Fully Insured Medical Questionnaire

1. Is your company currently in compliance with the Florida Department of Insurance financial and reserve requirements? Yes or No. If no, please explain your answer.

2. When did your organization enroll its first group in Florida for each type of coverage listed?

Type of Coverage	**Date**
PPO products	
HMO Products	
Consumer- Driven products	
Self-Funding	
Wellness/Disease Management	

3. Provide the enrollment data (including all plans) requested below for the organization submitting this Proposal:

a.) Florida Enrollment

	1/1/2014	**1/1/2015**	**1/1/2016**
Commercial Enrollment			
Medicare Enrollment			
Medicaid Enrollment			
Other Enrollment			
Total Enrollment			

b.) North Florida (_____ Counties) Enrollment

	1/1/2014	**1/1/2015**	**1/1/2016**
Commercial Enrollment			
Medicare Enrollment			
Medicaid Enrollment			
Other Enrollment			
Total Enrollment			

4. What percent of your Florida enrollment in 2015 and 2016 is from public sector clients? What percentage is fully-Insured vs. self-funded for 2016?

Florida Enrollment	**Total Enrollment**	**2015 % of Public Sector**	**2016 % of Public Sector**	**2016 % Fully-Insured**	**2016 % Self-Funded**
Enrollment					

5. Is your company offering its group medical coverage through a trust, licensed or registered outside the State of Florida? Yes or No. If yes, please provide the name of the trust and in which state it is licensed or registered.

6. What is your company's current commitment to continuing to offer group medical benefit plans in the State of Florida?

7. Does your company have any plans within the next 36 months to stop offering medical benefit coverage in Fort Walton Beach or the surrounding Counties?

8. Provide NCQA, JCAHO, AAA and/or any other accreditation status that applies to the programs you are proposing. Provide a copy of your accreditation letter(s). Please provide the dates for each certification and accreditation program you maintain.

9. Detail any mergers/acquisitions involving your organization which have occurred in the last 12-month period, and any which are planned for the next 12 to 24 months.

10. Is your company currently or in the past five (5) years been investigated by, asked to appear or give testimony, examined or audited by a State or Federal regulatory agency? Yes or No. If yes, please provide information and details of the outcome.

11. Does your company agree to cover all employees, retirees and dependents who are currently covered for medical benefits by the present carrier who may be actively at work, disabled, on leave of absence, on military leave or have other extenuating circumstances? Yes or No. If no, please explain your answer.

12. Describe, in detail, your out-of-area coverage for members, both within and outside the United States who may either reside out of area or who may be travelling out of area. Describe your capabilities for negotiating fees with out-of-area providers **and** the cost for such services.

13. Does your plan cover members that utilize services offered through a walk-in facility such as those located in a retail environment? Yes ___ No ___. If yes, are there any limitations?

14. Does your company offer the following in the State of Florida?

    a. True group Medicare Supplement Plan: Yes or No
    b. Medicare Advantage Plan: Yes or No
    c. Medicare Part D or a Senior Care: Yes or No
    d. EGWP Plan integrated with Insured product: Yes or No

    If yes, please provide a description of the benefits available with marketing and pricing materials for the plan.

15. Is your company willing to offer a multi-year rate guarantee on the premiums offered in your RFP response? Yes or No
    a. If yes, please explain the scope of guarantees.
    b. If no, please explain why not.

16. Will your company offer a percentage increase ceiling (guarantee) on the first renewal for the premiums offered in your RFP response? Yes or No. If yes, please provide the scope of the ceiling

17. Will your company guarantee the annual trend on medical and/or RX on the renewal in future years? Yes or No

    a. If yes, please provide detailed information of the guarantees.

18. Is your contract cancelable for any reason other than non-payment of premium? Yes or No
    a. If yes, please provide reasons for cancellation.

19. Is your company capable of sending and receiving employer information electronically for billing, enrollment and eligibility? Yes or No

20. For enrollment purposes, will your company accept an Excel Spreadsheet to transfer of the current eligibility files instead of conducting a hard copy enrollment? Yes or No. Please list any mandatory specifications in layman's terms. If no, how do you propose to do enrollment?

21. Can the City enter eligibility directly into your system through an administrative portal? Does this information update in real time? If not, how long does it take for eligibility information to become active in the eligibility and claim system?

22. Please explain how your company audits monthly eligibility and reconciles each month's billing?

23. Are eligibility and claims administered on the same system? Yes or No. If no, how are these functions integrated?

24. Will the City have a dedicated team for claims and customer service? Yes or No

25. Do you plan on major changes or upgrades to your administrative system or the platform you are proposing for the City in the next 24 months? Yes or No. If yes, please explain.

26. Will you provide the City with an eligibility contact person for eligibility file issues and questions? Yes or No.

27. What eligibility responsibilities does your organization expect the City to perform?

28. Will your company guarantee that they are HIPAA compliant? Yes or No.

29. Since the implementation of HIPAA, has your company been questioned, interviewed, audited or received a violation notice concerning HIPAA compliance? Yes or No. If yes, please provide details.

30. Will your company provide medical coverage for the retiree population who now participate in the group medical plan? Yes or No. If no, what alternatives are you offering for this group?

31. The City will need enrollment assistance each year for the annual open enrollment. Please confirm the type of enrollment assistance your company will be providing for the annual open enrollment?

32. Does your company subrogate claims? Yes or No. If yes, please provide the amount or percentage of cost saving to the plan attributable to this effort.

33. Is there a charge back to the City for Subrogation Services? Yes or No? If yes, how is the client charged?

34. Are Self Injectable drugs payable under the Medical portion of the plan? Yes or No.

35. Please provide your company's contract definition of durable medical equipment.

36. Please advise if the following reviews/certifications are required under your Medical plans as proposed.
    a. Preadmission certification? Yes or No.
    b. Second surgical opinion? Yes or No.
    c. Concurrent review? Yes or No.
    d. Large case management? Yes or No.

    Please provide the percentage of cost savings attributed to each area.

37. Who is responsible for ensuring the required reviews/certifications are performed when members use a network provider? Is the patient held financially harmless if this is not followed? Yes or No.

38. Please provide a copy of the renewal formula that will be used to rate the City's account.

Fully Insured Medical Questionnaire

Medical Management

1. The City is a strong proponent of aggressive Medical Management programs that will have a positive impact on the care of their participants and on the claims experience of their medical plan. Does your RFP proposal response include a comprehensive Medical Management program that identifies specific disease states of participating members? Please outline your Medical Management programs, including such components as Disease Management, Case Management, Discharge Planning, Continuation of Care, etc.

1. Is your Medical Management program included in the proposed rates or will there be an additional charge for the program? Yes or No. If not included in your proposal, please provide information on the additional cost to provide a Medical Management program.

2. Can you provide an option for the City to make participation in your Medical Management Programs mandatory for plan participants? Yes or No. If yes, is there an additional cost for this option? Please provide specifics of any additional cost. If no, why do you not provide this option?

3. How do you ensure the integration of the various components of your Medical Management programs? Do you provide multiple specialists for members with comorbidities or do you provide a single point of contact who manages the person. How do you manage "Handoffs" between one clinical area and another?

4. Does your company provide the services for the Medical Management program or is it subcontracted to an outside vendor?
   Indicate: Company provided or Sub-contracted
   If sub-contracted, please provide:

   The name and address of the sub-contracted company
   Number of years your company has worked with the sub-contracted company
   Number of clients currently using this subcontracted vendor
   Date of contract, beginning and expiration

5. If you subcontract your Medical Management, how does your subcontractor access patient benefits, eligibility, etc.?

6. Please outline the disease states your program targets, identifies and manages. Please provide a listing of the target diseases/conditions.

7. What criteria does your company use to select targeted diseases/conditions?

8. Does the client have the opportunity to customize the Medical Management program to the specific conditions prevalent to their membership? Yes or No. If yes, please provide details.

9. Do you have Case Managers who actively assist patients in managing their continuation of care needs as they progress in the care continuum i.e. from hospital, to SNF or to home? Please describe how plan participants are assisted and how the outreach is conducted to the member.

10. How does your company promote the member participation in the Medical Management program? When and how do you begin to offer assistance – at the time of diagnosis or during an active course of treatment?

11. Please describe your company's approach in encouraging members' participation in the program. Does your company offer incentives for members to participate in the disease management program? Yes or No. If yes, please provide details.

12. Briefly describe the member's interaction with your company's Medical Management program. (i.e.: brochures, call centers, outreach calls).

13. Does your Medical Management program integrate with the member's medical providers? (PCPs, specialists, hospitals)? Please provide details.

14. Does your company address appropriateness of care with the medical providers? Yes or No. If yes, how does your company engage the medical providers?

15. Does your company guarantee security measures to prevent employee health information from access to the employer? Yes or No. If yes, please provide information on you company's security measures. If no, please explain how you maintain HIPAA privacy for plan participants.

16. Please explain how your company monitors and measures the performance of your Medical Management program.

17. Will your company guarantee your ROI forecast? Yes or No. If yes, what type of guarantees could we expect?

18. Does your company develop predictive modeling from the information obtained from the Medical Management program? Yes or No. If yes, please describe how the predictive modeling is used at the client level.

19. Does your company share the predictive modeling with the client? Yes or No. If yes, please describe what type of information is shared with the client. How often is this information reviewed? How is it communicated?

Fully Insured Medical Questionnaire

Wellness

The City is requesting that Wellness programs be fully integrated into your pricing proposal. Please respond to the questions below specifically with regard to the initiatives included in your quoted premiums. If you offer additional services, please clearly indicate that they are supplemental services and indicate the cost for each of these services.

1. Is your wellness plan included in the proposed rates or will there be an additional charge for the program? If not included in your proposed rates, please provide the additional cost.

2. Does your company provide the services for your wellness program or is it a sub-contracted plan. Indicate Owned or Subcontracted.
   If sub-contracted, please provide:
   - The name and address of the sub-contracted company
   - How many years your company has worked with the sub-contracted company
   - How many clients your company currently has contracted with this vendor
   - Date of contract, beginning and expiration

3. Does your wellness program integrate and interact with your company's medical claim system? Yes or No.

4. Does your company guarantee security measures to prevent employee health information from access by the employer? Yes or No. If yes, please provide information on you company's security measures. If no, please explain how you remain in compliance with current regulations.

5. Please describe any evidence you have that demonstrates how your wellness program stands out among the competition. Does the client's active participation in your Wellness program impact rate increases?

6. Complete the chart below for each service your organization **will be** providing to the City (check all that apply). Provide samples of your resources:

	DELIVERY MODE					OUTSOURCED VENDOR
Wellness Services	Direct Mail	Online	Telephonic	Onsite	Seminars/One-on-One Counseling	Name of Vendor
Health Risk Assessment						
Biometric Screenings						
Diabetic Counseling						
Health Coaching						

	DELIVERY MODE					OUTSOURCED VENDOR
Wellness Services	Direct Mail	Online	Telephonic	Onsite	Seminars/One-on-One Counseling	Name of Vendor
Health Education & Awareness Campaigns						
Lunch and Learns						
Self Directed Programs						
Resource Facilitator						
Health Partnerships						
Follow Up Reports						
Other (add rows as needed)						

7. Describe the support that you provide in the development of a client's wellness program. Please include specifics regarding the strategic resources that are available to the client.

8. Is a wellness consultant assigned to the client to assist with the development and management of the wellness program? What are the qualifications of the wellness consultant? How is time allocated to the client?

9. Describe your capabilities to manage rewards and incentives. Provide examples of incentives and a recommended budget for incentives for a client of this size.

10. The City currently receives contributions from the vendor to support wellness activities and to drive participation into wellness programs. Describe your strategy to drive participation and maintain participant engagement, and outline the funds that you will provide to the City to support the wellness program.

11. Indicate participation and completion rates (pre and post) for clients you have provided the following types of onsite and online initiatives.

Onsite Initiatives	Participation Rates	Completion Rates
Walking Programs		
Exercise Programs		
Weight Loss Challenges (Total Weight Loss)		
Nutrition Programs		
Gym/Fitness Center Participation/Encouragement		

12. Complete the chart below and provide documentation and evidence for the Lifestyle Management Programs you will provide to the City (check all that apply). Provide evidence for gender specific education and awareness (i.e., breast care for women, cardiovascular disease for women, prostate for men).

Lifestyle Management Programs – Delivery Mode						
	Mailings	Self Directed Programs	Telephonic Coaching	Onsite Seminars Lunch and Learns	One-on-One Counseling	Other
Heart Disease						
Diabetes & Diabetic Counseling						
Cholesterol						
Hypertension						
Asthma						
Nutrition						
Fitness & Exercise						
Women's Health						
Men's Health						
Self Care						
Smoking Cessation						
Weight Management						
Stress Management						
Other: (identify)						

13. Indicate your capabilities to manage or offer the following (check all that apply):

	SERVICES				OUTSOURCED VENDOR	
	Include	Manage	Coordinate	Community Partnership	Name of Vendor	Service Not Offered
Onsite Clinic						
Lunch and Learns						
Fitness Center Discounts						
Weight Loss Competitions						
Stress Management (Yoga, Tai Chi, etc.)						

	SERVICES				OUTSOURCED VENDOR	
	Include	Manage	Coordinate	Community Partnership	Name of Vendor	Service Not Offered
Walking Programs						
Other: (identify)						

14. Indicate the type of reporting you use to track, analyze and assess cost savings (check all that apply):

	REPORTS	FREQUENCY Monthly, Quarterly or Annually
Enrollment		
Participation		
Utilization (Gyms)		
Health Risk Change (Pre & Post)		
Clinical Outcomes		
Participant Satisfaction		
Claims Savings	☐ Medical ☐ RX ☐ Diagnosis	
Short-Term Disability		
Absenteeism		
Productivity		
Quality of Life		
ROI		
Administration		
Wellness Savings		
Wellness Impact		

Fully Insured Medical Questionnaire

Prescription Drugs

1. Please provide the name of the company, PBM or organization that provides pharmacy and prescription drug services for your company.

2. Is the pharmacy company owned by your company or a sub-contracted vendor? Indicate Owned or Subcontracted.
   If sub-contracted, please provide:
   - The name and address of the sub-contracted company
   - How many years your company has worked with the sub-contracted company
   - How many clients your company currently has contracted with this vendor
   - Date of contract, beginning and expiration

3. Please provide the address(es) of the pharmacy claim facility(ies) in which the prescription drug claims will be paid.

   Retail claims facility:
   Mail Order claims facility:
   Specialty Drug claims facility:

4. Is your company currently negotiating a contract with your current prescription drug provider or considering making a change in the prescription drug or PBM provider? Yes or No. If yes, please provide details.

5. When does your current pharmacy contract with the pharmacy provider expire?

6. Is your company currently involved in any contract negotiations or contemplate any changes in the number of retail vendors/stores provided by the current contracted pharmacy retail vendors in your network? Yes or No. If yes, please provide details.

7. Within the next 36 months, does your company/PBM have plans to upgrade, change hardware/software or equipment at your prescription drug claim facility? Yes or No. If yes, please provide details.

8. Is there any situation that we need to be aware of that may cause a delay or disruption in the prescription drug claim adjudication at your company's claims facility? Yes or No. If yes, please provide details.

9. Please list the names of the major retail drug stores in your pharmacy network. Please include National and Regional chains.

10. Does your company have retail network prescription drug contracts with local (mom and pop) retail pharmacies? Yes or No. If yes, does your company intend to continue contracting with local pharmacies?

11. Do you maintain the same pricing contracts with all of your networked pharmacies? Yes or No. If no, please provide details.

12. Are all of your company's networked pharmacies on line? Yes or No. If yes, please provide details.

13. Does your company, PBM and/or network pharmacies screen for the following?
    a. Drug to drug interactions? Yes or No.
    b. Drug to disease interactions? Yes or No.
    c. Drug to Age interactions? Yes or No.
    d. Duplicate drug therapy? Yes or No.
    e. Early refills? Yes or No.
    f. Duplicate drug claims? Yes or No.
    g. Excessive dosages? Yes or No.
    h. Drug allergy interactions? Yes or No.
    i. Excessive physician prescriptions? Yes or No.

14. What precautions does your company take to ensure drug interactions are avoided?

15. Does your company track and monitor the dispensing records of the medical providers? Yes or No.

16. What is your company's position on medical providers who write excessive prescriptions? How do you deal with these physicians?

17. Does your company conduct pharmacy audits? Yes or No. If yes, please describe type, frequency, outcomes and evaluations and reporting.

18. What is your company's prescription drug trend for the following years?
    YTD 2017:
    2016:
    2015:
    2014:

19. What is your company's forecast for future trends in prescription drug costs?

20. Briefly explain the structure and function of your Pharmacy and Therapeutics Committee. How often does your Pharmacy & Therapy (P&T) committee meet and how often does a therapy class get reviewed?

21. Please provide information as to your company's philosophy in developing its drug formulary.

22. Are the formularies based on the lowest cost prescriptions available? If not describe how the financials are calculated into the preferred and non-preferred products.

23. Does your company look at prescription drug outcomes to determine its inclusion in the formulary?

24. How often is your drug formulary changed?

25. Are rebates shared with the plan sponsor under a fully insured scenario? Yes or No. If rebates are shared, how are they shared (e.g. reduced retention in the pricing formula)? Are there any guarantees on the amount to be credited?

26. How does your company communicate changes to the drug formulary and how often are communications provided to the members?

27. How can a member obtain information on your company's drug formulary?

28. Will your company allow the City to continue the use of their existing formulary? Yes or No.

29. Please provide a copy of the drug formulary your company is proposing for the City. Please place your formulary in Tab 6.

30. How does your prescription drug committee handle new prescription drugs being introduced to the marketplace?

31. How long does it take for a new prescription drug introduced to the marketplace to be reviewed by your company's drug committee for formulary inclusion?

32. How does your prescription drug committee handle name brands going generic and reviewing whether they will continue to be offered in the formulary?

33. Does your company's prescription drug program offer an open-formulary plan? Yes or No. Approximately, what is the percentage increase in premium to offer an open formulary plan?

34. Does your company allow members under certain circumstances to opt-out of the formulary when they need a specific drug not offered in your company's formulary? Yes or No. If yes, please provide the circumstances and how a member can initiate the opt-out.

35. Does your company offer an option of limiting the number of retail pharmacy outlets, limited network, as a means of prescription drug cost control? Yes or No. If yes, please provide the details on your program and the projected savings for the client.

36. The City currently uses a copay structure for non-specialty drugs and has a 20% coinsurance to a maximum of $250 per prescription for specialty medications. Can you match the following benefit structure? If you cannot match this exactly, please show the closest benefit structure you can offer.
    a. Tier 1 - $10
    b. Tier 2 - $50
    c. Tier 3 - $90
    d. Specialty Drugs – 20% to a maximum of $250 per Rx.

37. Does your company offer a mandatory generic prescription drug plan? Yes or No. If yes, please explain how the program works and the potential saving of offering such a plan.

38. Does your prescription drug program provide mail order services? Yes or No. If yes, please provide the name and address of the mail order company your company uses for mail order pharmacy.

39. Is your mail order provider company owned or sub-contracted? Indicate Owned or Subcontracted.
    If sub-contracted, please provide:
    The name and address of the sub-contracted company
    How many years your company has worked with the sub-contracted company
    How many clients your company currently has contracted with this vendor

Date of contract, beginning and expiration

40. What are the multiple of co-payments your company has available for a 90 day supply of prescription drugs? (1X, 1.5X, 2X, 2.5X, 3X). What is your standard offering?

41. How long has your company been using the services of your current prescription drug mail order provider?

42. Does you company plan on changing vendors or locations of the mail order facility with in the next 24 months? Yes or No. If yes, please explain.

43. Does your company plan on upgrading, changing software, changing hardware or equipment at your mail order facility? Yes or No. If yes, please explain.

44. Is there any situation that you are aware of that may cause a delay or disruption in the dispensing of mail order drugs at your company's facility? Yes or No. If yes, please explain.

45. Does your company offer a mandatory mail order program? Yes or No. If yes, please provide the details of the plan and potential savings when this type of plan.

46. Please provide the following information concerning the prescription drug discounts for retail/mail order prescription drugs?

    Retail average effective discount from AWP- generic drugs? _____

    Retail dispensing fee - generic drugs? _____

    Retail discount from AWP - brand name drugs? _____

    Retail dispensing fee - brand name drugs? _____

    Mail average effective discount from AWP-generic drugs? _____

    Mail dispensing fee-generic drugs? _____

    Mail discount from AWP-brand name drugs? _____

    Mail dispensing fee-brand name drugs? _____

47. Will your company provide the medical coverage to the City if the pharmacy coverage is carved out and placed with another company? Yes or No.

48. Please provide information on how your company handles the coverage of diabetic supplies. Are they covered under the prescription drug benefit, medical benefit or both? Please provide the co-payment/coinsurance level that these supplies would be provided.

49. Does your company utilize step therapy in its prescription drug benefit? Yes or No. If yes, is it mandatory for all clients or elective?

50. Please provide information as to how your company handles self injectable drugs under the prescription drug benefit.

51. Do you have administer a coordination of benefit (COB) provision on pharmacy benefits?

52. Does your company provide claim experience reporting specific to the prescription drug plan? Yes or No. If yes, please explain. If no, can this service be purchased for an additional fee?

53. Can you provide a fully insured EGWP program along with a fully insured medical plan? If so, please provide details as to how it works and the costs involved.

Fully Insured Medical Questionnaire

Claim Service

1. Please provide the location of the claim office where the City's claims will be processed.

2. Does your company own and operate the claim facility or is the service sub-contracted to another vendor? If it is subcontracted, please provide the information about the subcontractor.

3. What are your claim payment goals and results for 2015 and 2016? Please address turnaround time and claim payment accuracy.

4. What percentage of services was denied for medical necessity in 2015, 2016 and year to date 2017? Of those denials, what percentage was appealed and subsequently approved? Describe what types (top 5) of services are most frequently denied and why these services are denied.

PPO			
	2015	2016	2017 (YTD)
% Denied			
% Appealed			
Subsequently Approved			

HMO			
	2015	2016	2017 (YTD)
% Denied			
% Appealed			
Subsequently Approved			

5. Does your company have auto adjudication capabilities at this location? Yes or No.
    a. If yes, what percentages of claims are auto adjudicated?
    b. If no, are there plans to implement auto adjudication and when?

6. How many client companies does this claim facility service at this location?

7. How many client members are assigned to this location?

8. What is the ratio of claims processors to members?

9. Does your claim facility have specific claim processors that handle claims for:
    COB claims: Yes or No.
    Medicare claims Yes or No.
    Subrogation claims Yes or No.
    COBRA claims Yes or No.
    Catastrophic claims Yes or No.

10. Is your claims operation in compliance with the LANN requirements of Section 1557? What language interpretation services (languages) do you provide?

11. Does your claim facility have “toll free” telephone numbers available for the employer and member access? Yes or No.

12. Does your company offer claim viewing and/or claim submission via the internet or website? Yes or No. What restrictions are placed on the Group Plan Administration with regard to viewing claims information?

13. What are the days and hours of operation for this claim facility?

14. The claim facility is closed in observance of what specific holidays?

17. Does your company have any plans to change the location of the claim operation with-in the next 36 months? Yes or No. If yes, please provide the details.

15. Does your company have plans to down size or reduce the number of employees at the claim facility with-in the next 36 months? Yes or No. If yes, please provide the details.

16. Does your company have plans to upgrade, enhance or change the software or computer system used to process claims within the next 36 months? Yes or No. If yes, please provide the details

17. Does your company verify overage dependent eligibility? Yes or No.

18. How does your company handle overage dependents that are permanently disabled and remain on the medical plan?
    a. How often does your company verify these dependents?
    b. What procedures does your company use to verify these dependents?

Fully Insured Medical Questionnaire

Member Service

1. Where is the location of your member service unit that will be servicing the members of the City?
2. Is this a central or regional servicing office?
3. Does your company own and maintain the member service unit? Yes or No. If no, please explain.
4. What are the days and hours of operation for your member service unit?
5. Are there member service representatives available 24/7? Yes or No.
6. The Member Service operation is closed in observance of what specific holidays?
7. Does your company use home based member service representatives that report to this location? Yes or No. If yes, how long has your company been utilizing home based member service representatives and what percentage of member service calls are handled by home based employees.
8. Does your company use off shore based member service representatives at this location? Yes or No. If yes, how long has your company been utilizing off shore member service representatives and what percentages of member service calls are handled off shore?
9. Does your company have any plans with in the next 36 months to move or relocate the member service unit? Yes or No. If yes, please provide details.
10. Does your company plan within the next 36 months on downsizing the staff of the member service unit? Yes or No. If yes, please provide details.
11. Does your company plan within the next 36 months to up grade or change the computer system your member service unit is currently using? Yes or No. If yes, please provide details
12. Does your company's member service unit have a "toll free" telephone number for employer and member access?
13. What are your organization's target goals for the following metrics?

Member Service	Target Goal	2016 Actual Performance
Average Speed of Answer		
Average Length of Call		
First Call Resolution Rate		

Call Abandonment Rate		

14. Does your company supply a medical I.D. Card to each member with the appropriate benefits listed, member service and claim office “800” numbers? Yes or No.

15. Can members order and/or download new I. D. cards on-line via your company’s web site? Yes or No. If no, please give details as to how a member can request a new I.D. card.

16. Can HMO members change their PCP on-line via the web site? Yes or No. If yes, please provide details. If no, please provide details as to how a member changes PCPs with your company.

Fully Insured Medical Questionnaire

Financial Reporting
Medical/RX Claim Reports

1. Will your company provide financial and medical/Rx claim reporting at no charge to the City for each of the group medical plans you have responded to in this RFP? Yes or No.

2. At a minimum, The City will require the following reports on a monthly, quarterly, annual or ad hoc basis. Will your company supply the following reports?

   Monthly

   Total insurance premium/claims by month, paid and incurred, by plan with YTD: Yes or No.
   Loss ratio statistics: Yes or No.
   Lag Reports: Yes or No
   Claims broken out by medical and pharmacy: Yes or No.
   Claims broken out by employees and dependents: Yes or No.
   Claims broken out by plan of benefits: Yes or No.
   Claims broken out by actives and retirees under age 65 and over age: 65. Yes or No.
   Claims broken out by employees of the BOCC and each Constitutional Office: Yes or No.
   Number and types of encounters: Yes or No.
   Encounters by providers: Yes or No.

   Quarterly

   Demographic summary for medical and pharmacy: Yes or No.
   Key Statistics, Claims for office visits, specialist visits, inpatient, ambulatory, E.R. visits, admissions, days per 1,000, ALS, etc.: Yes or No.
   Catastrophic claims: Yes or No.
   Network discount analysis (billed versus paid analysis): Yes or No.
   Trend analysis: Yes or No.
   Inpatient analysis: Yes or No.
   Ambulatory analysis: Yes or No.
   Hospital utilization (top 25 hospitals) and profile: Yes or No.
   Top 25 diseases by claim amount: Yes or No.
   Pharmacy key statistics: Yes or No.
   Disease management statistics: Yes or No.
   Wellness statistics: Yes or No.

   Ad Hoc

   Detailed year to date roll up claim report Yes or No.
   Comprehensive year end claim report: Yes or No.
   Claims Detail by specific type of Provider or type of utilization: Yes or No.

3. Please provide samples of the financial and claim reports available from your company. Please clearly indicate which reports are standard and which are optional for an extra charge. Place the samples in Tab 6.

4. Does your company provide access to claim experience information on-line? Yes or No. Is this information real time if not, when are monthly reports available?

5. Is your company willing to provide a representative to attend meetings with the City to conduct detailed discussions concerning the financial medical/RX claim reports? Yes or No. If yes, how often?

Fully Insured Medical Questionnaire

Provider Networks

Please respond to each Provider Network question for all networks you are proposing.

1. What types of medical provider networks does your company offer in Fort Walton Beach, Florida and its surrounding counties?

    a. HMO Yes or No
    b. POS Yes or No
    c. EPO Yes or No
    d. PPO Yes or No

2. Does your company own or lease the medical network?

    a. If your company leases the network, please provide information concerning the network company.

3. Have you changed the size or structure of either the primary care or specialty care network for Surrounding Counties during the past 12 months? Yes or No. If yes, explain.

4. Complete the following GeoAccess summary for the City's employees. Your study must include a summary report for each of the items listed below. Each summary must indicate the total number and percentage of employees with access by zip code and by city for all networks that you are proposing. Please include GeoAccess Reports with your proposal in Tab 6.

    - Number and percentage of employees with two adult Primary Care Physicians (Family Practice, General Practice, Internists) within ten miles of the employee's zip code.
    - Number and percentage of employees with two Pediatricians within ten miles of the employee's zip code.
    - Number and percentage of employees with two OB/GYNs within ten miles of the employee's zip code.
    - Number and percentage of employees with two Specialists within twelve miles of the employee's zip code.
    - Number and percentage of employees with one hospital within twenty miles of the employee's zip code

PPO/POS	Adult PCP's 2 in 10 miles	Pediatricians 2 in 10 miles	OB/GYN 2 in 10 miles	Specialists 2 in 12 miles	Hospitals 1 in 20 miles
Number meeting standard					
% meeting standard					

HMO	Adult PCP's 2 in 10 miles	Pediatricians 2 in 10 miles	OB/GYN 2 in 10 miles	Specialists 2 in 12 miles	Hospitals 1 in 20 miles
Number meeting standard					
% meeting standard					

5. Complete the following GeoAccess summary for the City's participants using the same access standards as above. Please list the number of participants in the top 5 CITIES that do not meet the access standards.

List City and number without access	Adult PCP's 2 in 10 miles	Pediatricians 2 in 10 miles	OB/GYN 2 in 10 miles	Specialists 2 in 12 miles	Hospitals 1 in 20 miles
EXAMPLE					
Marathon - 5					
Key West - 3					
Key Largo - 1					
Key West - 1					
None					

6. Provide an electronic list (on a diskette or CD, in a usable Excel format) of your most up-to-date provider directory for Surrounding Counties. Please provide individual participating providers by name, even if they have the same TIN or NPID. The required format for the list follows:

Last Name| First Name| Middle Initial | Address | Address 2| City | State | Zip | NPID| Specialty| Network designation.

FORMATTING: Each item must be separated into separate cells and all numbers must be formatted as numbers. Provide this information for all of the networks that you are proposing. If you are using different networks, provide all networks proposed and identify each network. Please note that if the information is not provided in the exact format requested, your rating in this area will be compromised.

7. Have there been any changes to your hospital network that would affect City employees in 2016 or 2017? Yes or No. If yes, please explain the changes.

8. List what steps your organization will take to ensure that the proposed hospital network remains stable specifically within the Fort Walton Beach area.

9. Are there any hospitals in the North Florida area with which you are not contracted? Yes or No. If yes, list all hospitals.

10. Indicate your contract status for each of your participating hospitals as well as your top ten physician/physician group providers (by number of encounters) in North Florida Only. Indicate the current contract status and the contract's expiration date. If these differ by networks proposed, please complete for each network proposed.

PPO – North Florida

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/ Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
					6				
					7				
					8				
					9				
					10				

HMO – North Florida

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/ Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
					6				
					7				
					8				
					9				
					10				

11. Complete the following table for your proposed Networks for North Florida only. Use your current provider panel. (Use actual number of individual providers, not offices).

Provider Type	PPO North Florida	HMO North Florida
Allergy & Asthma		
Cardiologists		
Cardiovascular Surgeons		
Chiropractors		
Dermatologists		
Endocrinologists		

ENT		
Gastroenterologists		
General Surgeons		
Geriatricians		
Hematologists		
HIV/AIDS Physicians that specialize in HIV/AIDS treatment		
Infectious Disease		
Neurologists		
Neurosurgeons		
Non-OB Gynecologists		
Obstetrician/Gynecologists		
Oncologists		
Ophthalmologists		
Orthopedic Surgeons		
Pediatricians		
Podiatrists		
Primary Care Physician		
Pulmonologists		
Rheumatologists		
Urologist		

12. Complete the following exhibit for this and surrounding Counties for your PPO networks.

City	Number of PCPs	Number of Specialty Physicians	Percentage of PCPs Accepting New Patients	Percentage of Specialty Physicians Accepting New Patients	Percentage of Physicians Board Certified or Board-eligible

City	Number of Acute Care Hospitals	Number of Urgent Care Facilities	Number of Hospitals Offering Tertiary Care	Number of Hospitals Offering Inpatient Behavioral Health Care	Number of Lab Facilities	Number of Home Health Care Agencies	Number of Pharmacies

13. Complete the following exhibit for this and surrounding Counties for your HMO networks.

City	Number of PCPs	Number of Specialty Physicians	Percentage of PCPs Accepting New Patients	Percentage of Specialty Physicians Accepting New Patients	Percentage of Physicians Board Certified or Board-eligible

City	Number of Acute Care Hospitals	Number of Urgent Care Facilities	Number of Hospitals Offering Tertiary Care	Number of Hospitals Offering Inpatient Behavioral Health Care	Number of Lab Facilities	Number of Home Health Care Agencies	Number of Pharmacies

14. Are all hospital-based physicians (e.g., emergency, pathology, anesthesia and radiology) affiliated with network hospitals contracted? For the PPO? Yes or No. For the HMO? Yes or No. If no, list any hospital physician group(s) not contracted. Please include the hospital affiliation.

15. If covered services are not available within the contracted network, how do members obtain necessary service? Does this differ between the PPO and HMO products?

16. What fee schedule do you use for out-of-network benefits on the PPO/POS plan? Can you administer alternate fee schedules upon the City's request? Yes or No.

17. Are PCP and Specialist contracts evergreen? Yes or No. What are the termination requirements within your provider contracts as far as timeframes and notification? If this differs between the PPO and HMO please respond for both.

18. How and when do you notify clients and members of pending network terminations? If this differs between the PPO and HMO please respond for both.

19. What provisions are made for transition of care if a provider is terminated by your plan? What provisions are made if the provider terminates the contract? Will ongoing services be treated as in-network? If this differs between the PPO and HMO please respond for both.

20. Provide the number of contracted ancillary facilities/locations by plan type for North Florida only.

Provider Type	PPO	HMO
Ambulatory Surgery Centers		
Bone Density Testing		
Convenient Care Clinics/Retail Clinics		
DME Providers		

Home Health Care Agencies		
Hospice Agencies		
Hospice Facilities		
Mammogram Facilities		
Occupational Therapists		
Outpatient Laboratories		
Physical Therapists		
Radiology Centers		
Rehabilitation Facilities (Inpatient)		
Skilled Nursing Facilities		
Speech Therapists		
Urgent Care Facilities		

21. What types of Accountable Care Organization (ACO) or similar programs/models do you have in place already and what do you have planned for 2017 and 2018? Will any of these programs be available to the City's participants? If this differs between the PPO and HMO products please provide details for both.

22. Are there any costs/charges over and above the premium to the City in order for employees to receive care from an ACO or similar program/model? If yes, what are the costs and how will it work? If this differs between the PPO and HMO products please provide details for both

23. Who funds the incentive for the providers that participate in an ACO or similar program/model and how do they fund it? If this differs between the PPO and HMO products please provide details for both

24. How will members determine which providers are participants of the ACO or similar program/model? If this differs between the PPO and HMO products please provide details for both

25. Does your company offer medical provider information on line? Yes or No. If no, how is network information made available?

    If yes, can the provider information be accessed by:
    - Total network of physicians and hospitals? Yes or No.
    - Search by physician's name? Yes or No.
    - Search by physician's specialty? Yes or No
    - Search by physician's zip code? Yes or No.
    - Hospitals by county? Yes or No.
    - Hospitals by zip code? Yes or No.
    - Hospitals by physicians admitting privileges? Yes or No.
    - Can the network information be downloaded and printed? Yes or No.

14. Do members have to live in a networked zip code to be considered in-network? Yes or No.

15. How does your company handle out of state eligible dependents when the employee has selected an HMO plan for their coverage?

16. Is your company offering an open access option plan HMO and/or POS (non referral)?
    a. HMO: Yes or No.
    b. POS: Yes or No.

17. Does your company require the members to select a primary PCP for the HMO and/or POS products?
    a. Yes or No.

18. What are the procedures for a member to change a PCP? Can change be made on line?

19. How often can a member change their PCP? When is the new PCP provider effective?

20. Can female members select either a PCP or an OBGYN as their PCP?
    a. Yes or No. If no, how are OBGYN visits handled in your plan?

21. Are HMO/POS members required to obtain referrals for every specialist visit?
    a. Yes or No. If yes, please explain.

22. Can HMO/POS members access a specialist referral without a PCP visit? Yes or No.

23. Do any of your PCP's not have admitting privileges to your South Florida network hospitals? Yes or No. If yes, how many?

24. Does your company offer Urgent Care coverage? Yes or No.

25. Can members choose Urgent Care practices as their PCP in the HMO? Yes or No.

26. Do your contracts for PCP's and specialists contain any type of withhold or bonus arrangement? Yes or No. If yes, please explain.

27. Do your PCP and specialists contracts contain provisions for the employer and members to be held harmless from any fees for service that are plan eligible, but not paid by the plan regardless of the reason? (excludes co-payments, deductibles and coinsurance)

28. Do your PCP and specialist contracts contain wording to restrict the provider from balance billing for in network services? Yes or No. If no, how do you protect members using network providers from balance billing?

29. Do you subcontract for Behavioral Health and Substance Abuse services? Yes or No. If yes, please provide the details of your subcontractor.

30. Can the City's EAP directly refer a member to a Behavioral Health care provider? Yes or No. If no, describe the process for the EAP to obtain authorization for services.

31. How would transition of care be handled for members currently under care with a provider that is not in your existing network, including timeframes? How would transition of care be handled if a provider is terminated during the course of treatment?

32. List the Behavioral Health facilities under active contract in this and surrounding Counties.

Specialty	Facility Name	Location
Mental Health Facilities		
Inpatient		
Intensive Outpatient		
Substance Abuse Facilities		
Inpatient		
Intensive Outpatient		
Residential Treatment Facilities		

33. What percentage of your contract physicians are board certified in Psychiatry? _____ %

34. What is your overall network pricing as compared to prevailing Medicare reimbursement for hospitals and for physicians? Please answer separately for this and surrounding Counties.

35. Do any network contracts include outlier provisions? Yes or No. If yes, explain.

36. Are changes to your network pricing planned for 2017 or 2018? If so, describe.

37. Do your provider contracts include language to address "Never Events", including non-payment and hold harmless for such events? Are patients held harmless in these cases?

38. Provide hospital cost data for North Florida Only.

	PPO/POS		HMO	
	2015	2016	2015	2016
Average allowed cost per admission				
Average allowed cost per day				
Average discount level				
Average length of stay				
Days per 1000				
Admissions per 1000				

39. For out of network benefits in your POS and PPO plans, does your company use reasonable and customary or MAC (provider contracted rate) pricing for claim adjudication?

40. Are all of your contracted providers required to carry medical malpractice insurance? If any providers are not required to carry medical malpractice insurance, list all types of providers that are not required to maintain medical malpractice insurance.

41. If contracted providers are not required to maintain medical malpractice insurance, why? What percentage of your network providers carry no malpractice insurance?

42. Proposer must complete the CPT list (Exhibit E) in full for both the HMO and PPO/POS. The rates should be based on average reimbursements for North Florida providers separately, NOT on statewide or MSA provider averages. Use reimbursement rates as of January 1, 2017.

43. Have you changed affiliations for ancillary services (diagnostic services, prescription drug benefits, etc.) in this and surrounding Counties during the past 12 months? Yes or No. If yes, describe such changes.

44. Indicate if you have a "Centers of Excellence" program for each of the following and list your designated facilities for each:

	Yes or No	Facility(ies) Name(s):	In Network or Out of Network
Transplants			
Cardiovascular			
Cancer			
HIV/AIDS			
Neonatal			
Other _____			

45. Describe your organization's policies regarding your "Centers of Excellence" program. Indicate if the program is voluntary or mandatory.

46. When members access a Center of Excellence, are they considered to be in network and will receive the appropriate network benefits? Yes or No. If no, please explain.

47. Will your organization provide information directly to the plan participant to make provider selections that provide the best outcomes and best costs? If so, please explain.

48. What quality and cost data do you make available to members for selecting hospitals, clinics, imaging centers, labs and physicians in your network for provider comparison? What additional data will be available in 2017 and 2018?

49. What quality, cost, satisfaction, and outcome data is available for the plan sponsor regarding in network providers (specifically cancer care, orthopedics, maternity, heart disease, behavioral health, pediatrics, emergency care, etc.)? How is this data provided to plan sponsors?

50. Is your provider credentialing process conducted in-house or delegated to another organization? If delegated, provide name of the organization and how long the functions have been delegated.

51. Do credentialing policies and procedures meet accreditation standards? Yes or No. If yes, what accreditation organization?

52. How long does it take to credential a new physician? How often does your Credentialing Committee meet?

53. How often do you re-credential network providers?

54. Between re-credentialing cycles, do you conduct ongoing monitoring of practitioner sanctions, complaints and quality issues? Yes or No. If yes, how often?

55. Does your company provide a grievance procedure specifically for members who have problems with certain providers? Yes or No. If yes, please provide what types of complaints are heard and what the process is to file a grievance and have one heard? What is the time table for the procedure?

56. How often do you visit physicians on-site to explain contracts and contract changes? Please address surrounding counties specifically.

57. How many physicians have you terminated from this and surrounding Counties in 2015 and 2016 who failed to maintain credentialing standards and how many have been terminated due to quality assurance reasons?

58. Please describe your company's process in notifying the client and participants of changes in your company's provider network. Please provide recent communications.

59. What has been the percentage of turnover experienced for the past three years in this and surrounding Counties for the following medical providers:

PPO Network						
	2014	2014	2015	2015	2016	2016
PCPs						
Specialists						
Hospitals						

HMO Network						
	2014	2014	2015	2015	2016	2016
PCPs						
Specialists						
Hospitals						

60. What percentage of PCPs in your HMO network are "closed" and not accepting new members? In North Florida?

61. Please describe how your company handles the following situation:

    A member is currently enrolled as a patient in the employer's current carrier's PPO network. The PCP practice is closed to new patients in your HMO network. The employer changes medical carriers and the member enrolls in the new HMO plan at open enrollment. The member's PCP is in the new carrier network, the member wishes to remain with his current provider and enrolls in the new HMO medical plan requesting the current PCP.

    Is the member considered an existing patient when they enroll with the new carrier, or is the member considered a new patient and denied access to this PCP?

    Please explain in detail how your company and PCP contract address this issue.

62. Does your company plan to add any new PCP's and/or specialists to the City's network? If yes, please provide information on any new contracts or negotiations for the City.

63. Is your company currently, or with in the next 12 months, negotiating any existing contracts with any practice groups of PCPs or specialists? Yes or No.
    a. If yes, Please provide all pertinent information concerning the practice group, dates of contract, possible termination dates.

64. Please provide the names of all the hospitals in surrounding counties that your company will be negotiating new contracts with in the next 24 months?

65. Please provide the names of all the PCP or specialist groups in surrounding counties that your company will be negotiating new contracts with in the next 24 months?

66. Please provide the names of all the ancillary medical providers in surrounding counties that your company will be negotiating new contracts with in the next 24 months?

67. How does your contract handle the large up front deductible associated with the CDHPs? Do the providers collect the deductible at time of service or are they required to submit a claim form for processing and wait to bill at a later date?