2015 - Medical Provider Utilization Data -SEHIP.xlsx” with password = FbAy$2Km4, includes a list of all current medical providers and facilities. Provide the name of the network you are quoting in cell B2. In column I include a “Yes” or “No”, in each row, as to whether the provider or facility is currently participating in your quoted network. Please note there are two tabs within the file: a tab for professional and a tab for facility.

In addition, provide in an Excel spreadsheet format, a listing of the hospitals, physicians, pharmacists and dental providers with which your organization contracts in Alabama for the network you are proposing, including (for physicians) the practice specialty. Include the provider’s name, address of physical location where care is practiced (only one per physician with primary office of practice listed, not address of billing office), tax identification number and office ZIP Code.
Appendix D. Price Proposal

Instructions
Your response to the questions in this section should be self contained. That is, you should not reference your responses in other sections of this RFP in responding to questions.

Please do not deviate from the requested formats. Your proposal should include the financial response both on paper and electronically.

We are requesting quotes for the current medical and dental plans as outlined in this RFP.

Please use the provided enrollment counts as outlined in the tables.

Please assume a “paid claims” projection.

Please include all financial assumptions and caveats with your proposal. Such assumptions would include reasons for a change in the proposed fee at the time of the effective date (i.e., change in enrollment).

Financial Response Formats
Administrative Service Only (ASO) fees should be proposed in the format provided in the following pricing schedule tables. Fees must be proposed as a guaranteed fixed fee per employee per month and as a percentage of paid claims. ASO fees will be limited to the lesser of fixed fees or the percentage of paid claims for each contract year. If the Proposers wish to submit alternative pricing proposals, in addition to the SEIB’s requirement, please feel free to do so. The cost proposal is for a five-year period, assuming a constant enrollment.
### State Employees’ Health Insurance Program

#### Administrative Service Fees (PEPM)

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Option 2020</th>
<th>Option 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment (# of Employees)</td>
<td>51,000</td>
<td>51,000</td>
<td>51,000</td>
<td>51,000</td>
<td>51,000</td>
</tr>
<tr>
<td>Administrative Fees (PEPM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Administration (includes supplemental plans)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Network Access Fee</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Behavioral Health Administration Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Disease Management</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Gaps in Care Program</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dental Administration</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other (Explain)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services Under Consideration :</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Near-Site Clinics</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined fixed ASO Fee</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Administrative Fee as a % of claims</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Annualized Claims and Transactions (PEPM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected Paid Claims</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Expected Claim Transactions</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Run Out (PEPM) ASO Fee</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
## Appendix D. Price Proposal (continued)

### Inmate Hospital

<table>
<thead>
<tr>
<th>Administrative Service Fees (PEPM)</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Option 2020</th>
<th>Option 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment (# of Inmates)</td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
</tr>
<tr>
<td>Administrative Fees (PEPM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Administration</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Network Access Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Explain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined fixed ASO Fee</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Administrative Fee as a % of claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annualized Claims and Transactions (PEPM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected Paid Claims</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Expected Claim Transactions</td>
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<td></td>
<td></td>
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<tr>
<td>Run Out (PEPM) ASO Fee</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix D. Price Proposal (continued)

#### Workers Compensation

<table>
<thead>
<tr>
<th>Administrative Service Fees (PEPM)</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Option 2020</th>
<th>Option 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment (# of Employees)</td>
<td>32,000</td>
<td>32,000</td>
<td>32,000</td>
<td>32,000</td>
<td>32,000</td>
</tr>
<tr>
<td>Administrative Fees (PEPM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Access Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Administration Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Control Programs</td>
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<td></td>
</tr>
<tr>
<td>Return to Work Programs</td>
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</tr>
<tr>
<td>Other (Explain)</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Combined fixed ASO Fee</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Fee as a % of claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annualized Claims and Transactions (PEPM)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected Paid Claims</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Expected Claim Transactions</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Run Out (PEPM) ASO Fee</td>
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</tr>
</tbody>
</table>
Appendix D. Price Proposal (continued)

Services Included in Administrative Fee
Please indicate which of the following services are included in the administrative fees and which are covered at an additional cost together with the associated cost. Note that all fees that may be invoiced at any juncture over the lifetime of this contract must be listed, utilizing the “Other” category multiple times if necessary.

<table>
<thead>
<tr>
<th>Core Services</th>
<th>Medical and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation and mailing of SEIB approved benefit books</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Preparation and mailing of identification cards</td>
<td>Additional Charge</td>
</tr>
<tr>
<td>Subrogation/Conditional claim payment</td>
<td></td>
</tr>
<tr>
<td>Banking and financial arrangements</td>
<td></td>
</tr>
<tr>
<td>Record retention and review and audit</td>
<td></td>
</tr>
<tr>
<td>Independent review of medical bill over $25,000</td>
<td></td>
</tr>
<tr>
<td>Summary cost and utilization reports</td>
<td></td>
</tr>
<tr>
<td>External Review Program/Appeals</td>
<td></td>
</tr>
<tr>
<td>Network Management Services</td>
<td></td>
</tr>
<tr>
<td>Provide Utilization Management that includes utilization review, case management, and disease management.</td>
<td></td>
</tr>
<tr>
<td>Maintain a dedicated customer service unit to respond to member and provider inquiries</td>
<td></td>
</tr>
<tr>
<td>Maintain a full-time customer service employee in the SEIB’s office</td>
<td></td>
</tr>
<tr>
<td>Provide a Gaps in Care Program</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>