REQUEST FOR PROPOSAL
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
RFP # 043.16.B1

Medical Benefits for Employees of The Howard County Public School System

Prepared by:
KELLY Benefit Strategies
1 KELLY Way
Sparks MD 21152
410-527-3400

Issued by:

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042

Contents:

Sent via secure email: Proposal Forms; Census; Plan Information

REQUEST FOR PROPOSAL
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
RFP # 043.16.B1

BACKGROUND INFORMATION

Howard County Public School System (HCPSS) is soliciting proposals for Medical Benefits plans for active employees and retirees. Proposals are requested on a self-funded basis with stop-loss as described in the Requested Funding Section of this RFP.

HCPSS is soliciting proposals to obtain competitive pricing and is reflective of the current healthcare landscape.

IMPORTANT NOTE: The required proposal forms are NOT included in the RFP. Bidders must sign a Non-Disclosure Agreement* (NDA) *(Attachment 1) and request the Proposal Forms as noted on page 8 of the RFP.

In addition to the Medical Benefit plan, HCPSS is also soliciting proposals/bids **separately** for their Prescription Benefits Manager (PBM) under a separate RFP. Bidders must respond separately to each RFP.

CURRENT PLAN OPTIONS:

HCPSS offers active and retired employees a PPO plan administered by Aetna and two HMO options administered by Aetna and CareFirst. The benefit descriptions will be provided once the completed NDA is received.

HCPSS has retained KELLY Benefit Strategies (KBS) as the consultant for this RFP.

TERMS AND CONDITIONS

PART 1 – CONTRACT ADMINISTRATION DATA

APPOINTMENT OF CONTRACTING OFFER'S REPRESENTATIVE

The Contracting Officer's Representative shall be as follows:

Howard County Public School System
Douglas Pindell
Purchasing Officer
10910 Clarksville Pike
Ellicott City, MD 21042

No authority to modify any provisions of this basic contract is granted. Any deviation from the terms of the basic contract must be submitted for contractual action to the above Director of Purchasing Officer.

ADDRESS TO WHICH PAYMENT SHALL BE MAILED

Offeror shall indicate in the space provided below the address to which payment should be mailed, if such address is different from that shown for the offeror. (Page 1 of this solicitation).

_____

_____

PAYMENT TO CONTRACTOR

Payment will be made within 30 days after receipt of contractor invoice, by HCPSS as appropriate, provided that the school system has determined all contract provisions have been complied with.

CONTRACTOR'S INVOICE

The Contractor shall submit an original and one (1) copy of his/her invoice upon completion and acceptance of the services by HCPSS to the appropriate department agency.

Invoices shall contain the minimum information as follows:

a. Name and Address of Vendor
b. Invoice Date
c. Account Number
d. Applicable Group Numbers
e. Billing Period
f. Sufficient details to accommodate a monthly reconciliation (member name, effective date, level of coverage (Individual, Family, etc.) and monthly premium total for each member).

PART II – CONTRACT CLAUSES

OFFICIALS NOT TO BENEFIT

"No HCPSS Official or other Elected Official of Howard County shall be admitted to any share or part of this contract or to any benefit arising from it. However this clause does not apply to this contract to the extent this contract is made with a corporation for the corporation's general benefit provided the Official is not a major shareholder."

CONTRACTOR GRATUITIES TO HCPSS PERSONNEL

GRATUITIES

a. HCPSS may, by written notice to the Contractor, terminate the right of the Contractor to proceed under this contract if it is found, after notice and hearing, by the Procurement Office that Gratuities (in the form of entertainment, gifts or otherwise) were offered or given by the Contractor, or any agent or representative of the Contractor, to any Officer or Employees of HCPSS with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending, or the making of any determination with respect to the performance of such contract; provided that the existence of the facts upon which such findings are made shall be in issue and may be reviewed in any competent Court.

b. In the event this contract is terminated as provided in paragraph (a) hereof, HCPSS shall be entitled:

(1) To pursue the same remedies against the Contractor as it could pursue in the event of a breach of the contract by the Contractor, and;

(2) As a penalty in addition to any other damages to which it may be entitled by law, to exemplary damages in an amount which shall be not less than three nor more than ten times the costs incurred by the Contractor in providing such Gratuities to any such Officer and Employee.

(3) The right and remedies of HCPSS provided in this Clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

CONTINGENT FEES

A contingent fee is any commission, percentage, brokerage or other fee that is contingent on the success that a person or firm has in securing a contract with HCPSS. Improper influence is defined as any influence that induces an HCPSS contract on any basis other than the merits of the matter.

COVENANT AGAINST CONTINGENT FEES

a. The Contractor warrants that no person or agency has been employed or retained to solicit this contract upon an agreement or understanding for a contingent fee except a bona fide employee or agency. For breach or violation of this warranty, HCPSS shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract price or otherwise recover the full amount of the contingent fee.

b. "Bona Fide Agency" as used in this clause means an established commercial or selling agency maintained by a Contractor for the purpose of securing business that neither exerts nor proposes to exert improper influence to solicit or obtain HCPSS contracts nor holds itself out as being able to obtain any HCPSS contract through improper influence.

c. "Bona Fide Employee" as used in this clause means a person employed by a contractor and subject to the contractor's supervision and control as to time, place and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain HCPSS contracts nor holds out as being able to obtain any HCPSS contract through improper influence.

d. "Contingent Fee" as used in this clause means any commission, percentage brokerage or other fee that is contingent upon the success that a person or concern has in securing a HCPSS contract.

e. "Improper Influence: as used in this clause means any influence that induces a HCPSS employee to give consideration or to act regarding a HCPSS contract on any basis other than the merits of the matter.

DISPUTES

1. Except as otherwise provided in this contract, any Dispute concerning a question of fact arising under this contract which is not disposed of by agreement, shall be decided by the Director of Purchasing, shall be final and conclusive unless within 30 days from the receipt of such Decision the Contractor furnishes to the Director of Purchasing a written appeal addressed to the Director of Purchasing. The Decision of the Director of Purchasing or a duly authorized representative for the determination of such appeals shall be final and conclusive. This provision shall not be pleaded in any suit involving a question of fact arising under this contract as limiting Judicial review of any such Decisions to cases where fraud by such Official or the representative of such Official is alleged: Provided, however, that any such Decision shall be final and conclusive unless the same is fraudulent, capricious or arbitrary, or so grossly erroneous as necessarily to imply bad faith or is not supported by substantial evidence in connection with any appeal proceeding under this Clause, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal.

2. Pending final decision of a Dispute hereunder, The Contractor shall proceed diligently with the performance of the contract and in accordance with the Director of Purchasing's decision.

3. This Dispute Clause does not preclude consideration of questions of law in connection with Decisions provided for in paragraph (1) above. Nothing in this contract, however, shall be construed as making final the Decision of any Administrative Official or representative on a question of law.

DISCOUNT FOR PROMPT PAYMENT

In connection with any discount offered for prompt payment, time shall be computed from the date of completion of and acceptance of Services or the delivery and acceptance of services. For purposes of computing the Discount earned, payment shall be considered to have been made on the date the HCPSS check was mailed.

EXTRAS

Except as otherwise provided in this contract, no payment for Extras shall be made unless such Extras and the price therefore have been authorized in writing by the Director of Purchasing.

ASSIGNMENT OF CLAIMS

1. The Contractor may assign its rights to be paid amounts due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution. The assignee under such an assignment may thereafter further assign its right under the original assignment to any type of financing institution.

2. Any assignment or reassignment under this Clause shall cover all unpaid amounts payable under this contract, and shall not be made to more than one part, except, that the one party to whom assignment or reassignment is made may act as agent or trustee for two or more parties participating in the financing of this contract.

LATE BIDS, MODIFICATIONS OR WITHDRAWAL OF BIDS

1. Any Bid received at the office designated in the Solicitation after the exact time specified for receipt will not be considered unless:

A. it was sent by registered or certified mail not later than the fifth calendar day prior to the date specified for Bid receipt, or

B. it was sent by mail and HCPSS determines that late receipt was due solely to mishandling by HCPSS after it was received

i. Any modification or withdrawal of Bids is subject to the same conditions as in (a) above. A Bid may be withdrawn by a Bidder or authorized representative but only if the withdrawal is made prior to the exact time set for the receipt and opening of Bids.

ii. The only acceptable evidence to establish the mailing date of a dated Bid, modification, or withdrawal is a postmark (exclusive of a postage meter) legibly affixed by an employee of the U.S. Postal Service.

EQUAL OPPORTUNITY

During the performance of this contract the Contractor certifies that it shall not discriminate against any employee or applicant because of race, color, religion, sex or national origin and that this policy shall be included in all solicitations or advertisement for employees during the term of this contract.

UNNECESSARILY ELABORATE CONTRACTOR PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond that sufficient to complete and effective proposal are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate art work, expensive paper and bindings and expensive visual and other presentation aids are neither necessary nor wanted.

ORDER OF PRECEDENCE

In the event of an inconsistency between provisions of this solicitation, the inconsistency shall be resolved by giving precedence in the following order:

a. The schedule, and excluding the specifications;
b. Terms and conditions of the solicitations;
c. General provisions;
d. Other provisions of the contract when attached or incorporated by reference; and
e. The specifications.

TERMINATION FOR CONVENIENCE OF HCPSS

The Director of Purchasing, by written notice, may terminate this contract in whole or in part, when it is in HCPSS's interest. If this contract is terminated, HCPSS shall be liable only for payment, under the payment provisions of this contract, for services rendered before the effective date of Termination.

OPTION TO EXTEND SERVICES

HCPSS may require continued performance of any Services within the limits and at the rates stated in the Offeror's Proposal. The Director of Purchasing may exercise the Option by written notice to the Contractor within the period specified in the Schedule.

OPTION TO EXTEND THE TERM OF THE CONTRACT

1. HCPSS may extend the term of this contract by written notice to the Contractor within the time specified in the Specifications; provided that HCPSS shall give the Contractor a preliminary written notice of its intention to extend at least 60 days before the contract expires. The preliminary notice does not commit HCPSS to an extension.

2. If HCPSS exercises this Option, the extended contract shall be considered to include this Option provision. Any extension shall be subject to appropriation by the HCPSS.

3. The total duration of this contract, including the exercises of any Options under this Clause shall not exceed 8 (years).

CHANGES

The Director of Purchasing may at any time, in writing, and without notice, make changes, within the general scope of this contract, in the definition of services to be performed, and the time (i.e. hours of the day, days of the week, etc.) and place of performance thereof. If any such change causes an increase or decrease in the cost of the time required for performance of any part of the work under this contract, whether changed or not changed by any such order, an equitable adjustment shall be made in the contract price or delivery schedule, or both, and the contract shall be modified in writing accordingly. Any claim by the contractor for adjustment under this clause must be asserted within 30 days from the date of receipt by the contractor of the notification of change. Failure to agree to any adjustment shall be a dispute concerning a question of fact within the meaning of the clause of this contract entitled "Disputes". However, nothing in this clause shall excuse the contractor from proceeding with the contract as changed.

MULTI-AGENCY PARTICIPATION

Under §5-112, Paragraph (3) of the Education Article of the Annotated Code of Maryland HCPSS may, with the Board of Education approval, participate in contracts for goods or commodities that are awarded by other public agencies or by inter-governmental purchasing organizations if the lead agency for the contract follows the public bidding procedures. HCPSS therefore reserves the right to extend the terms and conditions of this solicitation to any and all other agencies within the state of Maryland as well as any other federal, state, municipal, HCPSS, or local governmental agency under the jurisdiction of the United States and its territories. This shall include but is not limited to private schools, parochial schools, non-public schools such as charter schools, special districts, intermediate units, non-profit agencies providing services on behalf of government, and/or state, community and/or private colleges/universities that require these goods, commodities and/or services. A copy of the contract pricing and the bid requirements incorporated in this contract will be supplied as requested to agencies.

Each participating jurisdiction or agency shall enter into its own contract with the Award Bidder(s) and this contract shall be binding only upon the principals signing such an agreement. Invoices shall be submitted in duplicate "directly" to the ordering jurisdiction for each unit purchased. Disputes over the execution of any contract shall be the responsibility of the participating jurisdiction or agency that entered into that contract. Disputes must be resolved solely between the participating agency and the Award.

NO INDIVIDUAL LIABLITY

No elected official, appointed official, employee, servant, agent or law enforcement officer shall be held personally liable under this Contract and any extension or renewals thereof because of its enforcement or attempted enforcement provided they are acting within the course and scope of their employment or governmental duties and responsibilities.

SEVERABILITY

In the event any portion of this solicitation/contract is found to be unconstitutional, illegal, null or void, by a court of competent jurisdiction, it is the intent of HCPSS to sever only the invalid portion or provision, and that the remainder of the solicitation/contract shall be enforceable and valid, unless deletion of the invalid portion would defeat the clear purpose of the solicitation/contract (ordinance), or unless deletion of the invalid portion would produce a result inconsistent with the purpose and intent of HCPSS in entering into this solicitation/contract.

SUFFICIENT APPROPRIATIONS

HCPSS's financial obligations, if any, under this Contract are contingent upon sufficient appropriations and authorization being made by the HCPSS for the performance of this Contract. The HCPSS's decision as to whether sufficient appropriations are available shall be accepted by the other party or parties to this Contract, and shall be final.

THIRD PARTY BENEFICIARY

It is specifically agreed between the parties executing this solicitation/contract that it is not intended by any of the provisions of this Contract to create in the public or any member thereof, third party beneficiary status in connection with the performance of the obligations herein without the written consent of HCPSS and notwithstanding its concurrence in or approval of the award of any contract or subcontract or the solicitation thereof in fulfilling the obligations of the Contract.

SUBMISSION INSTRUCTIONS

ISSUING OFFICE:

The Issuing Office is:

Howard County Public School System
c/o Douglas Pindell, Director of Purchasing
Dpindell@hcpss.org
10910 Clarksville Pike
Ellicott City MD 21042

CONSULTANT TO HCPSS:

Joseph G. DiMaggio, Jr.
KELLY Benefit Strategies
c/o Howard HCPSS Public Schools
1 KELLY Way
Sparks MD 21152

DUE DATE AND TIME:

Fifteen (15) paper copies (One '1' original) and eight (8) flash drive copies of your proposal must arrive at HCPSS by 3:00 PM on **April 1, 2016.** The proposal should be addressed to:

Howard County Public School System
c/o Douglas Pindell, Director of Purchasing
10910 Clarksville Pike
Ellicott City MD 21043

PRE-BID MEETING:

There will be a non-mandatory Pre-Bid meeting on **March 21, 2016 at 10:00 AM**. The meeting will be held at the issuing office address listed above. For those bidders not able to attend, the meeting will be accessible by teleconference by calling (877) 304-5031 passcode 1733028776 at any time during the conference.

CONFIDENTIALITY:

Respondents should give specific attention to the identification of those portions of their technical proposals that they deem to be confidential, proprietary information or trade secrets, and provide any justification of why such materials, upon request, should not be disclosed by HCPSS under Public Records. Respondents must clearly indicate each and every section that is deemed to be confidential, proprietary or a trade secret. It is not sufficient to preface your technical proposal with a proprietary statement.

EFFECTIVE DATE:

It is anticipated that services will begin January 1, 2017 through December 31, 2017 and annually thereafter.

PROPOSAL FORMS:

Bidders must request the Proposal Forms by submitting the Non-Disclosure Agreement (NDA), which is included in the RFP as Attachment #1. The Proposal Forms are NOT included in the RFP as the forms include confidential and/or sensitive information. The signed NDA should be emailed to anovotny@kellyway.com and the original must be submitted with your RFP. Once received, the Proposal Forms will be sent securely to you via email at the email address noted on the NDA. You must submit all Proposal Forms in order for your proposal to be considered. All forms must be provided in both written and electronic formats. Provide the electronic format on CD or Flash Drive. Do not retype or change the format of the proposal forms.

DEVIATIONS FROM RFP:

All proposals should meet the requirements set forth in this RFP. All proposals should be based on the requested benefits and census information included in this RFP. Any deviations must be clearly specified on **Proposal Form 4** titled "Deviations from Specifications."

QUESTIONNAIRES:

The enclosed questionnaires (Proposal Forms 1 and 2) must be completed and returned with the proposal. Complete the sections applicable to the coverages and services you are quoting. The questionnaires are included in the file attachments in Microsoft Word format. Please answer your questionnaire in Word and do not retype the document. Save the files as Proposal Form 1 – (contractor name) and Proposal Form 2 – (contractor name). If you do not follow this format, your proposal may be disqualified. If you are only quoting certain lines of coverage or services, please respond to the applicable sections and note "Not applicable" in the other sections.

ANNUAL ENROLLMENT ASSISTANCE:

Contractors must provide annual enrollment support to HCPSS including communications, attendance as requested at employee benefit meetings (estimated to be approximately eight – ten in the year), administration and any other services that HCPSS deems appropriate. HCPSS is requesting that contractors mail to employees who select their plan the certificates of coverage/booklets.

QUESTIONS:

All questions pertaining to this RFP shall be sent via email to anovotny@kellyway.com, jdimaggio@kellyway.com and dpindell@hcpss.org. Responses will be furnished by addendum sent via email to each respondent who has replied as outlined above. Deadline for receipt of questions and inquiries is ***March 22, 2016***. **Please note: questions regarding the motivating factors for the RFP, or regarding the satisfaction with current vendors or with the current vendor relationships, will not be answered. Questions that have already been addressed as part of this RFP or questions otherwise deemed unnecessary or frivolous by the Consultant will not be considered. No additional questions will be answered regarding decision criteria as this is clearly provided as part of the Evaluation Methodology section. Questions of a general nature may be posted with the associated response. Questions requiring a scope or other change will be included as part of an addendum. Questions that are specific to a particular bidder's situation will be provided a direct response.**

GRANDFATHERED STATUS:

HCPSS is considering relinquishing grandfathered plan status under the Patient Protection and Affordable Care Act of 2010 effective January 1, 2017. Please include quotes for plan designs assuming both grandfathered and non-grandfathered status.

RFP TIMELINE	DATE
RFP released	March 7, 2016
Pre-Bid Conference	March 21, 2016
Questions due to KBS	March 22, 2016
RFP due to HCPSS Procurement	**April 1, 2016**
Finalist Meetings	April 27, 2016
Final Decisions Made	May - June, 2016
Implementation	August, 2016
Effective Date	January 1, 2017

FINALIST – BEST AND FINAL OFFERS

It is at the discretion of HCPSS to interview selected vendors and request best & final offers as part of this bidding process.

EVALUATION METHODOLOGY

A numeric evaluation system based on 100 evaluation points will be used to score the proposals. The maximum points for each category are listed below.

I.	**Provider Networks** • ***Geographic Access*** • ***History/Stability*** • ***Size of Network*** • ***Match of top providers used (disruption analysis)***	**40 Points**
II.	**Cost Proposal** • ***Fixed costs and charges (including any 2nd and 3rd year guarantees)*** • ***Self Insured Rate Equivalents/Rates*** • ***Provider discounts/reimbursements*** • ***CPT Analysis*** • ***Performance Guarantees*** • ***Claim repricing*** • ***Utilization Management programs***	**35 Points**
III.	**Administration/Service** • ***Claims Administration*** • ***Service Standards/Results*** • ***Enrollment processes/capabilities*** • ***Data reporting*** • ***Network administration/referrals***	**10 Points**
IV.	**Utilization/Disease Management**	**10 Points**
V.	**Compliance with Specifications** • ***Proposal Instructions*** • ***Form Submission*** • ***Appropriateness of Questions*** • ***Plan Design*** • ***Client References***	**5 Points**
	TOTAL POINTS	**100 POINTS**

SECTION 1 – INSTRUCTIONS TO BIDDERS

A. Geographic Accessibility Report

You must provide a Geo Access Report for each Medical plan network you are quoting. Use the employee zip codes provided in the provided census files. Please note that there are three files: active, COBRA/leave of absence and retiree. Please produce the geo-access reports using: all active employees; the COBRA/LOA individuals, and the Pre-Medicare retirees. To determine if an employee is covered by your service area, use a standard of two (2) PCPs within 10 miles; for hospitals, one (1) within 20 miles; for specialists two (2) within 15 miles. Under PCPs, please break out pediatricians as a separate category. Do not count Nurse Practitioners, Physicians Assistants or OB/GYNs as PCPs.

B. Proposal Forms

In order for your proposal to be considered, the Proposal Forms must be completed and returned with your proposal based on the coverage options you are quoting.

C. Funding

All plans are requested on an ASO (i.e. self-insured) basis with Specific Stop loss as outlined in Section 2. You must indicate if fees are quoted on a mature or immature basis, as indicated in the proposal questionnaire.

D. Questionnaire

The questionnaires (Proposal Form 1 for Technical Proposal and Proposal Form 2 for Financial Proposal) will be provided once the completed NDA has been received. The questionnaires must be completed and returned with your proposal.

E. Census Data

Census data will be included with the Proposal Forms that will be available via secure email once the signed NDA is received.

F. Rate Guarantee

All rates must be guaranteed for a minimum of one (1) year. Your proposal should note any additional guarantees you are willing to offer. Annual renewals must also be guaranteed for one (1) year.

G. Rate Notification

Renewal rate action requirements must be made in writing by July 1st of each year.

H. Run-out Claims

Proposals should assume that the current carrier will pay the run-out claims.

I. Commissions

Do not include commissions in your proposal costs.

J. Network Directories

Network directories must be provided on disk. Directories should be organized by County and submitted in Excel or Windows compatible format.

K. Healthcare Reform (ACA) Assistance

You must provide guidance and support to HCPSS for provisions of ACA including employee and other communications, administration, and any other services HCPSS deems appropriate.

L. Claims Re-Pricing Instructions

Data Provided: Six months (July 2015 – December 2015) of paid claims is provided with claims line item detail to support a re-pricing analysis. The data is provided in an Excel spreadsheet format. The data includes the billed amount but does not include paid amounts, copay, coinsurance, deductible or any COB amounts. All member information was removed from the file except for member zip code.

Instructions:

The claims data to be re-priced will be included in the Medical Claims Detail spreadsheet M5A. For all line items of the spreadsheet, bidders must indicate if the provider is in-network, whether the claim was excluded from the re-pricing analysis and the re-priced allowed amount (re-priced amount paid). This detail information will be used to verify the total claims discounts proposed/guaranteed, a full disruption of the providers used by HCPSS and to verify the re-pricing summary information provided. If a claim is excluded from the re-pricing analysis, please provide an explanation in the Repricing Summary Bid Form M5.

If the re-priced paid amount is an average paid amount based on geographic factors or a projected discount amount, please provide a detailed explanation and submit it as “Medical Repricing (Vendor Name) – Explanation”.

The Medical Re-Pricing Summary (Form M5) provides a breakdown of the current summarized claims in the following categories:

- Inpatient
- Outpatient
- Physician (primary and specialty)
- Other (includes Lab, X-Ray, Diagnostic, Rx under Medical, Ambulance, DME, etc.)

Excluded claims totals (with summary explanation below the chart) must be provided on the Medical Re-Pricing Summary (Form M5).

SECTION 2 – CURRENT AND REQUESTED PLAN INFORMATION

- **Requested Plans**
  It is the intent of HCPSS to award administration of the proposed benefit plans on the following basis:

  Medical Plan Administration
  One or more benefit plan administrator(s) will be chosen for the Preferred Provider plans (2) and HMO(s) to be offered to eligible employees and retirees of HCPSS. Offerors may be awarded contracts for the administration of one or both medical benefit plans dependent on the best interest of HCPSS.

  Medical Plan Design
  3 PPO plan designs – current 100% plan; 80% plan; H.S.A.
  2 Open Access HMO plan designs – current 100% $10/15 plan; additional $25/40 plan

  Proposed benefit summaries will be provided once the completed NDA is received.

- **Current Structure**
  Currently the following groups of employees/retirees are structured as follows under the plans for billing/claims:

  - Active employees
  - Pre-Medicare retirees
  - Medicare retirees
  - COBRA
  - LOA
  - Food Service

- **Current Plan Information**
  - **ELIGIBILITY:** All Active employees regularly scheduled to work at least 17.5 hours per week except Food Service workers regularly scheduled to work at least 15 hours per week are eligible. Retirees of HCPSS that were enrolled in one of the HCPSS health plans at least one year prior to retirement and may only continue the type of coverage in force at the time of retirement.

  - **WAITING PERIOD:** The first of the month following date of employment.

  - **EMPLOYER CONTRIBUTIONS:** HCPSS contributes 87% towards all medical plans for both employee and dependents. HCPSS will contribute 85% for employees and dependents hired after June 30, 2011.

  - **CURRENT BENEFITS:** medical benefit summaries for the outline of the current School plans will be provided as PDF files once the NDA has been received.

  - **CURRENT FUNDING:** The HMO and PPO plans have specific stop-loss at $500,000 (no aggregate). Medical plans should be quoted without RX benefit administration. Plans should be quoted under a self-funded ASO arrangement.

    Stop-loss for self-funded medical plans should include pricing for $400,000, $450,000 and $500,000 individual stop-loss levels – no aggregate coverage.

    All fees for Disease Management programs you are proposing must be identified as part of your response in the Financial section of this solicitation.

    Include $100,000 annual wellness funding.

SECTION 3 – PERFORMANCE STANDARDS

The successful bidder(s) must be willing to agree substantially to the following performance standards and associated penalties for not meeting the standards. Not meeting one of the specified criteria within each category will result in 50% of the penalty being awarded to HCPSS. Additional penalties within each category will be pro-rated over the remaining items using the outstanding penalty dollars. **Unless specifically stated otherwise in your proposal, it will be assumed that your company agrees to these standards and penalties.**

Performance Standard	Penalty
1. Implementation	**5% of Fees**

- Produce and make available electronically, or via paper if requested, up-to-date provider directories at least weekly. Provider directories must be updated and available prior to the enrollment period; note: enrollment period begins before employee meetings.
- Produce and mail ID cards at least 10 days prior to the effective date, error free. It is the vendor's responsibility to work with HCPSS to achieve error free distribution.
- Code benefits in claim system with 100% accuracy and present testing results.
- Provide HCPSS with a benefits and financial contract within two months of the plan effective date.
- Provide a team trained in HCPSS benefits to be available to attend all employee meetings. Representatives must be fluent on all plan offerings you are proposing. Provide internal training schedule and attendance records.

2. Network Maintenance **15% of Fees**

- Maintain a satisfactory number of open providers (hospitals and physicians) in all managed care locations (90% of providers identified during bid phase). If, within one year, your network is not being maintained or employees are not able to access in-network providers (less than 85% of total claims are in network), the penalties apply.
- Report loss of provider and provider groups with membership greater than 50 employees within 10 days of notification of termination with plan network.
- At effective date, provider network Geo-Access and disruption reports will demonstrate less than a 5% change in pharmacies from originally quoted network statistics.

3. Customer Service **10% of Fees**

- For time on hold criteria, use an abandonment rate not to exceed 5%
- Provide callback and/or written response to plan participants or HCPSS' designated administrator for unresolved issues within 24 hours.
- Provide callback and/or written response to HCPSS administrator for inquiries within 24 hours.
- Claims processing (may be confirmed by outside audit)
    - Dollar accuracy rate of 99%
    - Procedural accuracy rate of 97%
    - Turnaround time: 90% of clean claims paid in 14 calendar days (an EOB asking for more information is not included in meeting turnaround targets).
- Produce agreed upon reports at agreed upon dates/intervals – monthly, quarterly and annual standard reports.
- Duplicate errors on part of vendor – if HCPSS documents a consistent pattern of mistakes or errors that go uncorrected for a substantial period of time (not to exceed two quarters), it will be determined that you have not met this standard.
- Conduct annual member satisfaction survey and achieve overall rating of 80% or better (survey format and rating methodology to be agreed upon by both parties). Survey results must be provided to HCPSS within 45 days of completion date.
- Billing and enrollment (eligibility)

- Initial: 99.5% loaded in system within five business days
- Ongoing: 99.5% loaded in system within three business days
- File errors must be documented and communicated within one business day

ATTACHMENT 1

Non-Disclosure Agreement
Confidential and Sensitive Data

WHEREAS, the Bidder is interested in submitting a formal bid for a Request for Proposals issued by Howard County Public School System (HCPSS) relating to employee benefits RFPs #043.16.B1.

WHEREAS in order for the Bidder to perform the work required to successfully submit a proposal, it will be necessary for HCPSS to provide the Bidder and the Bidder's employees, agents, and subcontractors (collectively the "Bidder's Personnel") with access to certain information HCPSS deems confidential information (the "Confidential Information").

NOW, THEREFORE, in consideration of being given access to the Confidential Information in connection with the RFPs, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the Bidder does hereby agree as follows:

1. Confidential Information means census data, medical or prescription utilization data, claims data, or any other information normally considered sensitive information provided by or made available by HCPSS to the Bidder in connection with RFPs, regardless of the form, format or media on or in which the Confidential Information is provided and regardless of whether any such Confidential Information is marked as such. Confidential Information includes, by way of example only, information that the Bidder views, takes notes from, copies (if HCPSS agrees in writing to permit copying), possesses or is otherwise provided access to and use of by HCPSS in relation to RFPs.

2. Bidder shall not, without HCPSS's prior written consent, copy, disclose, publish, release, transfer, disseminate use, or allow access for any purpose or in any form, any Confidential Information provided by HCPSS except for the sole and exclusive purpose of performing under the RFP. Bidder shall limit access to the Confidential Information to the Bidder's Personnel who have a demonstrable need to know such Confidential Information in order to perform under the RFP and who have agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information. Bidder will retain a listing of those Personnel who have had access to the HCPSS Confidential Information, and shall provide said listing to HCPSS upon request.

3. If the Bidder intends to disseminate any portion of the Confidential Information to non-employee agents who are assisting in the Bidder's response of the RFP or who will otherwise have a role in performing any aspect of the RFP, the Bidder shall first obtain the written consent of HCPSS to any such dissemination. HCPSS may grant, deny, or condition any such consent, as it may deem appropriate in its sole and absolute subjective discretion.

4. Bidder hereby agrees to hold the Confidential Information in trust and in strictest confidence, to adopt or establish operating procedures and physical security measures, and to take all other measures necessary to protect the Confidential Information from inadvertent release or disclosure to unauthorized third parties and to prevent all or any portion of the Confidential Information from falling into the public domain or into the possession of persons not bound to maintain the confidentiality of the Confidential Information.

5. Bidder shall promptly advise HCPSS in writing if it learns of any unauthorized use, misappropriation, or disclosure of the Confidential Information by any of the Bidder's Personnel or the Bidder's former Personnel. Bidder shall, at its own expense, cooperate with HCPSS in seeking injunctive or other equitable relief against any such person(s).

6. Bidder shall promptly advise HCPSS in writing if it learns of any unauthorized use, misappropriation, or disclosure of the confidential information by any of the Bidder's Personnel or the Bidder's former Personnel. Bidder shall, at its own expense, cooperate with HCPSS in seeking injunctive or other equitable relief against any such person(s).

7. A breach of this Agreement by the Bidder or by the Bidder's Personnel shall constitute a breach of this agreement between the Bidder and HCPSS.

8. Bidder acknowledges that any failure by the Bidder or the Bidder's Personnel to abide by the terms and conditions of use of the Confidential Information may cause irreparable harm to HCPSS and that monetary damages may be inadequate to compensate HCPSS for such a breach. Accordingly, the Bidder agrees that HCPSS may obtain an injunction to prevent disclosure, copying or improper use of the Confidential Information. The Bidder consents to personal jurisdiction in the Maryland State Courts. HCPSS's rights and remedies hereunder are cumulative and HCPSS expressly reserves any and all rights, remedies, claims and actions that it may have now or in the future to protect the Confidential Information and to seek damages from the Bidder and the Bidder's personnel for failure to comply with the requirements of this Agreement. In the event HCPSS suffers any losses, damages, liabilities, expenses, or costs (including, by the way of example only, attorney's fees and disbursements) that are attributable, in whole or in part to any failure by the Bidder shall hold harmless and indemnify HCPSS from and against any such losses, damages, liabilities, expenses, and costs.

9. Bidder and each of the Bidder's Personnel who receive or have access to any Confidential Information shall execute a copy of such executed Agreements to HCPSS.

10. The parties further agree that:

    a. This Agreement shall be governed by the State of Maryland;

    b. The rights and obligations of the Bidder under this Agreement may not be assigned or delegated, by operation of law or otherwise, without the prior written consent of HCPSS;

    c. HCPSS makes no representations or as to the accuracy or completeness of any Confidential Information;

    d. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement;

    e. Signatures exchanged electronically are effective for all purposes hereunder the same extent as original signatures; and

    f. The Recitals are not merely prefatory but are an integral part hereof.

Bidder Signature for Non-Disclosure Agreement: Company Name: _____

By: _____ Print Name: _____

Title: _____ Dated: _____

Contact Phone #:_____ Contact Email Address: _____

The following forms should only be provided once the completed NDA is received by the bidder

PROPOSAL FORM 1
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
(Proposal Form 1 – Technical Questionnaire)

*This questionnaire is to be completed by **all bid respondents quoting on Medical Benefit plans.***

HEALTH PLAN ADMINISTRATION

1. Provide information about your organization to include ownership, history providing health services and number of lives covered in your current book of business.

2. Identify any recent or anticipated changes in ownership, including but not limited to, acquisitions, mergers, acquisition of new venture capital, etc. Describe the potential impact if any of these events have occurred within the last year or are planned within the upcoming year.

3. Provide references of three current clients of similar size for whom you provide administration for the benefit plans you are quoting. Include date plan was effective, benefit plans administered, number of covered employees, name of entity/contact person and phone number.

Name/Address/phone	Plans Offered	# Covered Ee's	Plan Effective Date

4. Provide references of three former clients who have terminated your services in the past two years. Provide the same information as noted above.

Name/Address/phone	Plans Offered	# Covered Ee's	Plan Term Date

5. Do you agree to the Performance Guarantees noted in Proposal Form 3 of the specifications?

6. Identify the Account Management and Service Team that will be assigned to HCPSS.

Name	Address/Phone	Title	Role

7. What has been the incidence of account management turnover for the unit which will service HCPSS over the last two years?

8. Confirm you will not change the account management and service team assigned to HCPSS mid-year unless a change is requested by HCPSS or the change is necessary due to a termination of employment.

9. Confirm you understand all plans and services will be evaluated separately and your quote for each coverage or service you are proposing is on a stand-alone basis.

10. What capabilities do you have to communicate with **HR/Benefits staff members** of the HCPSS via the Internet, specifically:

Enrollment/Eligibility Update Capabilities	☐ No	☐ Yes
Communication of Plan Designs	☐ No	☐ Yes
Review of Network Directories	☐ No	☐ Yes
Selection of PCP/Changing PCP (if applicable)	☐ No	☐ Yes
Claim Status/EOBs	☐ No	☐ Yes
Order I.D. Cards	☐ No	☐ Yes
Costs for Medical Procedures	☐ No	☐ Yes
General Consumer Health Information	☐ No	☐ Yes

11. What capabilities do you have to communicate with **Plan members** of HCPSS via the Internet, specifically:

Enrollment/Eligibility Update Capabilities	☐ No	☐ Yes
Communication of Plan Designs	☐ No	☐ Yes
Review of Network Directories	☐ No	☐ Yes
Selection of PCP/Changing PCP (if applicable)	☐ No	☐ Yes
Claim Status/EOBs	☐ No	☐ Yes
Order I.D. Cards	☐ No	☐ Yes
Costs for Medical Procedures	☐ No	☐ Yes
General Consumer Health Information	☐ No	☐ Yes

12. Describe your Internet communication capabilities for the services you indicated you can provide in Questions 10 and 11 above. Any additional costs associated with these services should be identified in your Financial Proposal.

13. Describe the steps of your implementation process. Include a sample timetable for a January 1, 2017 effective date.

14. In lieu of using employee's Social Security Number, can the client use an employee ID number or an assigned number issued by the vendor for eligibility transmission?

15. Are you able to administer the proposed plans as described in the enclosed summary of benefits?

16. If no, indicate deviations or conditions on Bid Form 4.

17. Are you prepared to administer the Patient Protection and Affordable Care Act of 2010 provision that allows dependent children to remain on parental coverage up to the age of 26?

18. What level of support are you willing to commit to employer group Annual Open Enrollment meetings, new hire benefits orientation sessions, and other employer benefits events?

19. Please confirm you are you willing to print a hard copy of the Open Enrollment Workbook? Please confirm that you have included any cost in your financial proposal.

20. What level of support do you provide clients regarding changes in Federal and State legislative events that require communication to their benefit plan participants? Please provide samples of Notices you have developed to assist clients with changes in benefit plan administration requirements.

21. How do you communicate plan changes to members? Please confirm that all communication to employees and retirees of HCPSS will be provided to the employer and not released without prior employer approval.

22. Provide samples of system reports used to reconcile client files supplied by the on-line eligibility vendor with your files and describe your process for resolving eligibility mismatches.

23. Provide a detailed description of data elements required for initial eligibility file upload. Include description of lead time required prior to plan effective date, time required to upload to your system, and client reports to verify successful upload.

24. What cycle to you recommend for eligibility file exchanges following initial upload (weekly or other)?

25. Will you provide a dedicated eligibility team (or individual with back-up) to HCPSS for resolution of eligibility problems?

26. Do you provide required Evidence of Coverage (EOC) notices to terminating plan members? Confirm that you will provide this service for HCPSS.

27. Can you accept full-file eligibility transfers or do you require "changes-only" files for eligibility maintenance? Can you process using "term by absence" process if full-file method is acceptable?

28. Can you administer Dependent Verification for HCPSS on an ongoing basis? If yes, describe the procedure and your recommended approach. Any additional fees for this service should be described in Financial Questionnaire Proposal Form 2.

29. Can you provide a dedicated toll-free Customer Service number prior to the Plan Effective date to answer questions from potential members?

30. Do your customer service lines utilize a "phone-tree" to direct members to appropriate services? If yes, please provide a script of the phone tree currently in use.

31. Identify your website information. Can you provide access to your website for authorized representatives of HCPSS during the bid evaluation phase?

32. Can HCPSS provide a link from their website to yours through a secure single sign-on?

33. What are your procedures for releasing HCPSS health plan data to consultants, auditors, brokers or other third parties at the request of HCPSS? Please describe your procedures, timing of responding to such requests and include copies of any waivers or written authorizations you might require prior to releasing such data.

CLAIMS ADMINISTRATION AND CUSTOMER SERVICE

1. Where will your organization process claims?

2. Describe the organization, methods and procedures that would be used by your claims offices to respond to routine claim inquiries from plan members.

3. During what Eastern Standard Time hours would you be accepting such inquiries? Please specify.

4. Is there a toll-free number to the claim office?

5. Approximately what percentage of claim inquiries can you completely resolve:
   At first contact? Within 48 hours after first contact?

6. What telephone services are available 24 hours a day?

Customer Service-Automated (ID Cards, forms, etc.)	☐ No	☐ Yes	
Customer Service – Live	☐ No	☐ Yes	
Claims office	☐ No	☐ Yes	
Appeals officer	☐ No	☐ Yes	
RN	☐ No	☐ Yes	
Pharmacy Assistance (Pharmacist, Licensed Pharmacy tech, etc.)	☐ No	☐ Yes	
Other	☐ No	☐ Yes	Please Specify

7. If there is an additional cost to provide 24-hour service, please detail the cost and describe the specific service that will be provided for the additional cost in your Financial Proposal. Specific qualifications of the person/persons providing the 24-hour service must be included.

8. Briefly describe your claims processing system (including the handling of network and non-network claims). Confirm that your claims system is fully compliant with HITECH requirements to the HIPAA regulations.

9. Are you currently providing CMS with Mandatory Secondary Payer Reporting required by section 11 of MMSEA on behalf of any of your client groups? Confirm that you will provide this reporting for HCPSS.

10. How long has the current claim system been operational?

11. Are systems upgrades/changes planned within the next 3-5 years? Please Specify

12. Attach to your proposal specimen copies of the EOB forms and claim drafts which will be used for medical/Rx programs you are proposing.

13. Describe the claim payment expected performance and actual recent results (for 2014 and 2015), for the claim office(s) which will administer your plan(s), including payment accuracy, coding accuracy, customer service accuracy, and claim turnaround time.

14. Can employees communicate with the following via e-mail?

Customer Service	☐ No	☐ Yes	
Claims office	☐ No	☐ Yes	
Appeals officer	☐ No	☐ Yes	
Other	☐ No	☐ Yes	Please Specify

15. Will you have a designated claims unit for HCPSS?
    ☐ No ☐ Yes

16. Do you distribute member satisfaction surveys?
    ☐ No ☐ Yes

    If so, how often and what do you do with the results? Please provide a copy of the most recent member satisfaction survey and results.

Are providers given the results of these surveys?
☐ No ☐ Yes

17. What other ways do you measure member satisfaction?

Member Complaints	☐ No	☐ Yes
Requests to change provider	☐ No	☐ Yes
In-house claims/member service audits	☐ No	☐ Yes
Other	☐ No	☐ Yes

If other, please Specify

18. What has been the ratio of client service representatives to members over the past three years?

	Service Rep-to-Client Ratio
2013	
2014	
2015	

19. What is the turnaround time for claims processing and payments (x% in 5 business days)?

20. Provide the following member services statistics for the most recent four quarters: average telephone answering time; abandonment rate; average time waiting.

Quarter Reporting On	**Average Telephone Answering Time**	**Abandonment Rate**	**Average Time Waiting**

21. Describe your Disaster Recovery plan for data backup.

22. Describe the appeal process on denied claims. What are the different levels of review and your timing standards? What is your expectation regarding client involvement for self-funded plans? Are you compliant with the claims review and appeal process as required by PPACA?

23. Will your organization assume the role of claim fiduciary if requested under the alternative funding arrangements? If so, please identify any additional costs in your Financial Proposal.

24. How do you determine the reasonable and customary expense allowances you will use for non-network claims?

    What percentile is applied and what data sources are accessed for surgical and non-surgical services?

25. Provide your most recent statistics for the following Quality of Care Measures:

	Mid-Atlantic region (% of Members)
1. Childhood Immunizations	
MMR	
DPT	
OPV	
Hib	
2. Mammography	
3. Cholesterol Screening	
4. Pap Smear	
5. Low Birth Weight	
6. Pre-natal Care first trimester	
7. Asthma Admission rate	
8. Diabetic retinal Exam	

26. What percentage of participating physicians have "limited" their practice to current enrollment? Indicate % separately for each type of provider noted below:

Practice Type	% of Providers limiting enrollment to current members
Family/General	
Internal Medicine	
Pediatricians	
Cardiologists	
OB/GYN	
Radiologists	
Surgeons	
Anesthesiologists	
Orthopedic	
Neurology	
Urology	
Endocrinology	

27. What percentage of network physicians are board certified in their practice specialty, by category:

Practice Type	% Board Certified
Family/General	
Internal Medicine	
Pediatricians	
Cardiologists	
OB/GYN	
Radiologists	
Surgeons	
Anesthesiologists	
Orthopedic	
Neurology	
Urology	
Endocrinology	

28. Describe your criteria and process for network provider selection for hospitals, other institutional providers, other health care professionals, and specialists.

    a) Guidelines for determining a "cost-efficient" provider, such as relative practice patterns and fee levels.

    b) Your minimum requirements for malpractice and liability insurance.

    c) Methods for evaluating the provider's quality of care. Is an on-site pre-contractual audit routinely conducted? Are interviews performed regularly?

    d) The percentage of providers rejected out of total applicants for the past 3 years.

    e) Do you have a process for excluding or penalizing providers who do not meet performance standards? Address the following:

    Performance standards or criteria for exclusion or penalties.

    Due process protocol.

29. Indicate physician turnover over the past three years. Provide reasons for turnover.

30. What types of ancillary providers are included in your networks (such as labs, physical therapists, chiropractors, home health care agencies, nursing homes, hospices, etc.)? Indicate how many of each of the above provider types are in your network in Maryland.

31. Indicate which air ambulance providers are in your network. Specifically indicate which of the following are network providers: CEM/Stat Medivac; PHI; and Mid-Atlantic.

CARE MANAGEMENT

32. Describe the programs you are including as part of your proposal to control costs in the following areas:

    a) Hospital admissions
        1) Pre-certification
        2) Concurrent review
        3) Discharge planning

    b. Large claim case management

    c. Outpatient surgery review/ambulatory pre-certification

    d. Mental health/substance abuse treatment

    e. Maternity
        1) Short-stay incentives
        2) High risk pregnancy management

    f. Targeted disease management programs (i.e., heart disease, asthma, diabetes, etc.)

33. Do you have a UR program which interfaces with your claim system to identify potential large claim (or case management) situations? If so, describe in detail.

34. For clients who have “carved out” prescription drug benefits to a third party, how do you include that data for analysis?

35. What is your organization’s accreditation status for Utilization Management (UM) and Case Management (CM)?

36. What outcome measures do you use to quantify the success of your programs? Please provide sample client report.

37. Do you use predictive modeling to identify potential candidates for Case or Disease Management?

    ☐ No ☐ Yes

    If yes, please answer the following
    a. When did your organization begin using predictive modeling?
    b. Did your organization develop its own model or do you outsource this function?
    c. Do you integrate Rx with medical claim files for customers who have carved-out the Rx benefit?
    d. Describe how your predictive model works (how members are identified and what steps are taken once they are).
    e. Provide data that demonstrates the effectiveness of your predictive modeling.

38. Describe your organization’s overall spectrum of medical management programs. In particular, describe how there is coordination between Case and Disease Management Programs.

39. With respect to your own Disease Management Programs:
    a. When did your organization begin offering disease management programs?
    b. Do you manage your own programs or are they outsourced?
    c. How are members identified as potential candidates for these programs?
    d. How is member compliance tracked within these programs?
    e. Provide data to demonstrate the effectiveness of your disease management programs.

40. Describe your organization’s programs to improve patient safety.

41. What network initiatives do you have in place to control medical costs?

42. What innovative Utilization Management products have you recently introduced to your clients?

43. Can you model disease management effectiveness against claims history?

    ☐ No ☐ Yes

44. The issue of patient's rights, particularly the right to sue health plans over the denial of care, is generating much debate. How would your organization balance patient access to requested care with your mandate to manage health care expenditures for HCPSS?

45. Does your organization do targeted mailings and/or offer initiatives to people who have reached the age where they should be getting certain tests done (e.g. mammograms, colonoscopies)?

46. Do you offer care management and incentives to those members who trigger disease management "flags"? If yes, please describe your contact methods and follow-up guidelines in detail. If HCPSS specified that the CM / DM programs were to be operated as Voluntary and Self-Referral only, how would you support and promote your programs on that basis?

MANAGEMENT REPORTING

47. Provide samples of the management reports you would typically provide as part of your basic services. Indicate the frequency of each report. Indicate which management reports are available online to the client groups.

48. Please list all of the employee and claims data elements maintained on your system.

MENTAL HEALTH/SUBSTANCE ABUSE

49. Who will administer mental health/substance abuse for your firm?

50. How do you coordinate the care of co-morbidity cases that involve both health care and mental health care services?

51. Are services for professional mental health/substance abuse treatment capitated or fee-for-service?
    If capitated, indicate the fee with your financial quote.

52. Describe the process for obtaining referrals/approval for these benefits. Describe the level of professional training and credentialing for the plan representatives involved in the intake/screening process. What guidelines are followed for referrals to a specific type of provider?

53. Identify the location of the customer service center for managed mental health assistance; normal hours of operation; access to help after hours for emergent and urgent care.

54. If Customer Service for Managed Mental Health is outsourced, or provided by a specialty unity within your organization, what is the CSR to member ratio for managed mental health representatives? What are the standards for ASA and abandoned call rate?

PROPOSAL FORM 2
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
(Proposal Form 2 – Financial Questionnaire)

FINANCIAL PROPOSAL

ANSWERS TO THESE QUESTIONS ARE TO BE SUBMITTED SEPARATELY FROM ANSWERS IN TECHNICAL QUESTIONNAIRE SECTION OF THIS RFP. (Medical)

1. Explain in detail, for all plans you are quoting, how retention/fees are charged (i.e., by employee, as percent of claims dollars, by claim transaction).

2. Describe off-anniversary termination penalties, if any, which may apply.

3. Are your fees for the alternative funding quoted on a first-year non-mature basis, or on a mature basis?
   ☐ Non-mature basis ☐ mature basis

4. If on a non-mature basis, what would your fees be for the first year if they were on a mature year basis?

5. If the contract were terminated at the end of year one, would you charge a fee to process the run-out for the alternative funding arrangement? ☐ No ☐ Yes

6. If yes, what would that fee be?

7. Are you willing to guarantee any rates/fees beyond the first year of your contract?

8. Indicate whether billing statements and accompanying paid claims detail are available online to the HCPSS's benefits personnel. Provide a thorough explanation of how paid claim reports are reconciled to billing invoices.

9. Are you willing to put the administrative fees for your clinical management programs at risk for HCPSS if the targeted plan savings are not achieved in years 2 and beyond of the contract?

10. What second and third year renewal guarantees will you provide with regard to quoted fixed costs for the alternative funding arrangement?

11. Are you willing to include a Wellness budget as part of your proposal to pay employee incentives? If so, how much and for what duration of the contract?

12. Identify any costs if you are willing to serve as plan fiduciary under the alternative funding arrangement.

13. What, if any, costs are associated with the provision of a toll-free customer service line?

14. If you are willing to provide 24 hour customer service access, what, if any, costs are associated with that service?

15. If you are proposing a 24-hour nurse help-line as part of your Care Management proposal, what, if any, costs are associated with that service?

16. If you are proposing telehealth as part of your proposal, please describe the program and what costs, if any, are associated with that service?

17. Does your proposal include any capitated services? If yes, please identify on the appropriate bid form.

18. Explain your banking arrangements, including any balances/deposits required for alternative funding arrangements.

19. Please list and provide a description of and pricing for any client reports that are not part of your standard reporting package.

20. Please list any costs associated with providing HCPSS plan members with Health Risk Assessments.

21. Please confirm your fees include any costs associated with providing HCPSS plan members with printed copy of Enrollment Workbook.

22. Please list any costs associated with available wellness programs not included in your quoted fees such as weight loss, smoking cessation etc.?

23. Please list any additional charges if a third party is selected for RX?

PROPOSAL FORM 3
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
(Proposal Form 3 – Performance Guarantees)

Certain tasks are critical to the successful implementation and on-going operation of the HCPSS benefits programs. The successful respondent(s) must be willing to agree substantially to the following performance standards and associated penalties for not meeting the standards. **Unless specifically stated otherwise in your proposal, it will be assumed that your company agrees to these standards without exception.**

Performance Standards – Medical Benefit Plans

1. Implementation

☐ Code benefits in claims system with 100% accuracy. - *Failure to meet this guarantee for HCPSS will result in a penalty of $5,000.*

☐ Upload eligibility to enrollment system with 100% accuracy assuming receipt of "clean" files from client group - *Failure to meet this guarantee during initial implementation, and during succeeding annual open enrollment process, will result in a penalty of $5,000.*

☐ Produce up-to-date online and hard-copy provider directories and enrollment materials as requested by HCPSS no later than October 1 each year. *Failure to meet this guarantee will result in a penalty of $5,000.*

☐ Produce and mail ID cards at least 10 days prior to the effective date. It is the vendor's responsibility to work with HCPSS to achieve error-free distribution. *Failure to meet this guarantee will result in a penalty of $5,000.*

☐ Provide HCPSS with a benefits and financial contract within two months of the plan effective date. - *Failure to meet this guarantee will result in a penalty of $5,000.*

☐ Have a knowledgeable team available to attend all Employee and retiree meetings. Representatives must be fully trained in all plan offerings you are proposing. - *Failure to meet this guarantee will result in a penalty of $1,000 for each meeting not adequately staffed and professionally conducted.*

2. Network Maintenance

☐ Maintain a satisfactory number of open providers (hospital and physicians) in all managed care locations (90% of providers identified during proposal phase). – *Failure to meet this standard will result in a penalty of $5,000 per occurrence.*

☐ Maintain an online provider directory with updates no less than monthly - HCPSS *will monitor and provide documentation based member- reported deficiencies. If standard not met for more than 2 consecutive months a penalty of $2,500 per each successive month not cured will apply.*

☐ Report network changes to HCPSS on a quarterly basis- *Failure to meet this standard will result in a penalty of $1,000 for each missed reporting deadline.*

☐ Report loss of network provider/provider groups with membership greater than 50 plan participants within 10 days of when plan is notified of withdrawal. - *Failure to meet this standard will result in payment of $1,000 for each occurrence of untimely or missed communication.*

3. Customer Service

☐ For time on hold criteria, an abandonment rate of no more than 5% is to be maintained. Service Measurement Outcomes are to be reported to the group on a quarterly basis - *Failure to meet this standard in 2 or more successive quarters will result in a penalty of $2,500 per each quarter standard is not achieved.*

☐ Please confirm your Average Speed of Answer (ASA) standard. - *Failure to meet this standard in 2 or more successive quarters will result in a penalty of $2,500 per each quarter standard is not achieved.*

☐ Provide callback and/or written response to HCPSS designated contacts for unresolved issues within one business day. - Fo*r each instance where response exceeds standard, HCPSS will document response time. When 3 or more occurrences of non-responsive follow-up occur within a calendar quarter, a penalty of $5,000 will apply.*

☐ Claim processing standards (may be confirmed by outside audit)

- dollar accuracy rate of 99%
- procedural accuracy rate of 97%
- turnaround time:90% of clean claims paid in 14calendar days.
- 98% of claims requiring additional information paid within 30 calendar days

Failure to meet this standard in 2 or more successive quarters will result in apenalty of $2,500 for each quarter standard is not met.

☐ Produce agreed upon reports at agreed upon dates or intervals - *Failure to meet this standard will result in a penalty of $1,000 per missed delivery date.*

☐ Duplicate errors on part of carrier –HCPSS documents a consistent pattern of mistakes or errors that go uncorrected for a substantial period of time (not to exceed two quarters) it will be determined you have not met this standard. - *Failure to meet this standard will result in a penalty of $2,500 per occurrence.*

☐ Mass Communication of plan changes to plan members at the group level without prior review and approval of HCPSS is not permitted. -*Distribution of plan change information at the group level without prior review and approval by HCPSS will result in a penalty of $1,000 per occurrence.*

HCPSS will formally notify carrier in writing when a standard is not met and will provide backup information. Carrier will pay penalties within 30 days of written notice from HCPSS.

2017 PROPOSED MEDICAL PLAN DESIGNS

TYPE OF PLAN	Copay (PCP/Specialist)	Copay (Urgent Care / ER)	Deductible (IN/OUT)	Coinsurance (IN/OUT)	Plan Characteristics
Open Access HMO Select*	$10/$20	$15/$50	N/A	100%	Current HMO plan design; provides affordable premiums with low out of pocket costs at time of service.
Open Access HMO Primary	**$25/$40**	**$40/$150**	**N/A**	**100%**	Proposed HMO plan design to introduce additional cost sharing to mitigate per pay contributions.
PPO 100*	$15/$20	$25/$50	$0/$100	100%/80%	Current PPO plan; higher contributions due to typically higher utilization. A member taking this plan wants to have the lowest out of pocket costs when seeking medical care.
PPO 80	**$30/$40**	**$50/$150**	**$500/$1,000**	**80%/60%**	New moderate PPO option with more member cost share at lower premiums. An employee/retiree taking this plan wants maximum flexibility but open to higher cost share at time of service.
H.S.A. PPO	**N/A**	**N/A**	**$1300/$2600**	**100%/80%**	Lowest per pay contributions; savings vehicle available through Health Savings Account. Typical enrollee is a healthy younger employee looking for lowest per pay costs, willing to take a risk and pay higher out of pocket medical expenses.