STATE OF ALASKA
REQUEST FOR PROPOSALS

MEDICAL CLAIMS ADMINISTRATOR AND MANAGED NETWORK, DENTAL CLAIMS ADMINISTRATOR AND NETWORK

(medical and dental programs may be contracted separately)

ISSUED OCTOBER 12, 2018

RFP 190000025

ISSUED BY:

DEPARTMENT OF ADMINISTRATION
DIVISION OF RETIREMENT AND BENEFITS

PRIMARY CONTACT:

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OFFERORS ARE NOT REQUIRED TO RETURN THIS FORM.

IMPORTANT NOTICE: IF YOU RECEIVED THIS SOLICITATION FROM THE STATE OF ALASKA'S "ONLINE PUBLIC NOTICE" WEB SITE, YOU MUST REGISTER WITH THE CONTRACTING OFFICER LISTED ABOVE TO RECEIVE SUBSEQUENT AMENDMENTS. FAILURE TO REGISTER WITH THE CONTRACTING OFFICER MAY RESULT IN THE REJECTION OF YOUR OFFER.

Please note that the RFP process will be conducted via the internet, using the ProposalTech application. Proposal specifications are contained in the electronic RFP (eRFP), which can be found at ProposalTech's website (www.proposaltech.com). Proposers will need to register and login to the system at www.proposaltech.com/home/app.php/register using the username and password that are supplied to you in the invitation email you will receive from ProposalTech.

To access the eRFP, Proposers must first take the following actions:

- If you receive the ProposalTech invitation email, you have been identified as a contact for the RFP. **If you will not be a contact, please ensure that this communication is routed appropriately.** This information may not have been sent to any other parties within your organization.
- The primary contact should access the website to initiate review and acceptance of the RFP.
- **Primary contacts will be responsible for establishing permission to access the RFP for other individuals within their organizations**. Multiple users from your organization may access the RFP simultaneously.

Detailed instructions for the completion and submission of your proposal will be found in the eRFP. ProposalTech will be available to assist you with technical aspects of utilizing the system. Any questions regarding content should be submitted using the "Ask Questions" feature on the main RFP page for general questions and the "Related Q&A" link under specific content for specific questions.

If you would like to schedule a ProposalTech training session please contact ProposalTech at (877) 211-8316, choose option 4, or send an email to support@proposaltech.com.

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SECTION 1. INTRODUCTION & INSTRUCTIONS

SEC. 1.01 PURPOSE OF THE RFP

The Department of Administration, Division of Retirement and Benefits, is soliciting proposals from qualified and experienced firms to provide services for medical/vision/audio claims administration, network management and dental administration with a preferred provider network. The services are administrative only services for the State's self-funded medical/vision/audio and dental benefit plans for both its active employee and retired population. The State is interested in direct contracting. Third party or broker proposals are not acceptable.

SEC. 1.02 DEADLINE FOR RECEIPT OF PROPOSALS

Proposals must be received no later than **2:00 p.m.,** Alaska Time, on **December 3, 2018**. See Section 1.07 for further instructions.

SEC. 1.03 RFP SCHEDULE

The RFP schedule set out herein represents the State's best estimate of the schedule that will be followed. If a component of this schedule, such as the deadline for receipt of proposals, is delayed, the rest of the schedule may be shifted accordingly. All times are Alaska Time.

ACTIVITY	TIME	DATE
Educational Meeting	10:00 am	10/5/18
Issue Date / Draft RFP Released		10/12/18
Draft RFP Period Ends		10/24/18
Pre-Proposal Conference and Second Educational Meeting	9:30 am	10/29/18
Deadline to Submit Questions	4:30 pm	11/6/18
Responses to Questions		11/16/18
Deadline for Receipt of Proposals / Proposal Due Date	2:00 pm	12/3/18
Initial Evaluations and Proposal Analysis Starts		12/4/18
Shortlisting (optional)		1/28/19
Interview Period	TBD	2/7/19 – 2/15/19
Clarification Period Begins		2/19/19
Notice of Intent to Award		5/1/19
Contract Issued		6/3/19
Start Date		1/1/20

During the draft RFP period offerors should submit any initial questions or concerns about the RFP in writing to the Procurement Officer.

This RFP does not, by itself, obligate the State. The State's obligation will commence when the contract is approved by the Commissioner of the Department of Administration, or the Commissioner's designee. Upon written notice to the contractor, the State may set a different starting date for the contract. The State will not be responsible for any work done by the contractor, even work done in good faith, if it occurs prior to the contract start date set by the State or prior to a fully signed contract.

SEC. 1.04 EDUCATIONAL AND PRE-PROPOSAL CONFERENCES

An educational meeting was held at **10:00 a.m.** Alaska Time on **October 5, 2018.** The meeting was held via webinar and was an introduction to the procurement process being used for this solicitation. The meeting did not discuss the contents of this RFP. The general information provided in this meeting will be provided again during the pre-proposal meeting.

A recording of this meeting can be accessed here:
https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=191597

An in-person pre-proposal conference and second educational meeting will be held in Juneau at **9:30 a.m.** Alaska Time on **October 29, 2018**, to discuss the RFP with prospective offerors, allow them to ask questions concerning the RFP, and to provide a thorough education on the RFP process being used. To obtain the greatest benefit of this meeting, offerors are strongly encouraged to send their direct supervisory personnel/critical project team members (in lieu of executives, business development, or sales personnel).

Offerors should read the RFP in full and come to the meeting prepared to discuss any questions or concerns. Offerors with a disability needing accommodation should contact the contracting officer prior to the date set for the pre-proposal conference so that reasonable accommodation can be made. The meeting will be held at the following location:

Building: **Lecture Hall at the Andrew P. Kashevaroff (APK) Alaska State Library, Archives, & Museum**
Address: **395 Whittier Street, Juneau, AK 99801**

In-person participation is strongly recommended. Questions will only be taken from in-person participants. A listen-only webinar will be available to interested parties unable to attend in-person. Note that the conference may be recorded.

Pre-proposal conference webinar link:
https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=e0c099d2272b7405ab1dea8bab8bd0842

Call-in number: 1-855-244-8681
Access code: 807 504 422

SEC. 1.05 REQUIRED REVIEW

Offerors should carefully review this solicitation for defects and questionable or objectionable material. Comments concerning defects and objectionable material must be made in writing and received by the contracting officer at least ten days before the deadline for receipt of proposals. This will allow time for the issuance of any necessary amendments. It will also help prevent the opening of a defective solicitation and exposure of offeror's proposals upon which award could not be made. Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of the contracting officer, in writing, at least ten days before the deadline for receipt of proposals.

SEC. 1.06 QUESTIONS PRIOR TO DEADLINE FOR RECEIPT OF PROPOSALS

All questions must be in writing and submitted through ProposalTech. All questions require a written amendment to the RFP that will be posted to ProposalTech.

SEC. 1.07 RETURN INSTRUCTIONS

Offerors will submit all required documents through ProposalTech. After the initial draft period of the RFP, all offerors will receive access to the ProposalTech system. Offerors are to complete the sections related to the services they are proposing (medical, dental, or both). The electronic RFP system will all offerors to response to each section, as well as, allowing for the uploading of data files. All responses and files must be completed/uploaded on the ProposalTech system.

An offeror's failure to submit its proposal prior to the deadline will cause the proposal to be disqualified. Late proposals will not be opened or accepted for evaluation.

SEC. 1.08 ASSISTANCE TO OFFERORS WITH A DISABILITY

Offerors with a disability may receive accommodation regarding the means of communicating this RFP or participating in the procurement process. For more information, contact the contracting officer no later than ten days prior to the deadline for receipt of proposals.

SEC. 1.09 AMENDMENTS TO PROPOSALS

Amendments to or withdrawals of proposals will only be allowed if acceptable requests are received prior to the deadline that is set for receipt of proposals. No amendments or withdrawals will be accepted after the deadline unless they are in response to the State's request in accordance with 2 AAC 12.290.

SEC. 1.10 AMENDMENTS TO THE RFP

If an amendment is issued before the deadline for receipt of proposals, it will be provided via ProposalTech to all vendors participating in the RFP process.

After receipt of proposals, if there is a need for any substantial clarification or material change in the RFP, an amendment will be issued. The amendment will incorporate the clarification or change, and a new date and time established for new or amended proposals. Evaluations may be adjusted as a result of receiving new or amended proposals.

SEC. 1.11 ALTERNATE PROPOSALS

Offerors may only submit one proposal for evaluation. In accordance with 2 AAC 12.830 alternate proposals (proposals that offer something different than what is asked for) will be rejected.

SEC. 1.12 NEWS RELEASES

News releases related to this RFP will not be made without prior approval of the project director or contracting officer.

SECTION 2. BACKGROUND INFORMATION

SEC. 2.01 ABOUT THE DIVISION

The Division of Retirement and Benefits (Division) manages the State of Alaska's retirement systems and health benefit plans. The Division's scope of work includes serving as the point of contact for administrative, legal, legislative, and procedural issues regarding the management of the state-sponsored health, dental, and long-term care plans. Currently the Division manages eligibility and internally handles some of the work related to customer service, benefits processing, counseling,
and appeals.

The Commissioner of the Department of Administration is the plan administrator, but delegates policy development and the operation of state-sponsored health benefit plans to the Division's health team. This team is comprised of a Division Director, Chief Health Policy Administrator, Chief Health Operations Official, and support staff.

SEC. 2.02 ALASKACARE

AlaskaCare is the term used to describe the health plans administered through the State of Alaska. These plans are provided in accordance with Alaska statutes to a subset of state employees, and to public employees, teachers, and judicial officers of the state and political subdivisions who are eligible for retiree health benefits. The coverage provided is good worldwide.

The State of Alaska provides health and dental benefit plans to: (1) a portion of state employees; (2) defined benefit (DB) retired employees of the state, teachers, and participating political subdivision employees; and (3) defined contribution (DC) retired employees of the state, teachers, and participating political subdivision employees. The plans have different provisions and funding structures, but the State's group health and dental plans are self-funded. The State also offers a self-funded Dental/Vision/Audio (DVA) and long-term care benefit plan option to all eligible retirees. Benefits for most active state employees are subject to collective bargaining agreements.

The retirement health benefits fall into two major categories, those of the DB retirement plan (members who entered the retirement system prior to July 1, 2006), and the DC retirement plan (members who entered the retirement system on or after July 1, 2006). The DB retiree plan is an older plan design that has not been substantially updated since 2000, and is constitutionally protected against diminishment. However, the Division is currently working with the Retiree Health Plan Advisory Board to modernize the plan. The DC retirement medical plan was implemented in 2016, and currently has under 40 members. The State currently receives prescription drug subsidies through CMS Retiree Drug Subsidy program, but is implementing an employer group waiver program (EGWP) in both retiree health plans effective January 1, 2019.

There is a union labor/management committee that provide recommendations to the plan administrator for changes to the employee plan, and there is a newly established Retiree Health Plan Advisory Board (RHPAB) to provide recommendations to the plan administrator related to the retiree health plans.

The AlaskaCare plans (medical and dental) have many members who are covered by more than one AlaskaCare plan. This can be through coverage as a member and a dependent of their spouse, or through two of their own plans (i.e. employee plan and retiree plan, or two retirement plan benefits). The active employee and DC plans allow coordination of benefits up to 100% of the allowed charge. The DC plan has a government carve-out type coordination of benefits, where AlaskaCare applies the coinsurance calculation to the amount not covered by the primary plan.

SEC. 2.03 HISTORICAL FACTS AND FIGURES

Medical/Vision Summary of Services (from July 2017 – June 2018)

	Employee Economy Medical Plan	Employee Standard Medical Plan	Employee CDHP Medical Plan*	Total Employee Medical Plans	Employee Vision Plan	Retiree Medical Plan	Retiree Audio/Vision Plan
Avg. Subscribers Months	3,154	2,771	105	6,030	3,992	42,746	34,865
Avg. Member Months	7,608	7,633	249	15,490	10,981	71,950	54,361
Paid Medical Claims	$33,610,474	$60,524,578	$242,923	$94,377,975	$1,130,010	$312,270,873	$10,557,400
# of Medical Claims				254,999		2,132,775	-

Medical/Vision Summary of Enrollment (June 2018)

	Employee Economy Medical Plan	Employee Standard Medical Plan	Employee CDHP Medical Plan*	Total Employee Medical Plans	Employee Vision Plan	Retiree** Medical Plan	Retiree Audio/Vision Plan
# of Subscribers	3,225	2,586	106	5,917	3,975	43,060	35,227
# of Members	7,814	7,059	252	15,125	10,657	72,049	54,769

Dental Summary of Services (from July 2017 – June 2018)

	Economy Employee Plan	Standard Employee Plan	Total Employee Plans	Retiree Plan	Total
Avg. Subscribers Months	2,273	3,767	6,041	34,865	40,906
Avg. Member Months	5,152	10,310	15,462	54,361	69,823
Paid Dental Claims	$1,021,647	$5,007,626	$6,029,273	$31,511,909	$37,541,182
# of Dental Claims					163,563

Dental Summary of Enrollment (June 2018)

	Economy Employee Plan	Standard Employee Plan	Total Employee Plans	Retiree Plan	Total
# of Subscribers	2,312	3,744	6,056	35,227	41,283
# of Members	5,239	10,150	15,389	54,769	70,158

* CDHP plan was effective 01/01/2018

** The DC Retiree medical plan has 27 subscribers as of June 2018 and are included in the Retiree counts above

SEC. 2.04 ABOUT THE EXISTING MEDICAL ADMINISTRATION AND NETWORK MANAGEMENT SERVICES

As of January 1, 2014, Aetna has been the AlaskaCare medical Third Party Administrator (TPA) and network manager. The following information provides an understanding of current programs. Offerors should consider

current programs and vendor relationships, but should also consider the potential for program elimination and/or vendor changes.

Current medical administration services provided by Aetna include:

1. Claims adjudication
2. Pricing administration
3. Network access, management, and expansion
4. Vision network and claims administration through a partnership with VSP for the employee plan
5. Vision claims administration in the retiree indemnity plan
6. EAP access and claims administration, including hour allocations for Critical Incidence Stress Debriefings (CISD) and trainings
7. Precertification and claims administration for travel in situations where the service is not available locally, or can be provided at a lower cost in other locations
8. Access to telemedicine through TelaDoc
9. COBRA notices and premium billing/collection
10. Retiree direct billing services including premium billing/collection, monthly premium remittance to the State and eligibility sharing with long-term care vendor and, effective January 1, 2019 the pharmacy benefit manager
11. Retiree administration of lifetime maximum and annual reinstatement
12. Coordination plan as secondary payer for Medicare retirees
13. Administration of Flexible Spending Accounts and Health Reimbursement Arrangements, both traditional (DC retiree) and notional (active employee)
14. Integration as needed with other vendors as directed by the State. See “other vendor services” below
15. Data reporting (standard and ad-hoc reporting) and data warehouse through partnership with HDMS
16. Monthly universal outbound claim files
17. Eligibility maintenance
18. Verification of retiree dependent student eligibility
19. Verification of incapacitated dependent eligibility
20. Paper claims submission and processing
21. Online access capabilities (portal access for members and the State)
22. Comprehensive IT capabilities including access to claims history with denial reasons
23. Coordination of benefits
24. Subrogation support services
25. Health management services including: case management, disease management, and care consideration outreach
26. Access to Centers of Excellence
27. Distribution of ID cards
28. Access to provider directories
29. Clinical review and precertification determination
30. Medical necessity determinations and maintenance of clinical policy bulletins
31. Services for claims resolution and assistance with claims appeals (see special considerations discussed later in the RFP)
32. Local dedicated customer service teams in Anchorage and Juneau
33. Dedicated customer service representative (CSR) telephonic support with access to call logs and historical claims data
34. Provide MA1099-HC tax forms to all applicable Massachusetts members
35. Dedicated account management staff

Current Medical Plan Initiatives

The current vendor also works with the State on the identification, analysis, development and administration, and/or coordination of strategic initiatives. Examples include:

- Implementation of an enhanced travel benefit (SurgeryPlus)
- Tiered hospital and outpatient steerage and benefit payment differential (preferred facility, Alaska Regional Hospital)
- Implementation of telemedicine network (Teladoc)
- Three-tier pharmacy benefit design

All potential bidders will be expected to partner with the State on current and future design, administration, coordination, and implementation of any subsequent initiatives.

Pharmacy Benefit Management (PBM)

PBM Services were bid in 2018 for a 2019 implementation and are contracted separately. Beginning January 1, 2019, OptumRx will begin processing pharmacy claims.

Dental

The current dental network and TPA contract with Moda (Delta Dental) has been in place since January 1, 2014.

Current dental administration services provided by Moda include:

1. Claims adjudication
2. Access to a managed network of providers in Alaska and the rest of the United States
3. Network access, management, and expansion
4. Eligibility maintenance
5. Coordination of benefits
6. Data reporting (standard and ad-hoc reporting)
7. Distribution of ID cards
8. Access to provider directories
9. Services for claims resolution and assistance with claims appeals (see special considerations discussed later in the RFP)
10. Designated CSR telephonic support with access to call logs and historical claims data
11. Comprehensive IT capabilities including access to claims history with denial reasons
12. Dental procedure pricing tools
13. Designated account management
14. Online system providing covered participants and dependents with a designated contact for issue resolution and reconciliation

Other Vendor Services

The Division engages with other external vendors to provides the services listed below:

- OptumRx – provides pharmacy benefit manager services (all active employee and retiree plans)
- Teladoc – provides telephonic access to a doctor for non-emergency services (active employee only)
- SurgeryPlus – provides travel coordination and administration for certain elective procedures (active employee plan only)
- CHCS – provides TPA services for the long-term care plan (long term care plan only)
- Beacon Occupational Health and Safety Services, Inc. – provides access to employee clinics in Anchorage and Fairbanks (active employee plan only)
- HDMS – provides data warehouse services (all active employee and retiree medical and pharmacy plans)
- Pacific Health Coalition – provides access to annual health fairs, employee clinics (via Beacon Occupational Health and Safety Services, Inc. above), and pricing terms for Alaska Regional Hospital and Surgery Center of Anchorage.

SEC. 2.05 FINANCIAL STRUCTURE/MODEL

All of the State's health plans are self-funded and the current medical TPA receives a Per Employee Per Month (PEPM) administration fee for most services. The plan coverage provisions are on a calendar year basis, while the State's accounting and budget is based on a July to June fiscal year. The active employee, DB retiree, and DC retiree medical plans, and voluntary benefits (dental/vision/audio plan and long-term care plan) are accounted for separately through their respective trusts.

Like the medical plans, all of the State's dental plans are self-funded and the current dental TPA receives a PEPM administration fee for most services. The plan provisions are on a calendar year basis, while the State's accounting and budget is based on a July to June fiscal year. Administration of the retiree dental, vision, audio plan is shared between Moda and Aetna, with Moda providing dental TPA services and Aetna providing vision and audio TPA services. Moda provides dental TPA services for the employee dental plan as well.

SEC. 2.06 CURRENT MEDICAL PLAN FEATURES AND COVERAGE

The State administers three self-funded medical plans (the Economy, Standard, and newly added Consumer Choice Plan – a Consumer Directed Health Plan (CDHP)) for active state employees. These plans surrendered their grandfathered status under the federal Patient Protection and Affordable Care Act (ACA) on January 1, 2017. The State provides a supplemental vision plan for active employees. A number of active employee benefits are subject to certain collective bargaining agreement provisions.

The employee plan details can be found in the summary of plan benefits booklet available below.

- Active Employees: http://doa.alaska.gov/drb/pdf/ghlb/akcare/SelectBenefitsEmployeeBooklet-09012018.pdf

In addition to offering three self-funded medical plans to the active population, there are two retiree medical plans offered to eligible retirees for the State of Alaska. These include the DB medical plan and the DC medical plan. Vision and audio benefits are provided through a supplemental Dental, Vision, and Audio plan (DVA) to all retirees.

The retiree benefit plan details can be found in the summary of plan benefits booklet available below.

- Defined Benefit: http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2018final.pdf
- Defined Contribution: http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf

The vision and audio plans benefits are embedded into the respective retiree medical plan booklets, but offer identical benefits (there is only one dental, vision and audio plan).

Active Employee Medical Plans

	Active Employee Medical Plans		
	Standard Plan	**Economy Plan**	**Consumer Choice Plan**
Deductibles			
Annual individual deductible	$400	$600	$2,500
Annual family deductible	$800	$1,200	$5,000
Effective 1/1/19 *Annual individual deductible*	*$300*	*$500*	*$2,400*
Effective 1/1/19 *Annual individual deductible*	*$600*	*$1,000*	*$4,800*

	Active Employee Medical Plans		
	Standard Plan	**Economy Plan**	**Consumer Choice Plan**
Coinsurance			
Most medical expenses • $100 penalty if seek non-emergency care at emergency room of a hospital	80%	70%	70%
Most medical expenses after out-of-pocket limit is satisfied	100%	100%	100%
Medical expenses for your spouse or dependent children if they are eligible to be covered by a State employee health trust and that coverage (i) has been waived, (ii) pays less than 70% of the covered expenses, or (iii) has an individual deductible, of at least $5,000.	30%	30%	30%
Episode of Care received through SurgeryPlus benefits	100%	100%	100%
Facility services with a network provider	80%	70%	70%
Facility services with an out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center in other 49 states or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage	60%	50%	50%
Transplant services if an Institute of Excellence™ (IOE) facility is used	80%	70%	70%
Transplant services if a non-Institute of Excellence™ (IOE) facility is used	60%	50%	50%
Preventive care with a network provider or when use of an out-of-network provider has been precertified.	100%	100%	100%
Preventive care with an out-of-network provider	80%	70%	70%
Hearing benefit	80%	80%	80%
Inpatient mental disorder treatment with a network provider	80%	70%	70%
Inpatient mental disorder treatment with an out-of-network provider	60%	50%	50%
Inpatient substance abuse disorder treatment with a network provider	80%	70%	70%
Inpatient substance abuse disorder treatment with an out-of-network provider	60%	50%	50%

	Active Employee Medical Plans		
	Standard Plan	**Economy Plan**	**Consumer Choice Plan**
Individual Out-of-Pocket Limit			
Annual individual out-of-pocket limit The following expenses do not apply toward the out-of-pocket limit: • charges over the recognized charge; • non-covered expenses; • premiums; • precertification benefit reductions; • $100 penalty if seek non-emergency care at emergency room of a hospital; • Prescription drug expenses; • $25 copayment for non-preventive services to Coalition Health Clinic; • $5 copayment for general medical consultation under section 3.5.4, *Teladoc Services;* and • 45 visit charge for caregiver consultation under section 3.5.4, *Teladoc Services.*	$1,850 $3,700 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage	$2,850 $5,700 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage	$5,500 $11,000 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage
Effective 1/1/19 *Annual individual out-of-pocket limit* *The following expenses do not apply toward the out-of-pocket limit:* • *charges over the recognized charge;* • *non-covered expenses;* • *premiums;* • *precertification benefit reductions;* • *$100 penalty if seek non-emergency care at emergency room of a hospital;* • *Prescription drug expenses;* • *$25 copayment for non-preventive services to Coalition Health Clinic;* • *$5 copayment for general medical consultation under section 3.5.4, Teladoc Services; and* • *45 visit charge for caregiver consultation under section 3.5.4, Teladoc Services.*	*$1,750* *$3,500 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage*	*$2,750* *$5,500 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage*	*$5,400* *$10,800 if use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free- standing imaging center in Anchorage*

	Active Employee Medical Plans		
	Standard Plan	**Economy Plan**	**Consumer Choice Plan**
Family Out-of-Pocket Limit			
Annual family out-of-pocket limit The following expenses do not apply toward the out-of-pocket limit: • charges over the recognized charge; • non-covered expenses; • premiums; • precertification benefit reductions; • $100 penalty if seek non-emergency care at emergency room of a hospital; • Prescription drug expenses; • $25 copayment for non-preventive services to Coalition Health Clinic; • $5 copayment for general medical consultation under section 3.5.4, *Teladoc Services;* and • 45 visit charge for caregiver consultation under section 3.5.4, *Teladoc Services.*	$3,700 $7,400 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage	$5,700 $11,400 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage	$11,000 $22,000 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage
Effective 1/1/19 *Annual family out-of-pocket limit* *The following expenses do not apply toward the out-of-pocket limit:* • *charges over the recognized charge;* • *non-covered expenses;* • *premiums;* • *precertification benefit reductions;* • *$100 penalty if seek non-emergency care at emergency room of a hospital;* • *Prescription drug expenses;* • *$25 copayment for non-preventive services to Coalition Health Clinic;* • *$5 copayment for general medical consultation under section 3.5.4, Teladoc Services; and* • *45 visit charge for caregiver consultation under section 3.5.4, Teladoc Services.*	*$3,500* *$7,000 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage*	*$5,500* *$11,000 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage*	*$10,800* *$21,600 if use out-of-network provider for hospital, surgery center, rehabilitative facility, or free-standing imaging center services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage*
Benefit Maximums			
Individual limit on hearing aids • Maximum applies to a rolling 36 month period	$3,000		
Visit/Service Limits			
Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations	20 visits per benefit year		
Hearing exams	One per rolling 24 month period		
Home health care. See section 3.5.8, *Home Health Care*, for exceptions.	120 visits per benefit year Up to 4 hours = 1 visit		
Outpatient hospice expenses	Up to 8 hours per day		
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 therapy visits in a 24 hour period Up to 1 hour = 1 visit		

	Active Employee Medical Plans		
	Standard Plan	**Economy Plan**	**Consumer Choice Plan**
Employee assistance program	8 visits per problem per benefit year		
Travel Benefits: Therapeutic treatments	One visit and one follow-up per benefit year		
Travel Benefits:			
• Prenatal/postnatal maternity care	One visit per benefit year		
• Maternity delivery	One visit per benefit year		
• Presurgical or postsurgical or second surgical opinion	One visit per benefit year		
• Surgical procedure	One visit per benefit year		
• Allergic condition	One visit per benefit year for each allergic condition		
Travel Per Diems/Limitations			
Travel per diem without overnight lodging. See section 3.5.23, *Travel,* for applicable criteria.	$51/day		
Travel per diem with overnight lodging. See section 3.5.23, *Travel,* for applicable criteria.	$89/day		
Companion per diem for children under age 18. See section 3.5.23, *Travel,* for applicable criteria.	$31/day		
Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.24, *Transplant Services*, for other applicable criteria.	$50 per person/night, up to $100/night		
Limit on travel for transplant services	$10,000 per transplant occurrence		
Daily per diem for benefits under section 3.5.24 *SurgeryPlus Benefits*	$25 per patient per day Or $50 per patient and companion per day Begins the first day of authorized travel – ends last day of authorized travel		
Ground transportation expenses (in lieu of air fare) for benefits under section 3.5.24 *SurgeryPlus Benefits*	$50 when most direct route to care is at least 100 miles from place of residence, but less than 200 miles $100 when most direct route to care is 200 miles or more from place of residence		
Travel benefits without precertification	No benefits will be paid		
Precertification Penalties			
A $400 benefit reduction applies if you fail to obtain precertification for certain medical services. See section 3.4.3, *Services Requiring Precertification*.			

Active Employee Vision Plan

	Active Employee Vision Plan	
	Network Provider	**Out-of-Network Provider**
Exam	One per calendar year $10 copayment 100% after copayment	One per calendar year $10 copayment Maximum reimbursement limit of $100
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular • Progressive	One pair per calendar year $25 copayment 100% after copayment	One pair per calendar year Maximum reimbursement limit of: Single vision: $75 Lined bifocal: $115 Lined trifocal: $130 Progressive: $115

	Active Employee Vision Plan	
	Network Provider	**Out-of-Network Provider**
Lens options • Anti-reflecting coating • Polycarbonate • Scratch resistant coating	Once per calendar year 100%	Not covered
Frames	One every two calendar years $25 copayment 100% after copayment up to $130 allowance (or $70 allowance at Costco) 20% off amount over allowance	One every two calendar years Maximum reimbursement limit of $70
Contact lenses (necessary)	$60 copayment 100% after copayment 15% off usual and customary professional fees for evaluation and fitting	Not covered
Contact lenses (elective and in lieu of lenses and frame)	Once per calendar year $130 allowance for contacts	Once per calendar year Maximum reimbursement limit of $105
Additional pairs of glasses	30% off unlimited additional pairs of prescription glasses or non-prescription sunglasses from the same VSP doctor on the same day as eye exam 20% off unlimited additional pairs of prescription glasses or non-prescription sunglasses from any VSP doctor within 12 months of your last eye exam	Not covered
Laser VisionCare Program	Average of 15% discounts off or 5% off promotional offer for laser surgery, including PRK, LASIK and Custom Lasik from a VSP doctor	Not covered
Low vision supplemental testing (includes evaluation, diagnosis and prescription of vision aids where indicated) Low vision supplemental aids	Two tests every two calendar years Allowance up to $125 75% coinsurance $1,000 maximum benefit to all low vision services, testing and materials, every two calendar years	Not covered
Extra savings and discounts	Guaranteed pricing on retinal screening as an enhancement to eye exam, allowance up to $39	Not covered

Defined Contribution Retiree Medical Plan

Defined Contribution Retiree Medical Plan	
Deductibles	
Annual individual deductible	$300
Annual family deductible	$600

Defined Contribution Retiree Medical Plan	
Coinsurance	
Most medical expenses • $100 penalty if seek non-emergency care at emergency room of a hospital	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Facility services with a network provider	80%
Facility services provided to a non-Medicare age eligible benefit recipient or dependent with an out-of-network hospital, surgery center, rehabilitative facility, or free standing imaging center in other 49 states or non-preferred provider hospital, surgery center, rehabilitative facility, or free standing imaging center in Anchorage	60%
Transplant services if using a Center of Excellence facility as contracted and designated by the claims administrator	80%
Transplant services if not using a Center of Excellence facility as contracted and designated by the claims administrator	60%
Preventive care provided to a non-Medicare age eligible dependent by a network provider or when use of an out-of-network provider has been precertified.	100%, deductible does not apply
Preventive care provided to a non-Medicare age eligible benefit recipient or dependent from an out-of-network provider, or to a Medicare age eligible benefit recipient or dependent seeing any covered provider	80%
Inpatient mental disorder treatment with a network provider	80%
Inpatient mental disorder treatment provided to a non-Medicare age eligible benefit recipient or dependent from an out-of-network provider	60%
Inpatient substance abuse disorder treatment with a network provider	80%
Inpatient substance abuse disorder treatment provided to a non-Medicare age eligible benefit recipient or dependent from an out-of-network provider	60%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit Annual family out-of-pocket limit The following expenses do not apply toward the out-of-pocket limit: • charges over the recognized charge; • non-covered expenses; • premiums; • $100 penalty for non-emergency care at emergency room of a hospital • precertification benefit reductions; and • prescription drug expenses	$1,500 $3,000 $3,000 individual / $6,000 family if non-Medicare age eligible benefit recipient or dependent use out-of-network hospital, surgery center, rehabilitative facility, or free-standing imaging center for facility services outside Alaska, or non-preferred provider hospital, surgery center, rehabilitative facility, or free-standing imaging center in Anchorage
Visit/Service Limits	
Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations	20 visits per benefit year
• Home health care. See section **Error! Reference source not found.**, *Home Health Care*, for exceptions.	120 visits per benefit year Up to 4 hours = 1 visit
• Outpatient hospice expenses	Up to 8 hours per day
• Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 therapy visits in a 24 hour period Up to 1 hour = 1 visit
Travel Benefits: Therapeutic treatments	One visit and one follow-up per benefit year

Defined Contribution Retiree Medical Plan	
Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical or second surgical opinion • Surgical procedure • Allergic condition	One visit per benefit year in each category
Travel Per Diems and Limitations	
• Travel per diem without overnight lodging. See section 3.5.24, *Travel*, for applicable criteria.	$51/day
• Travel per diem with overnight lodging. See section 3.5.24, *Travel*, for applicable criteria.	$89/night
• Companion per diem for children under age 18. See section 3.5.24, *Travel*, for applicable criteria.	$31/day
Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.25, *Transplant Services*, for other applicable criteria.	$50 per person/night, up to $100/night
• Limit on travel for transplant services	$10,000 per transplant occurrence
• Travel benefits without precertification	No benefits will be paid
Additional Precertification Penalties	
In addition to the precertification limits in this schedule, a $400 benefit reduction applies if you fail to obtain precertification for certain medical services. See section 3.4.3, *Services Requiring Precertification* and section 3.4.4, *How Failure to Precertify Affects Your Benefits*.	

Defined Benefit Retiree Medical Plan

Defined Benefit Retiree Medical Plan	
Deductibles	
Annual individual deductible	$150
Annual family unit deductible	3 per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions • No deductible applies	100%
Preoperative testing • No deductible applies	100%
Outpatient testing/surgery • No deductible applies	100%
Skilled nursing facility	100%
In-patient mental disorder treatment without precertification	50%
Transplant services at an Institute of Excellence™ (IOE) facility	80%
Transplant services at a non-Institute of Excellence™ (IOE) facility or when out-of-network provider is used	60%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate different than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. *Subject to change every three years.*	$12,715

Defined Benefit Retiree Medical Plan	
Individual lifetime maximum on substance abuse treatment without precertification. *Subject to change every three years.*	$25,430
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without precertification	No benefits will be paid
Visit Limits	
Home health care	120 visits per benefit year Up to 4 hours = 1 visit
Outpatient hospice expenses	Up to 8 hours per day
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 hours of combined therapy in a 24-hour period
Travel Benefits: Therapeutic treatments	One visit and one follow-up per benefit year
Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical • Surgical procedures	One visit per benefit year
Travel Limitations	
Non-overnight stay traveling expenses	$31/day
Overnight lodging	$80/night
Overnight lodging (Transplants)	$50/person/night $100/night maximum
Companion expenses	$31/night
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain precertification for certain medical services.	

Retiree Vision Plan

Retiree Vision Plan	
Coinsurance	
All services (exam, lenses, frames)	80%
Benefit Maximums	
Exam	One per benefit year
Lenses	Two per benefit year
Frames	One set every two benefit years
Contact lenses in lieu of lenses and frames	Two per benefit year
Aphakic and medically necessary contact lens lifetime maximum	80% up to $400 lifetime maximum; thereafter 80% subject to elective contact lens benefit

Retiree Audio Plan

Retiree Audio Plan	
Coinsurance	
All services	80%
Benefit Maximums	
Individual limit • Maximum applies to a rolling 36 month period	$2,000

Other Major Plan Features:

1. State active members have access to a clinic for primary care needs in Anchorage and Fairbanks. (See Other Vendor Services, Sec. 2.04.)
2. The State has a preferred hospital arrangement in Anchorage with Alaska Regional Hospital for the active members and DC retired members. The current network strategy includes a benefit differential that steers in-patient and most out-patient procedures in Anchorage to a preferred hospital and associated ambulatory surgical center. (See Other Vendor Services, Sec. 2.04.)
3. The State contracts with a vendor, SurgeryPlus, for an enhanced travel benefit for the active plan members. (See Other Vendor Services, Sec. 2.04.)
4. There is a high volume of members covered under one or more AlaskaCare plans as the member and a dependent, requiring coordination of benefits internally and within each plan as well as between the various employee and retiree plans.
5. There is a high volume of members (approximately 10,000 members) covered under one or more of their own AlaskaCare plans (i.e. active plan and retiree plan, or more than one DB retiree plan coverage), requiring coordination between the plans.
6. Determination of recognized charge for the employee plan and the DC retiree plan:
    a. Providers: 90th percentile of prevailing charge rate for the geographic area where services were rendered as determined by FAIR Health.
    b. Facility: 185% of the Medicare allowed rate for those services in the Municipality of Anchorage and outside of Alaska.
    c. Free standing imaging: 50% of the amount billed by the provider for services and/or supplies rendered in the Municipality of Anchorage and outside of Alaska.
    d. Vision:
        i. Employee plan is based on a schedule of allowances.
        ii. Retiree DVA plan is lesser of amount billed by the provider for the service and/or supply or the 90th percentile of prevailing charge rate for the geographic area where services were rendered as determined by FAIR Health.
7. Determination of recognized charge for the DB retiree plan:
    a. 90th percentile of prevailing charge rate for the geographic area where services were rendered as determined by FAIR Health.

SEC. 2.07 CURRENT DENTAL PLAN FEATURES AND COVERAGE

The State offers the choice of two self-funded dental benefit plans (economy and standard) to eligible active employees. The economy plan is noncontributory for employees and dependents while the standard plan is a buy-up.

The active employee dental plan details can be found in the summary of plan benefits booklet available below.

- Active Employees: http://doa.alaska.gov/drb/alaskacare/employee/publications/booklet.html

The State also offers a separate dental plan for all eligible retirees. The retiree DVA plan is 100% voluntary and is only offered in conjunction with vision and audio services (aka Dental, Vision and Audio or "DVA"). The vision and audio benefits are administered separately by the medical TPA. A dental network was added January 1, 2014.

The retiree dental plan details can be found in the summary of plan benefits booklet available below.

- Defined Benefit Retirees: http://doa.alaska.gov/drb/alaskacare/retiree/publications/booklets.html
- Defined Contribution Retirees: http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf.

The key dental plan design features for the employees and retirees are summarized below:

Active Employee Dental Plans

	Active Employee Dental Plans	
	Standard Plan	**Economy Plan**
Annual individual deductible	$25 (waived for Class I services)	$25
Annual family deductible	$75 (waived for Class I services)	$75
Coinsurance		
Class I (preventive) services	100%	100%
Class II (restorative) services	80%	10%
Class III (prosthetic) services	50%	10%
Orthodontia	50%	Not covered
Benefit Maximums		
Annual individual maximum	$1,500	$500
Orthodontia lifetime individual maximum • This maximum is not included in the annual individual maximum	$1,000	Not covered

Retiree Dental Plan

Retiree Dental Plan	
Deductibles	
Annual individual deductible • Applies to Class II (restorative) and Class III (prosthetic) services	$50
Coinsurance	
Class I (preventive) services	100%
Class II (restorative) services	80%
Class III (prosthetic) services	50%
Benefit Maximums	
Annual individual maximum	$2,000

The recognized charge specific to the current dental carrier for a network dentist is the lesser of:

- 100% of the covered expense;
- 100% of the dentist's accepted filed fee with Delta Dental; or
- 100% of the dentist's billed charge.

The recognized charge specific to the current dental carrier for out-of-network dental care providers within the State of Alaska is the lesser of:

- what the dentist bills or submits for that service or supply; or
- 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies; except in the case of services rendered by an endodontist, 100% of the 80th percentile of the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

For out-of-network dental care providers outside the state, the recognized charge specific to the current dental carrier is the lesser of:

- what the dentist bills or submits for that service or supply; or
- the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

SEC. 2.08 STRENGTHS AND OPPORTUNITIES

(a) STRENGTHS

1. The State's offerings include plan designs and provisions that provide a high level of benefit value for its membership (both active employee and retiree).
2. The State currently has a bundled approach for the medical claim administration, utilizing a broad network of providers within the State of Alaska offering discounts that suggest the best return for the State.
3. The State currently has a broad dental network. It is seeking a robust dental network, efficient claims administration, and superior customer service for its upcoming contract.
4. Demonstrated evidence-based rationale for the determination of medical necessity and the denial of claims through transparent, publicly available, evidence based medical necessity criteria.
5. Strong engagement with stakeholder advisory groups.
6. Engaged retiree and active employee membership.
7. Strong customer care service representatives that accommodate all questions from our members and offer guidance for the best providers or services available to serve the member's needs.

(b) MEDICAL OPPORTUNITIES

1. Expansion of network providers and facilities in Alaska, particularly focusing on including primary care across the state and expanding options in specialty care.
2. Network management strategies with aggressive pricing that expand the State's current network discounts without restriction of the ability to develop and administer alternative reimbursement structures for providers, procedures and facilities that are in or out-of-network. This may include using a percentage of Medicare based on type of services, case rates, rapid pay discounts, diagnosis related groups and other similar strategies.
3. Flexibility in administering direct contracting and/or direct primary care arrangements.
4. Explore innovative solutions to expand value-based plan design, and proven experience and ability to administer these plans.
5. Providing effective case management, disease management and utilization management.
6. Continue to provide comprehensive, exceptional customer service for members, focusing on taking the member out of the middle and directly assisting them to resolve their questions.
7. Support in designing and developing a multi-year, comprehensive wellness and value-based benefit design.

(c) DENTAL OPPORTUNITIES

1. The State is seeking a vendor who can provide excellent customer service, member pricing and transparency tools, and timely claim adjudication.
2. The State desires a robust, expanded network.
3. The State is seeking a vendor who can provide a transparent methodology for determining out of network recognized charge in a manner that supports network expansion.
4. The State would like to explore innovative approaches to attracting providers in more rural locations, particularly within Alaska, as well as increasing specialist participation in the network.

SEC. 2.09 BACKGROUND ON HEALTH MANAGEMENT AND WELLNESS

The State currently provides the active employee plan members with condition management, and maternity management through Aetna's In Touch Care program. Case management is provided as well to identified members. Maternity management is also available for retiree members with high risk pregnancies. Members also have access to an online library of resource for information on lifestyle management, wellness and condition management. Members are not currently incentivized (or required) to participate in these programs. The State is seeking to implement a value-based plan design strategy effective January 1, 2020, and will incorporate a multi-year wellness incentive program. The State seeks vendors who can assist in designing a program that incentivizes participation in certain activities including condition management and case

management programs; and is open to considering innovative or alternative ideas that achieve the overall goal of empowering members in their health care choices.

SEC. 2.10 EXISTING CHALLENGES

The State of Alaska is challenged with rising health care costs. Due to its geography, many members live in remote areas with little to no competition in the local provider and facility market. In these situations, controlling cost can be difficult as both the cost of care and the member's access to care must be considered and carefully balanced. The State has explored a number of options to help control cost in addition to a carrier's network contracting ability, and seeks a vendor who can assist in identifying, supporting, developing, and administering provider contracts and agreements outside of their standard network.

The remote and isolated nature of many Alaskan communities presents a number of challenges in a member's ability to access care as many cities are not connected by roads and the only option for transportation is by plane or boat. Given the complexity of the medical system and the unique circumstances present in Alaska, it is especially challenging for members to navigate the health care system. Members require a responsive customer support team with a strong local presence and understanding of the state.

Additional challenges include:

1. Coordination of benefits for the active and retiree members is complex and requires a thorough understanding of the many ways members can have multiple coverages within, and between, the active employee and retiree plans. Members may be covered under multiple AlaskaCare plans as a dependent/spouse or through two/three of their own plans.
2. Due to the nature of the State's plan (e.g. coordination of benefit provision) a high level of claims may require manual adjudication.
3. The retiree health plan benefit has certain constitutional protections that must be maintained. It should always be assumed that the plan must be administered as explicitly outlined in the associated plan booklet. The State requires vendors to be able to administer all aspects of the health plan without requiring any modifications to the benefits. The State is currently working with the RHPAB to evaluate changes to the health plan in an effort to modernize the coverage; however vendors should be prepared to administer the plan as it is written today in its entirety.
4. All administrative appeals identified in the plan documents beyond Level I and Level II/External Review are administered by the State, which retains the status as the final fiduciary for appeals of adverse benefit determinations. The State is subject to certain due process requirements and vendors must be prepared to assist the State in meeting those requirements through the provision of certain verbiage in all appeals-related documents; transcripts and call records; clinical evidence and notes to support any coverage determinations; other support as needed by the State in responding to appeals or adverse decisions.
5. While the State attempts to receive information on all members, there are often cases where they have not been able to attain a member's full information.
6. It can be challenging to develop materials that capture the attention of the membership.
7. Administering the statutory eligibility requirements for incapacitated dependents and student verification as outlined for the DB and DC retiree health plans can be challenging.

SECTION 3.SCOPE OF WORK & CONTRACT INFORMATION

SEC. 3.01 SUMMARY

The State is soliciting proposals from qualified and experienced firms to provide medical claims administration with managed network services and dental claims administration with managed network services to the AlaskaCare active employee and retiree benefit plans. With the issuance of this RFP, the State is focusing on providing exceptional customer service, broad network access with reduced costs for members and the ability to administer value-based initiatives including the ability to carve-out certain services and/or set maximum allowable charges based on a percentage of Medicare for any procedure or service, including dialysis. This RFP provides an opportunity for offerors to showcase what they bring to the table as well as demonstrate leadership in these areas. Offerors are encouraged to exhibit a strong customer service model, provide strategies to improve network provider retention while demonstrating creative ways to recruit in the more rural areas, and achieve long-term trends that will allow the State to maintain high quality benefits. Accurate, consistent, timely, and comprehensive management reporting is also critically important.

Replication of Current Benefit Design

The State requires all bidders to replicate the current plan designs offered to both the active and retiree populations **and will not accept any deviations.**

Alaska Public Sector Participation

The winning bidder will allow for other Alaska public entities to participate in the State's contract terms (subject to certain mutually agreed upon requirements) with both the medical TPA and dental offeror(s). Should additional public entities participate, the State expects to be advantaged by pricing that reflects increased economies of scale. Participating entities would contract directly with the chosen offeror(s) for medical TPA and/or dental services on the terms and conditions agreed upon with the State, but by way of a separate contract with the winning offeror(s).

Value-Based Benefit Design and Provider Contracting

The State desires a vendor that can support the implementation of value-based benefit plan design and the inclusion of value-based arrangements in Alaska provider contracts.

SEC. 3.02 GOALS AND OBJECTIVES

The State is seeking a partner to assist with the following services:

1. Providing high-quality, exceptional customer service that will "take the member out of the middle."
2. Providing fiscally sustainable, high-quality benefits.
3. Providing a robust and high-value networks for members within Alaska and the rest of the United States.
4. Ability to partner with the State in identifying, administering, coordinating, and implementing strategic initiatives that the State is undertaking or may consider in the future which may include but are not limited to employer sponsored clinics, alternative network and provider payments.
5. Providing navigation and cost transparency tools to support member decision-making.
6. Ensuring the use of evidence-based guidelines in clinical determinations, and providing those guidelines in a publicly accessible way.
7. Providing high accuracy in claims processing.
8. Ability to accurately process the State's multiple coordination of benefit provisions.
9. Demonstrated ability to manage integration with vendors that, coupled with the medical benefits administration, will offer high quality outcomes at the most cost-effective prices.
10. Supporting the State in identifying, recommending and implementing innovative quality-oriented claims administration processes and procedures to achieve State objectives, reduce costs, and improve quality of service.

11. Providing effective tools and resources to support members in managing their health.
12. Providing seamless implementation for State and its members.
13. Coordinating clinical management with the any other vendor or TPA contracted by the State.
14. Ability to pay claims in accordance with the State's current or desired plan of benefit without restrictions imposed by national or other provider agreements, including the ability to adjudicate claims or issue payments on behalf of the State for dialysis claims, fixed wing hospital-to-hospital air ambulance transport or any other condition or service, as well as the ability to carve-out a benefit or service.

SEC. 3.03 MEDICAL MAJOR DELIVERABLES

The awarded offeror will be required to provide, perform, or deliver the following (including but not limited to):

1. Medical administrative services
2. Access to a managed network of providers and facilities throughout Alaska and the United States
3. Exceptional customer service, preferably through a dedicated customer/member service unit with CSR telephonic support, problem-solving team with access to call logs and historical claims data
4. Competitive multi-year administration fees and superior network discounts
5. Transparent and concise contract language that accurately reflects all responses provided in the RFP
6. Proactive, flexible, and expert support for all clinical programs
7. Flexible, accurate, claims adjudication that can support and accommodate the State's strategic goals
8. Pricing administration
9. Integrated services with other vendors (e.g. disease management, centers of excellence, medical, data warehouse vendors, etc.), if applicable
10. Comprehensive collection and utilization of data to inform and guide policy and plan design decisions
11. Eligibility maintenance
12. Continued network expansion and increasing discounts
13. Vision network and claims administration
14. EAP access and claims administration, including hour allocations for Critical Incidence Stress Debriefings (CISD) and trainings
15. New member welcome kits, that are customizable to include information on other vendor services (i.e. SurgeryPlus travel, Teladoc, etc.)
16. Paper claims submissions and processing capability
17. Ability to recertify and adjudicate reimbursements for travel when services are not available locally, or are provided less expensive (when factoring in travel costs) elsewhere
18. Online access capabilities – include prior authorization and override entries
19. Coordination of benefits
20. Subrogation support services
21. Comprehensive IT capabilities including access to claims history – with denial reasons
22. Clinical programs including patient and provider education, clinical support, prospective, concurrent, and retrospective review, case management review
23. Robust process for tracking and monitoring fraud/abuse
24. Network provider management
25. Data reporting (standard and ad-hoc reporting)
26. Transfer of monthly data files to the State's data warehouse
27. Distribution of ID cards and provider directories - include web link to online directories
28. Contract with external review organizations to review clinical appeals
29. Designated account management
30. Ability coordinate with the administrator of a health reimbursement arrangement or flexible spending account
31. Coordination with PBM and other contracted vendors to support the optimal return for our medical plan options

32. Ability to estimate Medicare payment amounts for those Medicare age retirees that do not enroll in Medicare
33. Provide MA1099-HC tax forms to all applicable Massachusetts members
34. Ability to administer and pay claims related to the State's current or future plan of benefits including coordination of benefits, payments based on Medicare multipliers for in-network as well as out-of-network and tiered provider arrangements, enhanced travel, etc.

SEC. 3.04 MEDICAL SUPPLEMENTAL SERVICES

The awarded offeror may include the supplemental services below. The State reserves the right to adopt some, all, or none of these services:

1. COBRA notices and premium billing/collection
2. Retiree direct billing services including premium billing/collection, monthly premium remittance to the State and eligibility sharing with the long-term care vendor
3. Ability to administer a health reimbursement arrangement or flexible spending account
4. Access to a member discount programs that could include vision hardware, fitness, weight management, hearing and natural products/services (massage therapy, acupuncture, chiropractic care and dietetic counseling)
5. Data warehouse services
6. Disease management and wellness services

SEC. 3.05 DENTAL MAJOR DELIVERABLES

The awarded offeror will be required to provide, perform, or deliver the following (including but not limited to):

1. Dental claims administration and network management services
2. Access to a managed network of dentists in Alaska and the rest of the United States
3. Network provider management and expansion, particularly among specialists in Alaska
4. Exceptional customer service through a designated or dedicated customer/member service unit with CSR telephonic support
5. Competitive financial arrangement and network pricing terms
6. Proactive, flexible, and expert support for all clinical programs
7. Eligibility maintenance
8. Claim adjudication including claim resolution
9. Contract with external review organizations to review clinical appeals
10. Paper claims submissions and adjudication
11. Coordination of benefits
12. Robust process for tracking and monitoring fraud/abuse
13. Integration as needed with other State vendors, if applicable
14. Data reporting (standard and ad-hoc) with a preference for online reporting capabilities
15. Member online portal for tracking claim status and decision support tools for in-network price discovery by ADA service codes
16. Comprehensive IT capabilities with including access to claims history (with denial reasoning) and override capability
17. Distribution and production of ID cards and directories - include web link to online directories
18. New member welcome kits
19. Competitive multi-year administration fees and superior network discounts
20. Comprehensive collection and utilization of data to inform and guide policy and plan design decisions
21. Designated account management
22. Transparent and concise contract language that accurately reflects all responses provided in this RFP

SEC. 3.06 MANDATORY REQUIREMENTS

The mandatory requirements for the medical contract are provided in M-6 – Mandatory Requirements. The mandatory requirements for the dental contract are provided in D-6 – Mandatory Requirements. The offeror must meet all of these requirements. **Failure to meet all mandatory requirements will result in immediate disqualification.**

SEC. 3.07 CONTRACTUAL REQUIREMENTS

The State's contractual requirements are provided in M-7 for the medical plan and D-7 for the dental plan – Contractual Requirements. The form is for the offeror to confirm if they can or cannot meet each contractual requirement listed in the form. Space is provided to explain "no" responses.

SEC. 3.08 METHOD OF AWARD

The State of Alaska will be awarding by lot:

Lot 1) Medical/Vision/Audio Services

Lot 2) Dental Services

Offerors may submit proposals for one or both lots. If submitting proposals for both lots, proposals must be submitted separately using the forms designated for each lot. Proposals that are qualified, for instance offering a discount contingent on being awarded both lots, submitted using the incorrect form(s), or otherwise restrict the rights of the State may be deemed non-responsive and rejected per Section 7.07 Right of Rejection.

SEC. 3.09 CONTRACT TERM AND WORK SCHEDULE

The contract term for each lot will be for an initial period of five (5) years beginning January 1, 2020, with up to five (5) years additional renewal options. Renewals will be exercised at the sole discretion of the State.

Unless otherwise provided in this RFP, the State and the successful offeror/contractor agree: (1) that any holding over of the contract excluding any exercised renewal options, will be considered as a month-to-month extension, and all other terms and conditions shall remain in full force and effect and (2) to provide written notice to the other party of the intent to cancel such month-to-month extension at least 30-days before the desired date of cancellation.

SEC. 3.10 UNIQUE CONSIDERATIONS

Geography:

As outlined in sec. 2.10 *Existing Challenges*, the AlaskaCare membership is spread throughout Alaska from our main population hubs of Anchorage, Fairbanks, Juneau, Matanuska-Susitna, and Kenai to small villages of less than 100 residents. Only 20% of Alaska is accessible by road, and due to Alaska's size, even communities connected by roads can still be eight or more hours drive away.

Many communities, including Juneau, the state's capital and the third largest concentration of AlaskaCare members, have no road connections outside of their locale, so aircraft and boats are the major means of transport. There are members who live in rural locations, and commercial airlines do not provide service to most of these areas.

Cost and access:

Given the remote and isolated nature of Alaska, the cost of services is typically higher than in other states, and there is limited competition among providers. Establishing network participation can be challenging, especially in areas with only one provider for a given services. Members seeking access to care may not be able to access the care they need within their community, or they may not be able to find a network provider in their community.

The State is seeking a vendor that can assist in developing innovative solutions that they can administer to expand network participation by Alaska-based providers while protecting the membership from additional out-of-pocket expense and without increasing total cost to the plan.

Multiple coverages and internal coordination of benefits:
AlaskaCare members can earn multiple retiree health plan benefits. This results in a member having two or more of their own coverage plans under the AlaskaCare retiree plan, as well as coverage as dependent if they are married to another retiree or State of Alaska employee. This requires the AlaskaCare plan to customize plan coordination to address the multiple plans for a single member.

Further, AlaskaCare members can be covered by the same plan more than once. For example, they can be covered under the AlaskaCare employee plan as an employee directly, and received secondary coverage by the same AlaskaCare employee plan as a dependent under a spouse who is also an employee covered under the plan.

Customer service:
Alaska is in its own time zone. Member contact centers will need to provide service based on Alaska Standard Time. In addition, approximately 40% of the retiree population live outside of Alaska, including some who live abroad.

Retiree health plan:
Certain aspects of the retiree health plan are protected from diminishment by the state constitution. Vendors must be prepared to administer the health plans as outlined in the plan booklets without deviation. The Division is working with an advisory board to evaluate certain plan changes. However, this is an ongoing effort that may take several years.

SEC. 3.11 STATE OF ALASKA ROLES AND RESPONSIBILITIES

The State is responsible for the plan, its operation, and the benefits provided thereunder. The State has the sole and complete authority to determine eligibility of persons to participate in the plan. The State is responsible to supply the TPA in writing or by electronic medium acceptable to the TPA all information regarding the eligibility of individuals identified as plan participants under the plan, including but not limited to the identification of dependents under the plan, and shall notify TPA of any changes in eligibility.

All administrative appeals identified in the plan documents beyond Level I and Level II/External Review shall be administered by the State, which retains the status as the final fiduciary for appeals of adverse benefit determinations.

The State is responsible for reimbursement of all accurately processed benefit payments which have been paid by the TPA on behalf of the State, on or before the termination date or that relate to runoff claims.

The State is responsible for satisfying any and all plan reporting and disclosure requirements imposed by law, including updating the plan to reflect any changes in benefits.

Under the ACA, the State is responsible to provide additional reports and disclosures to federal agencies and employees, including, without limitation: uniform notices of coverage requirements under Section 2715 of the PHSA; information to the Secretary of Health and Human Services (the "Secretary") regarding claims data and policies, financial information, information to the Secretary on denied claims, and other information under Section 2715A of the PHSA; information to the Secretary relating to provider reimbursement structures that improve quality of care, including wellness and health promotion activities under Section 2717 of the PHSA; notices to employees regarding state based health insurance exchanges and information related to the plan under Section 18B of the Fair Labor Standards Act; and information to the Internal Revenue Service and employees related to

the employees covered under the plan, plan premiums, and other plan information under Sections 6055 and 6056 of the Internal Revenue Code.

SEC. 3.12 LOCATION OF WORK

The location the work is to be performed, completed and managed in the United States. The State will not provide workspace for the contractor.

If the offeror cannot certify that all work will be performed in the United States, the offeror must contact the contracting officer in writing to request a waiver at least 10 days prior to the deadline for receipt of proposals. The request must include a detailed description of the portion of work that will be performed outside the United States, where, by whom, and the reason the waiver is necessary.

Failure to comply with these requirements may cause the State to reject the proposal as non-responsive, or cancel the contract.

SEC. 3.13 CONTRACT PAYMENT

No payment will be made until the contract is approved by the Commissioner of the Department of Administration or the Commissioner's designee. Under no conditions will the State be liable for the payment of any interest charges associated with the cost of the contract. The State is not responsible for and will not pay local, state, or federal taxes. All costs associated with the contract must be stated in U.S. currency.

SEC. 3.14 PROPOSED PAYMENT PROCEDURES

The State will make payments based on a negotiated payment schedule. This schedule will be negotiated during the clarification period (reference RFP Section 5.11).

SEC. 3.15 THIRD PARTY SERVICE PROVIDERS

The contractor must provide, on an annual basis, a Type 2 Statement on Standards for Attestation Engagements (SSAE) SOC 2 report. Failure to provide this report may be treated as a material breach and may be a basis for a finding of default.

SEC. 3.16 SUBCONTRACTORS

U.S. based subcontractors may be used to perform work under this contract. If an offeror intends to use subcontractors, the offeror must complete M-10 for the medical plan and D-10 for the dental plan – Subcontractors, as provided with this RFP.

Subcontractor experience shall not be considered in determining whether the offeror meets the requirements set forth in M-6 for the medical plan and D-6 for the dental plan– Mandatory Requirements.

An offeror's failure to provide this information with their proposal may cause the State to consider their proposal non-responsive and reject it.

During the Clarification Period (RFP Section 5.11), the State will require a signed written statement from each subcontractor proposed in M-10 for the medical plan and D-10 for the dental plan – Subcontractors that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to the contract award, the State will also require evidence that each subcontractor possesses a valid Alaska Business License.

During the course of the contract, the substitution of one subcontractor for another may be made only at the discretion and prior written approval of the project director or contracting officer.

SEC. 3.17 JOINT VENTURES

Joint ventures **WILL NOT** be accepted.

SEC. 3.18 RIGHT TO INSPECT PLACE OF BUSINESS

At reasonable times, the State may inspect those areas of the contractor's place of business that are related to the performance of a contract. If the State makes such an inspection, the contractor must provide reasonable assistance.

SEC. 3.19 CONTRACT PERSONNEL

Any change of the project team members named in the proposal must be approved, in advance and in writing, by the project director or contracting officer. Personnel changes that are not approved by the State may be grounds for the State to terminate the contract.

SEC. 3.20 INSPECTION AND MODIFICATION – REIMBURSEMENT FOR UNACCEPTABLE DELIVERABLES

The contractor is responsible for the completion of all work set out in the contract. All work is subject to inspection, evaluation, and approval by the project director. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract. The project director may instruct the contractor to make corrections or modifications if needed in order to accomplish the contract's intent. The contractor will not unreasonably withhold such changes.

Substantial failure of the contractor to perform the contract may cause the State to terminate the contract. In this event, the State may require the contractor to reimburse monies paid (based on the identified portion of unacceptable work received) and may seek associated damages.

SEC. 3.21 CONTRACT CHANGES – UNANTICIPATED AMENDMENTS

During the course of this contract, the contractor may be required to perform additional work. That work will be within the general scope of the initial contract. When additional work is required, the project director will provide the contractor a written description of the additional work and request the contractor to submit a firm time schedule for accomplishing the additional work and a firm price for the additional work. Cost and pricing data must be provided to justify the cost of such amendments per AS 36.30.400.

The contractor will not commence additional work until the project director has secured any required State approvals necessary for the amendment and issued a written contract amendment, approved by the Commissioner of the Department of Administration or the Commissioner's designee.

SEC. 3.22 NONDISCLOSURE AND CONFIDENTIALITY

Contractor agrees that all confidential information shall be used only for purposes of providing the deliverables and performing the services specified herein and shall not disseminate or allow dissemination of confidential information except as provided for in this section. The contractor shall hold as confidential and will use reasonable care (including both facility physical security and electronic security) to prevent unauthorized access by, storage, disclosure, publication, dissemination to and/or use by third parties of, the confidential information. "Reasonable care" means compliance by the contractor with all applicable federal and state law, including the Social Security Act and HIPAA. The contractor must promptly notify the State in writing if it becomes aware of any storage, disclosure, loss, unauthorized access to or use of the confidential information and provide any required remedies.

As used in this agreement, "confidential information" shall mean any and all technical and non-technical information about State, including, but not limited to data and information processed by State in connection with evaluating the services. The term shall also include all "protected health information" (as defined by 45 C.F.R. § 160.103) and any other personally identifiable information (PII) regarding any individual who is, or may become,

eligible for the State's plan (including, but not limited to, such plan's pharmacy benefit). The recipient hereby agrees to abide by State's determination that such information is confidential information and that the same is of a special and unique nature and value, important and material, that it gravely affects the effective and successful conduct of the business and that it may include PII or other information of State or state employees and their dependents that is to be maintained as confidential.

Examples of confidential information include, but are not limited to: technology infrastructure, architecture, financial data, trade secrets, equipment specifications, user lists, passwords, research data, and technology data (infrastructure, architecture, operating systems, security tools, IP addresses, etc.).

If confidential information is requested to be disclosed by the contractor pursuant to a request received by a third party and such disclosure of the confidential information is required under applicable state or federal law, regulation, governmental or regulatory authority, the contractor may disclose the confidential information after providing the State with written notice of the requested disclosure (to the extent such notice to the State is permitted by applicable law) and giving the State opportunity to review the request. If the contractor receives no objection from the State, it may release the confidential information within 30 days. Notice of the requested disclosure of confidential information by the contractor must be provided to the State within a reasonable time after the contractor’s receipt of notice of the requested disclosure and, upon request of the State, shall seek to obtain legal protection from the release of the confidential information.

The following information shall not be considered confidential information: information previously known to be public information when received from the other party; information freely available to the general public; information which now is or hereafter becomes publicly known by other than a breach of confidentiality hereof; or information which is required to be disclosed by a party under applicable law or pursuant to subpoena or other legal process and which as a result becomes lawfully obtainable by the general public.

SEC. 3.23 INDEMNIFICATION

The contractor shall indemnify, hold harmless, and defend the State from and against any claim of, or liability for error, omission or negligent act of the contractor, its agents, or network providers, under this agreement. The contractor shall not be required to indemnify the contracting agency for a claim of, or liability for, the independent negligence of the State. If there is a claim of, or liability for, the joint negligent error or omission of the contractor and the independent negligence of the State, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis. “Contractor” and “State”, as used within this and the following article, include the employees, agents and other contractors who are directly responsible, respectively, to each. The term “independent negligence” is negligence other than in the contracting agency’s selection, administration, monitoring, or controlling of the contractor and in approving or accepting the contractor’s work.

SEC. 3.24 INSURANCE REQUIREMENTS

Without limiting contractor's indemnification, it is agreed that contractor shall purchase at its own expense and maintain in force at all times during the performance of services under this agreement the following policies of insurance. Where specific limits are shown, it is understood that they shall be the minimum acceptable limits. If the contractor's policy contains higher limits, the State shall be entitled to coverage to the extent of such higher limits.

Certificates of Insurance must be furnished to the contracting officer prior to beginning work and must provide for a notice of cancellation, non-renewal, or material change of conditions in accordance with policy provisions. Failure to furnish satisfactory evidence of insurance or lapse of the policy is a material breach of this contract and shall be grounds for termination of the contractor's services. All insurance policies shall comply with and be issued by insurers licensed to transact the business of insurance under AS 21.

Workers' Compensation Insurance: The contractor shall provide and maintain, for all employees engaged in work under this contract, coverage as required by AS 23.30.045, and; where applicable, any other statutory obligations including but not limited to Federal U.S.L. & H. and Jones Act requirements. The policy must waive subrogation against the State.

Commercial General Liability Insurance: covering all business premises and operations used by the Contractor in the performance of services under this agreement with minimum coverage limits of $1,000,000 combined single limit per claim.

Commercial Automobile Liability Insurance: covering all vehicles used by the contractor in the performance of services under this agreement with minimum coverage limits of $300,000 combined single limit per claim.

Professional Liability Insurance: covering all errors, omissions or negligent acts in the performance of professional services under this agreement with minimum coverage limits of $5,000,000 per claim /annual aggregate.

SEC. 3.25 TERMINATION FOR DEFAULT

If the project director or contracting officer determines that the contractor has refused to perform the work or has failed to perform the work with such diligence as to ensure its timely and accurate completion, the State may, by providing written notice to the contractor, terminate the contractor's right to proceed with part or all of the remaining work. This clause does not restrict the State's termination rights under the contract provisions of Appendix A, attached along with this RFP as Attachment 6.

SECTION 4. PROPOSAL FORMAT AND CONTENT

SEC. 4.01 RFP SUBMITTAL FORMS

This RFP contains Submittal Forms, specific to the medical and dental services requested, which must be completed by the offeror and submitted as their proposal. Offerors must complete the submittal forms that correspond with the services they are proposing. An electronic copy of the forms are posted along with this RFP. **Offerors shall not re-create these forms, create their own forms, or edit the format structure of the forms unless permitted to do so.** Do not exceed any page limits identified on the attachments. All attachment documents must be written in the English language, be single sided, and be single-spaced with a minimum font size of 10.

Unless otherwise specified in this RFP, the Submittal Forms shall be the offeror's entire proposal. Do not include any marketing information in the proposal.

Any proposal that does not follow these requirements may be deemed non-responsive and rejected. Failure to submit a submittal form in its entirety, or submitting a submittal form that states N/A, may be deemed non-responsive and rejected.

SEC. 4.02 SPECIAL FORMATTING REQUIREMENTS

The offeror must ensure that their proposal meets all of the special formatting requirements identified in this section. This includes requirements regarding anonymity and maximum page limits. Any Submittal Form that does not follow the completion instructions may receive a '1' score for the evaluated Submittal Form or the entire proposal may be deemed non-responsive and rejected.

Anonymity: Some Submittal Forms listed below must not contain any names that can be used to identify who the offeror is (such as company names, offeror name, company letterhead, personnel names, project names, sub-consultant names, manufacturer or supplier names, or product names).

Page Limits: Some Submittal Forms listed below have maximum page limit requirements. Offerors must not exceed the maximum page limits. Note, the page limit will likely be converted to a character limit that is roughly equivalent to the maximum page limits listed below, assuming a single sided document.

Medical TPA Submittal Packet	Anonymous Document	Maximum Page Limits
M-1 – Offeror Information and Certifications		
M-2 – Service Approach	YES	10
M-3 – Risk Assessment Plan – Controllable Risks	YES	2
M-3 – Risk Assessment Plan – Non-Controllable Risks	YES	2
M-4 – Value Opportunity Assessment	YES	4
M-5 – Performance Qualifications		
M-6 – Mandatory Requirements		
M-7 – Contractual Requirements		
M-8 – GeoAccess Analysis – Active Employees		
M-8 – GeoAccess Analysis – Non-Medicare Retirees		
M-9 – Network Disruption Analysis – Active Employees		
M-9 – Network Disruption Analysis – Non-Medicare Retirees		
M-10 – Subcontractors		
M-11 – Financial Workbook (Attachment 3)		
M-12 – Performance Guarantees – Administrative		
M-12 – Performance Guarantees – Clinical		

Dental TPA Submittal Packet	Anonymous Document	Maximum Page Limits
D-1– Offeror Information and Certifications		
D-2 – Service Approach	YES	5
D-3 – Risk Assessment Plan – Controllable Risks	YES	2
D-3 – Risk Assessment Plan – Non-Controllable Risks	YES	2
D-4 – Value Opportunity Assessment	YES	2
D-5 – Performance Qualifications		
D-6 – Mandatory Requirements		
D-7 – Contractual Requirements		
D-8 – GeoAccess Analysis – Active Employees		
D-8 – GeoAccess Analysis – Non-Medicare Retirees		
D-9 – Network Disruption Analysis – Active Employees		
D-9 – Network Disruption Analysis – Retirees		
D-10 – Subcontractors		
D-11 – Financial Workbook (Attachment 4)		
D-12 – Performance Guarantees – Administrative		

Any Submittal Form that is being evaluated and does not follow these instructions may receive a '1' score for the evaluated Submittal Form, or the entire response may be deemed non-responsive and rejected. The State also reserves the right, in its sole discretion, to modify a proposal to remove any minor information that may be non-compliant.

SEC. 4.03 OFFEROR INFORMATION AND CERTIFICATIONS

The offeror must complete and submit this Submittal Form. The form must be signed by an individual authorized to bind the offeror to the provisions of the RFP.

By signature on the form, the offeror certifies they comply with the following:

a) the laws of the State of Alaska;

b) the applicable portion of the Federal Civil Rights Act of 1964;

c) the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government;

d) the Americans with Disabilities Act of 1990 and the regulations issued thereunder by the federal government;

e) all terms and conditions set out in this RFP;

f) a condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury;

g) that the offers will remain open and valid for at least 90 days; and

h) that programs, services, and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government.

If any offeror fails to comply with [a] through [h] of this paragraph, the State reserves the right to disregard the proposal, terminate the contract, or consider the contractor in default.

The Submittal Form also requests the following information:

i) The complete name and address of offeror's firm along with the offeror's Tax ID

j) Information on the person the State should contact regarding the proposal

k) Names of critical team members/personnel

l) Addenda acknowledgement

m) Conflict of interest statement

n) Alaska preference qualifications

An offeror's failure to address/respond/include these items may cause the proposal to be determined to be non-responsive and the proposal may be rejected.

SEC. 4.04 SERVICE APPROACH

The offeror must complete and submit this Submittal Form. This submission will not be scored, but will be provided to the PEC, and the content of this document will inform the evaluation process. The service approach should demonstrate to the State that the offeror can visualize what they are going to do to successfully deliver this service. The service approach should summarize the following:

Medical TPA

1. **Network Plan:** summarize the offeror's comprehensive network plan, operations, capabilities, discounts, access points, disruption, and offerings.
2. **Customer and Member Support:** summarize the offeror's comprehensive customer service approach. This may include clinical support, advantages with the claims and appeals process, quality control procedures, ability to provide a highly trained member services team focused on AlaskaCare members, ability to offer hours of operation that meet Alaska residents' needs, and customer satisfaction as applicable.
3. **Health Management/Employee Assistance Plan/Value-Based Benefits (as applicable):** summarize the offeror's experience in providing solutions for health management, employee assistance programs and value-based benefit structures. This includes the offeror's ability to support the State of Alaska's strategic initiatives.
4. **Claims Adjudication:** summarize the offeror's ability to adjudicate claims based on the current plan design, including internal coordination of benefits, process for determining medically necessary criteria, support for foreign claims, and ability to process upwards of 1.5 million claims per year.
5. **Benefit Account Administration:** discuss the offeror's ability to administer the State's benefit account needs, including acceptance of electronic eligibility files, support for incapacitated dependents review, support for the student verification process, and retroactive eligibility determinations.
6. **Clinical Management:** summarize the offeror's approach to utilization management, and other applicable care management programs.
7. **Vision and Audio Services:** summarize the offeror's ability to provide vision and audio services.

Dental TPA

1. **Network Plan:** summarize the offeror's comprehensive network plan, operations, capabilities, discounts, access points, disruptions, and offerings.
2. **Customer and Member Support:** summarize the offeror's comprehensive customer service approach. This may include clinical support, advantages with the claims and appeals process, quality control procedures, ability to provide a highly trained member services team focused on AlaskaCare members,

ability to offer hours of operation that meet Alaska residents' needs, and customer satisfaction as applicable.

3. **Claims Adjudication:** summarize the offeror's ability to adjudicate claims based on the current plan design, including internal coordination of benefits, process for determining dentally necessary criteria, support for foreign claims, and ability to process upwards of 60,000 claims per year.
4. **Benefit Account Administration:** discuss the offeror's ability to administer the State's benefit account needs, including acceptance of electronic eligibility files and retroactive eligibility determinations.
5. **Clinical Management:** summarize the offeror's approach to providing clinical management services.

SPECIAL NOTE: The offeror must not disclose their costs in this Submittal Form. This form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is and cannot exceed the page limit (described in Section 4.02).

SEC. 4.05 RISK ASSESSMENT PLAN

The offeror must complete and submit this Submittal Form. The Risk Assessment Plan should address risks that may impact the successful delivery of this project, considering all expectations as described in this RFP. The offeror should list and prioritize major risk items that are unique and applicable to this project. This includes areas that may cause the project to not be completed on time, not finished within budget, generate any change orders, or may be a source of dissatisfaction for the State. The offeror should rely on and use their experience and knowledge of completing similar projects to identify these potential risks.

Each risk should be described in non-technical terms and should contain enough information to describe to a reader why the risk is a valid risk. The offeror should also explain how it will avoid or minimize the risks from occurring. If the offeror has a unique method to minimize the risk, the offeror should explain it in non-technical terms. The Risk Assessment Plan gives the opportunity for the offeror to differentiate its capabilities based on its ability to visualize, understand, and minimize risk to the State and the risk to a successful outcome of the system. The offeror should categorize the 'risks' into the following definitions:

a. Assessment of Controllable Risks: This includes risks, activities, or tasks that are controllable by the offeror, or by entities/individuals that are contracted to by the offeror. This includes things that are part of the technical scope of what the offeror is being hired to do. This may also include risks that have already been minimized before the project begins due to the offeror's expertise (i.e. risks that are no longer risks due to the offeror's expertise in delivering this type of project). All controllable risks and strategies to mitigate them must be included in the offeror's base proposal cost and schedule (if there are any impact at all).

b. Assessment of Non-Controllable Risks: This includes risks, activities, or tasks that are not controllable by the offeror. This may include risks attributed by State, state personnel, parties hired by State, risks that are caused by other agencies, or completely uncontrollable risks. These can also be areas/risks that can contribute to contingency. Although these risks may not be controlled by the offeror, the offeror should identify a strategy that can be followed or used to mitigate these risks. All non-controllable risks and strategies to mitigate them must not be included in the offeror's base proposal cost or schedule.

Please use the following format when completing the Submittal Form:

- Risk = Title of the risk
- Description = A brief description of why the risk is a risk? Background of how the risk may impact the project/service if it occurs.
- Strategy = Strategy to prevent/minimize the risk from occurring, or strategy to minimize the impact of the risk if it occurs.

SPECIAL NOTE: The offeror shall not disclose their costs in this Submittal Form. This Submittal Form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is and cannot exceed the page limit (as described in Section 4.02).

SEC. 4.06 VALUE OPPORTUNITY ASSESSMENT

The offeror must complete and submit this Submittal Form. The purpose of the Value Opportunity Assessment is to provide offerors with an opportunity to identify any value-added options or ideas that may benefit the State, the project, or the service. If the offeror can include more scope or service within the constraints of the State's plan, the offeror should provide an outline of potential value-added options. This may include ideas or suggestions on alternatives in implementation timelines, project scope, project cost, goals, deliverables, methodologies, etc. Value-added ideas must not be included in the offeror's base cost proposal.

Please use the following format when completing the Submittal Form:

- Idea = Title of the idea/opportunity
- Description = A brief description of why the idea adds value to the client or service (what benefits or impacts the idea will bring in the short/long term). Do not make any reference to the proposed cost, but you may refer to the potential impact to the cost and schedule in terms of estimated percentages.

SPECIAL NOTE: The offeror must not disclose their costs in this Submittal Form. This Submittal Form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is and cannot exceed the page limit (as described in Section 4.02).

SEC. 4.07 PERFORMANCE QUALIFICATIONS

The offeror will be required to collect Performance Qualifications (PQ) as outlined in this section. This submission will not be scored, but will be provided to the PEC, and the content of this document will inform the evaluation process. The offeror will be responsible for collecting customer satisfaction surveys from clients/departments/references (herein referred to as 'references') and submitting this information with their proposal. PQ surveys will be required for both the offeror and the Account Manager (listed in M-1 / D-1).

Step 1) Identify who to survey:

- Identify a list of references that will complete the surveys.
- The offeror should survey references that are highly satisfied with their work.
- The offeror should survey references that have similar requirements (as outlined in this RFP).
- The survey must be evaluated by the owner. The survey cannot be completed by any third-party representatives/consultants of the owner.
- The offeror must submit at least one survey and no more than three surveys evaluating the account manager. The offeror must submit three surveys evaluating the offeror/firm.

Step 2) Preparing the surveys:

- The offeror is responsible for preparing the surveys.
- The survey questionnaire is separated into three different parts. In order to receive credit for a returned survey, the offeror shall provide all required information in Parts A and B on the survey.
- The offeror shall enter their company name / key personnel names (in Part A of the survey).
- The offeror shall enter background information about the project being evaluated (in Part B of the survey). All information is required. Failure to provide this information, or listing "n/a" or "confidential" will result in no credit for the survey.

Step 3) Distributing and collecting the surveys:

- Prior to distributing the surveys, the offeror should contact each reference to ensure that they are able and willing to complete the survey.
- The offeror should fax, email, mail, or deliver the survey to each reference.
- The offeror must modify the return information (located at the bottom of the survey) so the survey is returned to the offeror for collection.
- The reference must provide their customer satisfaction ratings and any general comments in Part C of the survey. All returned surveys must be evaluated and signed by the reference. If a survey is not signed, it will not be considered.
- The State may contact the reference to clarify a survey rating, check for accuracy, or to obtain additional information. If the reference cannot be contacted, the survey may be deleted, and no credit given for that reference.
- Returned surveys must be packaged together and submitted with the proposal.

SEC. 4.08 MANDATORY REQUIREMENTS

The offeror must complete and submit this Submittal Form. In order to be considered responsive, the offeror must acknowledge that they can meet all mandatory technical requirements identified in M-6/D-6. An offeror's failure to respond, or failure to meet these minimum prior experience requirements will cause their proposal to immediately be considered non-responsive and their proposal will be rejected.

SEC. 4.09 CONTRACTUAL REQUIREMENTS

The offeror must complete and submit this Submittal Form.

SEC. 4.10 GEOACCESS ANALYSIS

The offeror must complete and submit this Submittal Form.

SEC. 4.11 NETWORK DISRUPTION ANALYSIS

The offeror must complete and submit this Submittal Form.

SEC. 4.12 SUBCONTRACTORS

The offeror must complete and submit this Submittal Form.

SEC. 4.13 FINANCIAL WORKBOOK

The offeror must complete and submit this Submittal Form.

Proposed costs must all direct and indirect costs associated with the performance of the contract, including, but not limited to, total number of hours at various hourly rates, direct expenses, payroll, supplies, overhead assigned to each person working on the project, percentage of each person's time devoted to the project, and profit.

SEC. 4.14 PERFORMANCE GUARANTEES

The offeror must complete and submit this Submittal Form.

SEC. 4.15 INTENT TO PROPOSE AND NON-DISCLOSURE AGREEMENT

To access the claims file and census files needed to prepare the financial workbook, GeoAccess Analysis and Network Disruption Analysis, the offeror must complete and submit an intent to propose (ITP) and non-disclosure agreement (NDA) form to the contracting officer, as provided as an attachment to this RFP. The agreement will be available through ProposalTech after the initial draft period of the RFP. Completed forms must be submitted through ProposalTech.

The State will not furnish or provide these files to any offeror until receipt of this agreement. The State reserves the right to clarify and verify any offeror's ability to perform the services required under this solicitation prior to granting access to any of the files.

Upon receipt of the NDA and verification of the offeror's eligibility to receive the files, the offeror will be provided access to the following information:

Claims File: This file provides de-identified claims detail for the State for the period of July 2017 – June 2018. The file includes zip codes for all providers utilized in the data period and should be used to conduct the Network Disruption Analysis, and as applicable will be used for a re-pricing exercise.

Census Files: These files provide information including participant residence zip codes and should be utilized for the GeoAccess analysis.

Access to these files will be provided to the offeror by ProposalTech once the NDA and ITP are agreed to and accepted.

SECTION 5. EVALUATION CRITERIA AND CONTRACTOR SELECTION

SEC. 5.01 THIRD-PARTY CONSULTING ASSISTANCE

The State has retained The Segal Group (Segal) as a subject matter expert to assist the State with this RFP process. This assistance includes:

- Developing language and content for the RFP
- Attending and participating in the pre-proposal meetings
- Developing the GeoAccess Analysis, Network Disruption Analysis, and Financial Workbook
- Analyzing proposals and serving as an overall technical industry resource for the proposal evaluation committee (PEC)
- Analyzing and developing reports related to the proposals, contractual requirements responses, GeoAccess Analysis, Network Disruption Analysis, and Medical M-11 / Dental D-11 – Financial Workbook
- Presenting findings from analysis to procurement and the PEC at the PEC meeting(s)
- Developing questions and areas of interest for the interviews and attending interviews
- Attending meetings and assisting the State during the clarification period (reference RFP Section 5.11)

SEC. 5.02 SUMMARY OF EVALUATION PROCESS

The State will use the following steps to evaluate and prioritize proposals:

1. Proposals will be assessed for overall responsiveness and compliance with mandatory requirements. Proposals deemed non-responsive or not in compliance with mandatory requirements will be eliminated from further consideration.
2. Each responsive proposal that has passed all mandatory requirements will be assigned a unique code.
3. A proposal evaluation committee (PEC), made up of at least three state employees or public officials, will evaluate specific parts of the responsive proposals.
    a. The anonymous Submittal Forms, from each responsive proposal, will be sent to the PEC. No cost information, schedule information, or team information will be shared or provided to the PEC.
    b. The PEC will independently evaluate and score the documents based on the degree to which the proposal has met the requirements of the Submittal Form.
4. After independent scoring, the PEC will have a meeting, chaired by the contracting officer, where the PEC will have a group discussion prior to finalizing their scores. Prior to the meeting, Segal will analyze the proposals, GeoAccess Analysis, and Network Disruption Analysis, and present their analysis in writing to the contracting officer. This analysis will also be anonymous and will be reviewed by the contracting officer to ensure anonymity prior to sending to the PEC for the group meeting. The PEC may take the analysis into consideration prior to finalizing their scores. Segal may also participate in the PEC meeting but will not provide any identifying information in any discussions with PEC members prior to the PEC members finalizing their scores.
5. The evaluators will submit their final individual scores to the contracting officer, who will then average and compile the evaluator's scores.
6. The contracting officer will prioritize the proposals based on: evaluator scores, fee/cost information, and Alaska preferences (as outlined in this section).
7. The contracting officer may shortlist the proposals and the State may conduct interviews with the top-rated offerors. Segal may assist in preparing questions for the interviews and assisting the State with follow-up questions during the interviews.
8. The PEC will evaluate and score the interviews and submit their scores to the contracting officer. The PEC will have a meeting, chaired by the contracting officer, where the PEC will have a group discussion prior to finalizing the interview scores. The PEC may consult with Segal for technical assistance before finalizing the interview scores. The contracting officer will incorporate these scores into the final prioritization.

9. The State, with Segal's assistance, will then conduct clarifications, negotiations, and award a contract if the clarifications and negotiations are successful.

SEC. 5.03 EVALUATION CRITERIA

Proposals will be evaluated based on their overall value to State, considering both cost and non-cost factors as described below. Note: An evaluation may not be based on discrimination due to the race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, disability, or political affiliation of the offeror. **Failure to provide required information or submitting "N/A" or the equivalent may cause the proposal to be deemed non-responsive and rejected.**

MEDICAL TPA

Overall Criteria – Medical TPA		Weight
Responsiveness		Pass/Fail
Completion of Offeror Information and Certifications	(M-1)	Pass/Fail
Completion of Service Approach	(M-2)	Pass/Fail
Completion of Performance Qualifications	(M-5)	Pass/Fail
Mandatory Requirements Compliance	(M-6)	Pass/Fail
Completion of Contractual Requirements	(M-7)	Pass/Fail
Completion of GeoAccess Analysis	(M-8)	Pass/Fail
Completion of Network Disruption Analysis	(M-9)	Pass/Fail
Completion of Subcontractor Form	(M-10)	Pass/Fail
Completion of Performance Guarantees	(M-12)	Pass/Fail

Qualifications Criteria – Medical TPA		Weight
Risk Assessment Plan	(M-3)	100
Value Opportunity Assessment	(M-4)	150
Interviews – Account Manager		150
Interviews – Implementation Manager		50
Interviews – Medical Director		50
Interviews – Network/Contracting Manager		100
Interviews – Member Services Manager		50
	Total	650

Preference – Medical TPA		Weight
Alaska Offeror's Preference		100
	Total	100

Cost Criteria – Medical TPA		Weight
Financial Workbook	(M-11)	250
	Total	250

DENTAL TPA

Overall Criteria – Dental TPA		Weight
Responsiveness		Pass/Fail
Completion of Offeror Information and Certifications	(D-1)	Pass/Fail
Completion of Service Approach	(D-2)	Pass/Fail
Completion of Performance Qualifications	(D-5)	Pass/Fail
Mandatory Requirements Compliance	(D-6)	Pass/Fail
Completion of Contractual Requirements	(D-7)	Pass/Fail
Completion of GeoAccess Analysis	(D-8)	Pass/Fail
Completion of Network Disruption Analysis	(D-9)	Pass/Fail
Completion of Subcontractor Form	(D-10)	Pass/Fail
Completion of Performance Guarantees	(D-12)	Pass/Fail

Qualifications Criteria – Dental TPA		Weight
Risk Assessment Plan	(D-3)	100
Value Opportunity Assessment	(D-4)	100
Interviews – Account Manager		100
Interviews – Implementation Manager		50
Interviews – Clinical Reviewer		50
Interviews – Network Manager		50
Interviews – Member Services Manager		50
	Total	500

Preference – Dental TPA		Weight
Alaska Offerors Preference		100
	Total	100

Cost Criteria – Dental TPA		Weight
Financial Workbook	(D-11)	400
	Total	400

SEC. 5.04 SCORING METHOD AND CALCULATION

The PEC will evaluate responses against the questions set out in Section 5.06 and assign a single score for each section. Offeror's responses for each section will be rated comparatively against one another with each PEC member assigning a score of 1, 5, or 10 (with 10 representing the highest score, 5 representing the average score, and 1 representing the lowest score). Responses that are similar or lack dominant information to differentiate the offerors from each other will receive the same score. Therefore, it is the offeror's responsibility to provide dominant information and differentiate themselves from their competitors.

After the PEC has scored each section, the scores for each section will be totaled and the following formula will be used to calculate the amount of points awarded for that section:

$$\frac{\text{Offeror Total Score}}{\text{Highest Total Score}} \times \text{Max Points} = \text{Points Awarded}$$

Example (Max Points for the Section = 100):

	PEC Member 1 Total Score	PEC Member 2 Total Score	PEC Member 3 Total Score	PEC Member 4 Total Score	Combined Total Score	Award Points
Offeror 1	10	5	5	10	30	75
Offeror 2	5	5	5	5	20	50
Offeror 3	10	10	10	10	40	100

In this example, **Offeror 3** received the highest combined total score and thus was awarded the maximum amount of points for that section.

Offeror 1 was awarded 75 points:

$$\frac{\text{Offeror Total Score (30)}}{\text{Highest Total Score (40)}} \times \text{Max Points (100)} = \text{Points Awarded (75)}$$

Offeror 2 was awarded 50 points:

$$\frac{\text{Offeror Total Score (20)}}{\text{Highest Total Score (40)}} \times \text{Max Points (100)} = \text{Points Awarded (50)}$$

SEC. 5.05 PASS/FAIL CRITERIA

Pass/Fail submittal forms will not be scored, but will be provided to the PEC, and the content of these documents will inform the interview process.

(a) MANDATORY TECHNICAL REQUIREMENTS

The offeror must confirm that they meet all mandatory requirements as identified in M-6 / D-6. An offeror's failure to meet these requirements will cause their proposal to be considered non-responsive and rejected.

(b) SERVICE APPROACH

The Service Approach will be evaluated against the questions outlined below. Note: This submission will not be scored by the evaluation committee, however the content of this submission will be used by the committee to inform the evaluation process. An offeror's failure to submit a service approach will cause their proposal to be considered non-responsive and rejected.

1) How well has the offeror demonstrated an understanding of the purpose and scope of the project?
2) How logical is the approach/methodology to fulfilling the scope objectives and goals of the State?
3) How well has the offeror demonstrated an understanding of the deliverables the State expects it to provide?

(c) PERFORMANCE QUALIFICATIONS

This submission will be evaluated based on the customer's satisfaction with the offeror and the account manager. Note: This submission will not be scored by the evaluation committee, however the content of this submission will be used by the committee to inform the evaluation process. An offeror's failure to submit performance qualifications will cause their proposal to be considered non-responsive and rejected.

(d) NETWORK DISRUPTION ANALYSIS AND GEOACCESS ANALYSIS

These documents will not be scored although the Network Disruption and the GeoAccess analysis will be shared with PEC members and is implicitly incorporated into the claims cost analysis. Segal will present their findings to the PEC for consideration after the PEC has completed their initial round of individual scoring. Segal will evaluate the Network Disruption analysis based upon the information provided in the proposal response to the excel financial documents provided. Proposals will be measured upon the providers/facilities used by the active and

retired participants in the plans for which a proposal is being submitted, as measured from the experience of the plan over the past one year. Special consideration will be made of the offeror's ability to provide a network of providers in all of the areas in which participants reside (including rural and remote areas). The census file submitted to offerors includes residence zip code locations.

Disruption Analysis - shows how disruptive it will be for plan participants to switch to a different network of providers. By looking at the State's claims activity for the prior year, an analysis can match providers (and facilities) used by plan participants to the prospective network. This can help the PEC gauge expected in-network usage with the prospective network.

Network disruption will be analyzed as follows:

- The percentage of providers in the offeror's network that are available to members and are included in the claims data file.
- The percentage of claims in the offeror's network that are included in the claims data file.
- An evaluation of the number of facilities that are available to participants based upon a distribution within the state.

GeoAccess Analysis – is a tool to evaluate provider networks composition and accessibility by matching the home zip codes of plan participants to zip codes of network providers. Access criteria is specified in the RFP. The GeoAccess analysis identifies areas that will have higher non-network utilization and may present opportunities for network build-out.

SEC. 5.06 EVALUATED CRITERIA

The State of Alaska will use the actual average scores in their analysis. The Offeror with the highest average ratings will receive the maximum number of points for that section. Points will be awarded to the other offerors using the formula set out in Section 5.04

(a) RISK ASSESSMENT PLAN

The Risk Assessment plan will be evaluated against the questions set out below.

1) How well has the offeror identified pertinent risks, issues, challenges, and potential problems related to this specific project/service?
2) How well has the offeror identified a clear and concise approach/methodology that can logically mitigate the risks?
3) The offeror's ability to provide verifiable documented results of mitigation strategies (the impacts of their mitigation approach).

(b) VALUE OPPORTUNITY ASSESSMENT

The Value Opportunity Assessment will be evaluated against the questions set out below.

1) How well has the offeror identified pertinent ideas or opportunities that are specific to this project/service?
2) The offeror's ability to provide verifiable documented results of the ideas/opportunities (actual impacts of these ideas).

(c) INTERVIEWS OF KEY PERSONNEL

The State may conduct interviews with the key personnel from each of the shortlisted offerors, as identified below (the State reserves the right to request additional personnel).

Medical Service Team Members:

1) Account Manager – Individual that will lead the overall program/service and will be responsible for the day-to-day operations of the program. (Interview length: 75 minutes)
2) Implementation Manager – The implementation manager coordinates all set-up activities, team members, and deadlines. (Interview length: 30 minutes)
3) Medical Director – Provides medical expertise for the plan, including oversight case management, utilization review, and engagement statistics. (Interview length: 30 minutes)
4) Network/Contracting Manager – The person in charge developing the network and contracting with providers/facilities. (Interview length: 45 minutes)
5) Member Services Manager – The person in charge of ensuring the customer service representatives are trained and prepared to provide accurate information and exceptional customer service to members. (Interview length: 30 minutes)

Dental Service Team Members:

1) Account Manager – Individual that will lead the overall program/service and will be responsible for the day-to-day operations of the program. (Interview length: 45 minutes)
2) Implementation Manager – The implementation manager coordinates all set-up activities, team members, and deadlines. (Interview length: 30 minutes)
3) Clinical Reviewer – Provides dental expertise for the plan, including oversight case management. (Interview length: 30 minutes)
4) Network/Contracting Manager – The person in charge developing the network and contracting with providers/facilities. (Interview length: 30 minutes)
5) Member Services Manager – The person in charge of ensuring the customer service representatives are trained and prepared to provide accurate information and exceptional customer service to members. (Interview length: 30 minutes)

The individuals that will be interviewed must be the same individuals that are identified in M-1 /D-1 of the offeror's proposal. No substitutes, proxies, phone interviews, or electronic interviews will be allowed. No other individuals (from the offeror's organization) will be allowed to sit in or participate during the interview session. Individuals who fail to attend the interview will be given a "1" score, which may jeopardize the offeror's competitiveness.

Interviewees may not bring notes, presentation materials, or handouts. The State will interview individuals separately (not as a team). Interviewees may be prohibited from making any reference to their proposed cost/fees. Interviewees may be asked questions regarding their experience, knowledge and understanding of the scope of work, obstacles and challenges, strategies, and their plan/approach. The State may request additional information prior to interviews. Segal will attend interviews and may assist the State in asking follow up questions during the interviews. The PEC will score each interview individually, and may consult with Segal before finalizing the interview scores.

(d) CONTRACT COST

Costs will not be evaluated/scored by the PEC. Offerors must use the tables in M-11/ D-11– Financial Workbook (Attachments 3 and 4) to display their proposed fees and claims costs. Comment sections have been provided through these form(s) to allow offerors to provide supplemental explanations, if necessary.

Segal will perform a financial analysis of the proposed fees and claims. Segal utilizes client specific claims data for the re-pricing analysis to estimate claims cost that is trended to the renewal contract period using annual trend rates of 4% for medical and 3.5% for dental. These repriced claims costs will be added to the offeror's administrative services organization (ASO) rate to develop an annual total cost. Annual total cost will be summed for each of the five initial contract years to develop the total initial contract cost.

Additionally, for medical services, offerors will have the opportunity to provide a discount guarantee for each year. If an offeror provides such a guarantee it will be incorporated into the Total Cost as follows:

- If the discount guarantee is lower than the existing network discounts as demonstrated in the claims repricing, no penalty will be assed as it is assumed the guarantee will be met; or
- If the discount guarantee is higher than the existing network discounts as demonstrated in the claims repricing, it will be assumed the guarantee is not met and the Total Cost will be adjusted to reflect the penalty in any given year.

The annual Total Cost will be adjusted to reflect the discount guarantee penalty and the discounts submitted in the claims repricing. In this way, each bid is compared using the client specific utilization and spending patterns and projected forward using Segal's industry knowledge on emerging medical market trends. Overall scoring/assessment will be done on a Total Cost basis.

Re-Pricing – compares detailed covered charges against a prospective network's allowed charge for each service. This approach can help estimate how much those claims would have cost the offeror's proposed network. It also provides a measure for what kind of discounts would have been received with an offeror's proposed network using the actual claims data from July 2017 – June 2018. Re-pricing helps evaluate if a proposed network will save the State more money than the incumbent network.

Example: Scaled Penalty

Discount percentage from repricing file	38%
Discount guarantee	40%
Penalty for missing guarantee	Scaling penalty: 37% - 39.99999% achieved, 10% admin fee penalty 34% - 36.99999% achieved, 20% admin fee penalty 31% - 33.99999% achieved, 30% admin fee penalty
Illustrative administrative cost year one	$500,000
Illustrative billed claims cost	$10,000,000
Illustrative allowed/discounted claims cost	$6,200,000
Illustrative annual cost	$6,700,000
Basis for penalty for discount guarantee	38% achieved (resulting in a penalty of 10% of admin fees)
Determination of penalty	$500,000 * .10 = $50,000
New illustrative annual cost (used in cost proposal evaluation)	$6,200,000 + $500,000 - $50,000 = $6,650,000

Example: Percentage of Discount Not Achieved

Discount percentage from repricing file	38%
Discount guarantee	40%
Penalty for missing guarantee	25% of claims discount not achieved up to 5% of administration fees
Illustrative administrative cost year one	$500,000
Illustrative billed claims cost	$10,000,000
Illustrative allowed/discounted claims cost	$6,200,000
Illustrative annual cost	$6,700,000
Basis for penalty for discount guarantee	25% of differential up to 5% of admin fees

Determination of penalty	(40% - 38% x $10,000,000 = $200,000, which is greater than 5% x $500,000 = $25,000
New illustrative annual cost	$6,200,000 + $500,000 - $25,000 = $6,475,0000

Dependent on the availability of data, Segal will also use the Uniform Data Specifications (UDS) workgroup as another validation of proposed discounts provided by the offeror. Facilitated by Milliman, UDS is a collaborative effort by the major insurance carriers and consulting firms to reach consensus on the definition of financial terms, claim categories, and general methodology for preparation of data files for use in discount comparison. Carriers provide their book of business claims data by network semi-annually and discount results can be measured at a 3-digit zip code level for inpatient, outpatient and professional services. UDS is useful for validating re-pricing results and any network self-reported discounts.

Segal reserves the right to seek clarification on the submitted pricing through the procurement officer. If there is any ambiguity between an offeror's response and the information provided in the claims repricing file, the claims repricing file will serve as the source of information for evaluation purposes.

The RFP Results – Financial document will display the total costs for each offeror. The distribution of points based on cost will be determined as set out in 2 AAC 12.260(c). After the contracting officer applies any applicable preferences, the offeror with the lowest total costs will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined using the following formula:

[(Price of Lowest Cost Proposal) x (Maximum Points for Cost)] ÷ (Cost of Each Higher Priced Proposal)

SEC. 5.07 APPLICATION OF PREFERENCES

Certain preferences apply to all contracts for professional services, regardless of their dollar value. The Alaska Bidder, Alaska Veteran, and Alaska Offeror preferences are the most common preferences involved in the RFP process. Additional preferences that may apply to this procurement are listed below. Guides that contain excerpts from the relevant statutes and codes, explain when the preferences apply and provide examples of how to calculate the preferences are available at the following website:

http://doa.alaska.gov/dgs/pdf/pref1.pdf

- Alaska Products Preference - AS 36.30.332
- Recycled Products Preference - AS 36.30.337
- Local Agriculture and Fisheries Products Preference - AS 36.15.050
- Employment Program Preference - AS 36.30.321(b)
- Alaskans with Disabilities Preference - AS 36.30.321(d)
- Alaska Veteran's Preference - AS 36.30.321(f)

The Division of Vocational Rehabilitation in the Department of Labor and Workforce Development keeps a list of qualified employment programs and individuals who qualify as persons with a disability. As evidence of a business' or an individual's right to the Employment Program or Alaskans with Disabilities preferences, the Division of Vocational Rehabilitation will issue a certification letter. To take advantage of these preferences, a business or individual must be on the appropriate Division of Vocational Rehabilitation list prior to the time designated for receipt of proposals. Offerors must attach a copy of their certification letter to the proposal. **An offeror's failure to provide this certification letter with their proposal will cause the State to disallow the preference.**

(a) ALASKA BIDDER PREFERENCE

An Alaska Bidder Preference of 5% will be applied to the price in the proposal. In order to claim this preference, you must complete and include the Alaska Bidder Preference Qualification form within Attachment M-1 / D-1 with your proposal. The preference will be given to an offeror who:

1) holds a current Alaska business license prior to the deadline for receipt of proposals;
2) submits a proposal for goods or services under the name appearing on the offeror's current Alaska business license;
3) has maintained a place of business within the state staffed by the offeror, or an employee of the offeror, for a period of six months immediately preceding the date of the proposal; and
4) is incorporated or qualified to do business under the laws of the state, is a sole proprietorship and the proprietor is a resident of the state, is a limited liability company (LLC) organized under AS 10.50 and all members are residents of the state, or is a partnership under AS 32.06 or AS 32.11 and all partners are residents of the state.

(b) ALASKA VETERAN PREFERENCE

An Alaska Veteran Preference of 5%, not to exceed $5,000, will be applied to the price in the proposal. The preference will be given to an offeror who qualifies under AS 36.30.990(2) as an Alaska bidder and is a:

A. sole proprietorship owned by an Alaska veteran;
B. partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans;
C. limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans; or
D. corporation that is wholly owned by individuals, and a majority of the individuals are Alaska veterans.

(a) ALASKA OFFEROR PREFERENCE

If an offeror qualifies for the Alaska Bidder Preference, the offeror will receive an Alaska Offeror Preference. 2 AAC 12.260(e) provides Alaska offerors a 10% overall evaluation point preference. Alaska bidders, as defined in AS 36.30.990(2), are eligible for the preference. An Alaska offeror will receive 10% of the total available points added to their overall evaluation score as a preference.

SEC. 5.08 SHORTLISTING

After proposals have been prioritized, the State may shortlist and interview the top three highest ranking offerors. The State may increase or decrease the number of offerors in this list based on the competitiveness of the proposals and/or from feedback from the PEC.

SEC. 5.09 FINAL PRIORITIZATION

After the shortlisted offerors have been interviewed and scored by the PEC, the contracting officer will compile all scores and perform a final prioritization of offerors.

SEC. 5.10 COST REASONABLENESS

Prior to performing clarifications and negotiations, the contracting officer will perform a cost reasonableness assessment of all shortlisted proposals in the following manner:

a. If the highest prioritized offeror's total cost points is within 5% of the second highest prioritized offeror's total cost points, the State reserves the right to proceed to invite the highest prioritized offeror to the clarification period.
b. If the highest prioritized offeror exceeds this range, the State reserves the right to invite the second highest prioritized offeror to the clarification period.

<u>Measurement – calculated as 5% of the point allocation:</u>
*Highest Total Cost Points: 300 * (1-.05) = 285*
Second Total Cost Points must be 285 or greater

SEC. 5.11 CLARIFICATION PERIOD

The State will invite the highest (or second highest) prioritized offeror to the clarification period. The clarification period is carried out prior to the signing of a contract. The intent of this period is to allow the apparent best-value offeror an opportunity to clarify any assumptions, issues, or risks, and confirm that their proposal is accurate. The State's objective is to have the services completed on time, without any cost increases, in a timely and efficient manager, and with high customer satisfaction. It is the offeror's responsibility to ensure that the offeror understands the State's expectations. The offeror is at risk, and part of the risk is understanding State's expectations.

The offeror will be required to pre-plan the project in detail to ensure that there are no surprises, and to prepare a clarification document (which will be incorporated into the contract), containing at a minimum the information as described below:

a. Verify the Fee/Cost Proposal: Clarify the fee schedule. The offeror is expected, in good faith, to incorporate and submit any additional data, supporting schedules, or substantiation reasonably required.

b. Provide a Project Schedule: Prepare a high-level schedule of the project (with major milestones or tasks). If requested, prepare a detailed milestone schedule. This may include transition and implementation.

c. Provide a Client Action Item Schedule: Prepare a schedule of any/all activities, actions, or decisions needed from the State (including specific due dates and client names responsible for the activities). This must be a separate document from the overall project schedule. This should be provided in a very simple format. Identify the roles and responsibilities of the State or its personnel.

d. Align Expectations: Coordinate the project/service (schedule, cost, activities) with all critical parties (subcontractors, consultants, suppliers, manufacturers, networks, etc.). Create a detailed project plan. Review any unique technical requirements with the State.

e. Key Assumptions: Provide a summary of the major assumptions that have been made in preparing the proposal. This should include items/tasks that the offeror has assumed the State will perform, items/tasks required from the State, and items/tasks that have not been included in the proposal (items that the offeror feels are outside the scope of work). This should also include any critical expectations or responsibilities that the offeror has of the State, state personnel, or other parties/organizations that are not contracted to by the offeror.

f. Risk Mitigation Approach: Identify all risks, activities, or concerns that may be unforeseen or not within the control of the offeror. This should include everything (realistically) that may prevent the offeror from being successful on this project. This may include: contractor risks, designer risks, owner risks, other party risks, and unforeseen risks. Identify if there are any strategies to mitigate these items. Provide a plan of how unforeseen risks will be managed. Identify what (if anything) concerns you the most, or is very unique about this project

g. Financial Resources and Responsibility: Provide necessary information on the offeror's ability to meet its financial obligations. Financial analysis includes and is not limited to standard accounting ratio analysis. Offeror will be required to provide the most recent three years audited financial statements (Balance Sheet, Income Statement, and Cash-Flow Statement), including notes to the financial statements or the period of the company's existence, if shorter. Provide the most recent interim financial statements. Required if the latest available financial statement date is six months or more than the RFP document submission date. Interim financial statements must be signed and attested to by an authorized officer as a fair representation, in all material aspects, of the company's financial condition in accordance with generally accepted accounting principles. Provide any sub-consultant's financial stability information and

qualifications of the sub-consultant's key personnel (if the sub-consultant will perform at least 25% of the work). The State may request clarifications or additional documentation, other than the aforementioned documents as stated above. However, no request by the offeror to submit additional information for re-evaluation of financial resources and responsibility will be accepted.

h. Provide an organizational chart specific to the personnel assigned to accomplish the work called for in this RFP; illustrate the lines of authority; designate the individual responsible and accountable for the completion of each component and deliverable of the RFP. If requested, provide resumes on all key personnel.

i. Provide any additional requested documentation: Provide a detailed project/work plan, past and current client references, staffing plans, contracts, insurance, background checks, additional references and reference information, etc.

The potential best-value offeror will be required to conduct and participate in several meetings throughout the clarification period. At a minimum, the State will require the offeror to conduct a kickoff meeting at the beginning of the clarification period. The offeror will lead the kickoff meeting and is expected to be prepared to present the following information:

- Description of their plan for project execution and management
- High level schedule for project delivery
- Address any major concerns provided by the State
- Address all project assumptions
- Identify major risks to project delivery (focusing on risks that the offeror does not directly control) and the associated risk mitigation strategy. Clearly identify any information or actions needed from the State to support successful project delivery.
- Propose a schedule for items that must be reviewed in detail and resolved during the clarification period.

The potential best-value offeror will be required to hold a final summary meeting at the end of the clarification period. This meeting is to present a summary of the final details that were discussed and resolved during the clarification period. The offeror will lead the meeting to present the entire proposal, project execution plan, and identified risks and mitigation plans.

The State reserves the right at its sole discretion to negotiate with the potential best-value offeror during the clarification period. This may include, but is not limited to, modifying the scope of the project (time, cost, quality, expectations, etc.). An invitation to the clarification period does not constitute a legally binding offer to enter into a contract on the part of the State to the offeror. At any time, during the clarification period, if the State is not satisfied with the progress being made by the invited offeror, the offeror fails to provide the information in a timely manner, fails to negotiate in good faith, or if the offeror and the State fail to agree to terms, or fail execute a contract, the State may terminate the clarification period activities and then commence or resume a new clarification period with an alternative offeror.

SEC. 5.12 OFFEROR NOTIFICATION OF SELECTION

If the State and offeror are able to agree to terms and complete the clarification period, the contracting officer will issue a written Notice of Intent to Award (NIA) and send copies to all offerors who submitted proposals. The NIA will set out the names of all offerors and identify the proposal selected for award.

SECTION 6. POST AWARD PROCEDURES AND ACTIVITIES

SEC. 6.01 PERFORMANCE EVALUATIONS

The awarded contractor will be closely monitored for contract compliance. In summary, the State will evaluate the contractor's overall performance on the awarded contract. This may include, but is not limited to:

- Ability to follow state rules, policies, and regulations
- Ability to successfully manage and deliver the project
- Ability to minimize delays
- Ability to minimize cost increases
- Ability to provide and submit accurate monthly reports
- Overall quality and performance of the services
- Accuracy of billing
- Responsiveness to correct deficiencies
- Conformance to the terms and conditions of the contract

The project evaluation assessment will be performed at regular intervals. These ratings may be used and considered during the solicitation and competition of future projects within the State of Alaska.

SECTION 7. GENERAL LEGAL INFORMATION

SEC. 7.01 ALASKA BUSINESS LICENSE AND OTHER REQUIRED LICENSES

Prior to the award of a contract, an offeror must hold a valid Alaska business license. However, in order to receive the Alaska Bidder Preference and other related preferences, such as the Alaska Veteran and Alaska Offeror Preference, an offeror must hold a valid Alaska business license prior to the deadline for receipt of proposals. Offerors should contact the **Department of Commerce, Community and Economic Development, Division of Corporations, Business, and Professional Licensing, PO Box 110806, Juneau, Alaska 99811-0806**, for information on these licenses. Acceptable evidence that the offeror possesses a valid Alaska business license may consist of any one of the following:

- copy of an Alaska business license;
- certification on the proposal that the offeror has a valid Alaska business license and has included the license number in the proposal;
- a canceled check for the Alaska business license fee;
- a copy of the Alaska business license application with a receipt stamp from the state's occupational licensing office; or
- a sworn and notarized statement that the offeror has applied and paid for the Alaska business license.

You are not required to hold a valid Alaska business license at the time proposals are opened if you possess one of the following licenses and are offering services or supplies under that specific line of business:

- fisheries business licenses issued by Alaska Department of Revenue or Alaska Department of Fish and Game;
- liquor licenses issued by Alaska Department of Revenue for alcohol sales only;
- insurance licenses issued by Alaska Department of Commerce, Community and Economic Development, Division of Insurance; or
- Mining licenses issued by Alaska Department of Revenue.

Prior the deadline for receipt of proposals, all offerors must hold any other necessary applicable professional licenses required by Alaska Statute.

SEC. 7.02 STANDARD CONTRACT PROVISIONS

The contractor will be required to sign the State's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A). This form is attached with the RFP for your review. The contractor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Law, and the State reserves the right to reject a proposal that is non-compliant or takes exception with the contract terms and conditions stated in the Agreement. Any requests to change language in this document (adjust, modify, add, delete, etc.), must be set out in the offeror's proposal in a separate document. Please include the following information with any change that you are proposing:

1. Identify the provision that the offeror takes exception with.
2. Identify why the provision is unjust, unreasonable, etc.
3. Identify exactly what suggested changes should be made

SEC. 7.03 PROPOSAL AS A PART OF THE CONTRACT

Part or all of this RFP and the successful proposal may be incorporated into the contract.

SEC. 7.04 ADDITIONAL TERMS AND CONDITIONS

The state reserves the right to add terms and conditions during contract negotiations. These terms and conditions will be within the scope of the RFP and will not affect the proposal evaluations.

SEC. 7.05 HUMAN TRAFFICKING

By signature on their proposal, the offeror certifies that the offeror is not established and headquartered or incorporated and headquartered in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report. The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: http://www.state.gov/j/tip/

Failure to comply with this requirement will cause the State to reject the proposal as non-responsive, or cancel the contract.

SEC. 7.06 INFORMAL DEBRIEFING

When the contract is completed, an informal debriefing may be performed at the discretion of the contracting officer or project director or contracting officer. If performed, the scope of the debriefing will be limited to the work performed by the contractor.

SEC. 7.07 RIGHT OF REJECTION

Offerors must comply with all of the terms of the RFP, the state Procurement Code (AS 36.30), and all applicable local, state, and federal laws, codes, and regulations. The contracting officer may reject any proposal that does not comply with all of the material and substantial terms, conditions, and performance requirements of the RFP. Offerors may not qualify the proposal nor restrict the rights of the state. If an offeror does so, the contracting officer may determine the proposal to be a non-responsive counter-offer and the proposal may be rejected. Minor informalities that:

- do not affect responsiveness;
- are merely a matter of form or format;
- do not change the relative standing or otherwise prejudice other offers;
- do not change the meaning or scope of the RFP;
- are trivial, negligible, or immaterial in nature;
- do not reflect a material change in the work; or
- do not constitute a substantial reservation against a requirement or provision;

may be waived by the contracting officer.

The State reserves the right to refrain from making an award if it determines that to be in its best interest. **A proposal from a debarred or suspended offeror shall be rejected.**

SEC. 7.08 STATE NOT RESPONSIBLE FOR PREPARATION COSTS

The State will not pay any cost associated with the preparation, submittal, presentation, or evaluation of any proposal.

SEC. 7.09 DISCLOSURE OF PROPOSAL CONTENTS

All proposals and other material submitted become the property of the State of Alaska and may be returned only at the state's option. AS 40.25.110 requires public records to be open to reasonable inspection. All proposal information, including detailed price and cost information, will be held in confidence during the evaluation process and prior to the time a Notice of Intent to Award is issued. Thereafter, proposals will become public information.

Trade secrets and other proprietary data contained in proposals may be held confidential if the offeror requests, in writing, that the contracting officer does so, and if the contracting officer agrees, in writing, to do so. The offeror's request must be included with the proposal, must clearly identify the information they wish to be held confidential, and include a statement that sets out the reasons for confidentiality. Unless the contracting officer agrees in writing to hold the requested information confidential, that information will also become public after the Notice of Intent to Award is issued.

SEC. 7.10 ASSIGNMENT

Per 2 AAC 12.480, the contractor may not transfer or assign any portion of the contract without prior written approval from the contracting officer.

SEC. 7.11 DISPUTES

A contract resulting from this RFP is governed by the laws of the State of Alaska. If the contractor has a claim arising in connection with the agreement that it cannot resolve with the State by mutual agreement, it shall pursue the claim, if at all, in accordance with the provisions of AS 36.30.620 – AS 36.30.632. To the extent not otherwise governed by the preceding, the claim shall be brought only in the Superior Court of the State of Alaska and not elsewhere.

SEC. 7.12 SEVERABILITY

If any provision of the contract or agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected; and, the rights and obligations of the parties will be construed and enforced as if the contract did not contain the particular provision held to be invalid.

SEC. 7.13 SUPPLEMENTAL TERMS AND CONDITIONS

Proposals must comply with Section 7.07 Right of Rejection. However, if the State fails to identify or detect supplemental terms or conditions that conflict with those contained in this RFP or that diminish the State's rights under any contract resulting from the RFP, the term(s) or condition(s) will be considered null and void. After award of contract:

If conflict arises between a supplemental term or condition included in the proposal and a term or condition of the RFP, the term or condition of the RFP will prevail; and

If the State's rights would be diminished as a result of application of a supplemental term or condition included in the proposal, the supplemental term or condition will be considered null and void.

SEC. 7.14 CONTRACT INVALIDATION

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

SEC. 7.15 SOLICITATION ADVERTISING

Public notice has been provided in accordance with 2 AAC 12.220.

SEC. 7.16 SITE INSPECTION

The State may conduct on-site visits to evaluate the offeror's capacity to perform the contract. An offeror must agree, at risk of being found non-responsive and having its proposal rejected, to provide the State reasonable access to relevant portions of its work sites. Individuals designated by the contracting officer at the State's expense will make site inspection.

SEC. 7.17 PROTEST

AS 36.30.560 provides that an interested party may protest the content of the RFP. An interested party is defined in 2 AAC 12.990(a) (7) as "an actual or prospective bidder or offeror whose economic interest might be affected substantially and directly by the issuance of a contract solicitation, the award of a contract, or the failure to award a contract."

If an interested party wishes to protest the content of a solicitation, the protest must be received, in writing, by the contracting officer at least ten days prior to the deadline for receipt of proposals.
AS 36.30.560 also provides that an interested party may protest the award of a contract or the proposed award of a contract.

If an offeror wishes to protest the award of a contract or the proposed award of a contract, the protest must be received, in writing, by the contracting officer within ten days after the date the Notice of Intent to Award the contract is issued.

A protester must have submitted a proposal in order to have sufficient standing to protest the proposed award of a contract. Protests must include the following information:

- the name, address, and telephone number of the protester;
- the signature of the protester or the protester's representative;
- identification of the contracting agency and the solicitation or contract at issue;
- a detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and the form of relief requested.

Fax copies containing a signature are acceptable.

The contracting officer will issue a written response to the protest. The response will set out the contracting officer's decision and contain the basis of the decision within the statutory time limit in AS 36.30.580. A copy of the decision will be furnished to the protester by certified mail, fax or another method that provides evidence of receipt.

All offerors will be notified of any protest. The review of protests, decisions of the contracting officer, appeals, and hearings, will be conducted in accordance with the state Procurement Code (AS 36.30), Article 8 "Legal and Contractual Remedies."

SECTION 8. ATTACHMENTS

- Attachment 1: Medical Submittal Form Packet
- Attachment 2: Dental Submittal Form Packet
- Attachment 3: Medical Financial Workbook
- Attachment 4: Dental Financial Workbook
- Attachment 5: Standard Agreement Form
- Attachment 6: Appendix A
- Attachment 7: Appendix B2