Medical Submittal Form Packet

MEDICAL SUBMITTAL FORM 1 – Offeror Information and Certifications

PROJECT INFORMATION

RFP NUMBER: _____

PROJECT NAME: _____

OFFEROR INFORMATION

Company Name: _____

Address: _____

Tax ID: _____

Alaska Business License #: _____

CONTACT INFORMATION

Provide contact information for the individual that can be contacted for clarification regarding this proposal:

Name _____

Title _____

Address _____

Email _____

Telephone _____

CRITICAL TEAM MEMBERS

Provide the names of all critical team members that will be assigned to this contract. Note: These individuals cannot be removed or replaced from this project, or their positions, unless approved in writing the project director or contracting officer.

Name of Account Manager _____

Name of Implementation Manager _____

Name of Medical Director _____

Name of Provider/Network Manager _____

Name of Customer Service Manager _____

ADDENDA ACKNOWLEDGEMENT

The offeror acknowledges receipt of the following addenda and has incorporated the requirements of such addenda into their proposal. Failure to identify and sign for all addendum may subject the offeror to disqualification. The offeror must list all addenda's (by number), then initial and date to confirm that you have received and incorporated them into your proposal. *The offeror may add more rows as necessary.*

Number	Initials & Date

Number	Initials & Date

Number	Initials & Date

CERTIFICATIONS

	Criteria	Response*
1	The offeror is presently engaged in the business of providing the services and work required in this RFP.	□ Yes □ No
2	The offeror confirms that it has the financial strength to perform and maintain the services required under this RFP.	□ Yes □ No
3	The offeror accepts the terms and conditions set out in the RFP (including the Standard Agreement Form – Appendix A) and agrees not to restrict the rights of the State.	□ Yes □ No
4	The offeror confirms that they can obtain and maintain all necessary insurance as required on this project.	□ Yes □ No
5	The offeror certifies that all services provided under this contract by the contractor and all subcontractors shall be performed in the United States.	□ Yes □ No
6	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.	□ Yes □ No
7	Offeror complies with the American with Disabilities Act of 1990 and the regulations issued thereunder by the federal government.	□ Yes □ No
8	The offeror certifies that programs, services, and activities provided to the general public under the resulting contract are in conformance with the Americans with Disabilities Act of 1990.	□ Yes □ No
9	Offeror complies with the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government.	□ Yes □ No
10	Offeror complies with the applicable portion of the Federal Civil Rights Act of 1964.	□ Yes □ No
11	The offeror can provide (if requested) financial records for the organization for the past three years.	□ Yes □ No
12	The offeror has not had any contracts terminated by the State of Alaska (within the past five years).	□ Yes □ No
13	The offeror certifies that it is not currently: debarred, suspended, proposed for debarment, or declared ineligible for award by any public or federal entity.	□ Yes □ No
14	The offeror certifies that they do not have any governmental or regulatory action against their organization that might have a bearing on their ability to provide services to the State.	□ Yes □ No
15	The offeror certifies, within the last five years, they have not been convicted or had judgment rendered against them for: fraud, embezzlement, theft, forgery, bribery, falsification or destruction of records, false statements, or tax evasion.	□ Yes □ No
16	The offeror does not have any judgments, claims, arbitrations or suits pending/outstanding against your company in which an adverse outcome would be material to the company.	□ Yes □ No
17	The offeror is not (now or in the past) been involved in bankruptcy or reorganized proceeding.	□ Yes □ No
18	Offeror certifies they comply with the laws of the State of Alaska.	□ Yes □ No

** Failure to answer or answering "No" may be grounds for disqualification. Please complete the grid below with additional information on any subject where the Offeror responded "No" to a question above.*

"No" Answers Clarification (add rows as necessary)

No.	Clarification

CONFLICT OF INTEREST STATEMENT

Indicate below whether or not the firm or any individuals that will work on the contract has a possible conflict of interest (e.g., currently employed by the State of Alaska or formerly employed by the State of Alaska within the past two years) and, if so, the nature of that conflict. The Commissioner of the Department of Administration reserves the right to consider a proposal non-responsive and reject it or cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity services to be provided by the offeror. The Commissioner's determination regarding any questions of conflict of interest shall be final.

Does the offeror, or any individuals that will work on this contract, have a possible conflict of interest?

** Failure to answer may be grounds for disqualification.*

□ Yes □ No

If "Yes", please provide additional information regarding the nature of that conflict:

ALASKA PREFERENCES

Identify if your firm qualifies for any Alaska Preferences:

Alaska Bidder Preference: Do you believe that your firm qualifies for the Alaska Bidder Preference? Note: If you answer 'yes', please complete the additional information requested below.	□ Yes □ No
Alaska Veteran Preference: Do you believe that your firm qualifies for the Alaska Veteran Preference? Note: If you answer 'yes', please complete the additional information requested below.	□ Yes □ No
Please list any additional Alaska Preferences below that you believe your firm qualifies for.	
1. 2. 3. 4. 5. 6.	

ALASKA BIDDER PREFERENCE

To qualify for and claim the Alaska Bidder Preference, you must answer YES to all questions below. If the procuring agency is unable to verify a response, the preference may not be applied. Knowingly or intentionally making false or misleading statements on this form, whether it succeeds in deceiving or misleading, constitutes misrepresentation per *AS 36.30.687* and may result in criminal penalties.

If you answered 'yes' to the Alaska Bidder Preference, complete the following information:

1	Does your business hold a current Alaska business license per *AS 36.30.990(2)(A)* • If YES, enter your current Alaska business license number	□ Yes □ No
2	Is your business submitting a bid or proposal under the name appearing on the Alaska business license noted in Question 1 per *AS 36.30.990(2)(B)*?	□ Yes □ No
3	Has your firm maintained a place of business within the state staffed by the bidder or offeror, or an employee of the bidder or offeror, for a period of six months immediately preceding the date of the proposal per *AS 36.30.990(2)(C)*? • If YES, please complete 3A and 3B	□ Yes □ No
3A	**Place of Business** Street Address: City: ZIP: "**Place of business**" is defined as a location at which normal business activities are conducted, services are rendered, or goods are made, stored, or processed; a post office box, mail drop, telephone, or answering service does not, by itself, constitute a place of business per *2 AAC 12.990(b)(3)*. • Do you certify that the Place of Business described in Question 3A meets this definition?	□ Yes □ No
3B	The bidder or offeror, or at least one employee of the bidder or offeror, must be a resident of the state under *AS 16.05.415(a)* per *2 AAC 12.990(b)(7)*. • Do you certify that the bidder or offeror OR at least one employee of the bidder or offeror is physically present in the state with the	□ Yes □ No

	intent to remain in Alaska indefinitely and to make a home in the state per *AS 16.05.415(a)(1)*? • Do you certify that that the resident(s) used to meet this requirement has maintained their domicile in Alaska for the 12 consecutive months immediately preceding the deadline set for receipt of bids or proposals per *AS 16.05.415(a)(2)*? • Do you certify that the resident(s) used to meet this requirement is claiming residency ONLY in the State of Alaska per *AS 16.05.415(a)(3)*? • Do you certify that the resident(s) used to meet this requirement is NOT obtaining benefits under a claim of residency in another state, territory, or country per *AS 16.05.415(a)(4)*?	□ Yes □ No □ Yes □ No □ Yes □ No
4	Per *AS 36.30.990(2)(D)*, is your business (**CHOOSE ONE**): • Incorporated or qualified to do business under the laws of the state? o If YES, enter your current Alaska corporate entity number: • A sole proprietorship AND the proprietor is a resident of the state? • A limited liability company organized under AS 10.50 AND all members are residents of the state? • A partnership under former AS 32.05, AS 32.06, or AS 32.11 AND all partners are residents of the state?	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No

ALASKA VETERAN PREFERENCE

If you answered 'yes' to the Alaska Veteran Preference, complete the following information:

Does your firm hold a current Alaska business license prior to the deadline for receipt of proposals?	□ Yes □ No
Does your firm qualify under AS 36.30.990(2) as an Alaska bidder?	□ Yes □ No
Is your firm a sole proprietorship owned by an Alaska veteran?	□ Yes □ No
Is your firm a partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans?	□ Yes □ No
Is your firm a limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans?	□ Yes □ No
Is your firm a corporation that is wholly owned by individuals, and a majority of the individuals are Alaska veterans?	□ Yes □ No

SIGNATURE

By signature below, I certify under penalty of law that I am an authorized representative of Click or tap here to enter text. and all information on this form is true and correct to the best of my knowledge.

Printed Name _____

Title _____

Date _____

Signature _____

MEDICAL SUBMITTAL FORM 2 – Service Approach

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed ten pages (reference RFP section 4.02 and 4.04).

MEDICAL SUBMITTAL FORM 3 – Risk Assessment Plan

PART 1 – Assessment of Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference section 4.02 and 4.05).

Risk 1: _____
Description: _____
Strategy: _____

Risk 2: _____
Description: _____
Strategy: _____

Risk 3: _____
Description: _____
Strategy: _____

Risk 4: _____
Description: _____
Strategy: _____

Risk 5: _____
Description: _____
Strategy: _____

MEDICAL SUBMITTAL FORM 3 – Risk Assessment Plan

PART 2 – Assessment of Non-Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02 and 4.05).

Risk 1: _____
Description: _____
Strategy: _____

Risk 2: _____
Description: _____
Strategy: _____

Risk 3: _____
Description: _____
Strategy: _____

Risk 4: _____
Description: _____
Strategy: _____

Risk 5: _____
Description: _____
Strategy: _____

MEDICAL SUBMITTAL FORM 4 – Value Opportunity Assessment

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02 and 4.06).

Idea 1: _____
Description: _____

Idea 2: _____
Description: _____

Idea 3: _____
Description: _____

Idea 4: _____
Description: _____

Idea 5: _____
Description: _____

MEDICAL SUBMITTAL FORM 5 – Performance Qualifications

The State of Alaska (Division of Retirement and Benefits) is analyzing performance information on Medical TPA/Networks and their critical personnel. The firm/individual listed below has identified you as a client. The State of Alaska greatly appreciates your time in completing this survey. The State of Alaska may contact you to clarify the survey rating, check for accuracy, or to obtain additional information (reference RFP section 4.02 and 4.07).

PART A – VENDOR NAME

Name of the TPA Firm: _____

Name of the Account Manager: _____

PART B – PROJECT BACKGROUND

Client Name: _____

Business Type: _____

Location (City/State): _____

Start Date of Service: _____ Number of Employee Participants: _____

End Date of Service: _____ Number of Retiree Participants: _____

Average Number of Claims Processed Per Month: _____

PART C – REFERENCE EVALUATION

Please rate your overall level of satisfaction on a scale of 1 to 10 (with 10 representing that you were very satisfied and 1 representing that you were very unsatisfied).

CRITERIA	UNIT	RATING
Ability to manage costs	(1-10)	
Ability to manage schedule	(1-10)	
Ability to meet quality expectations	(1-10)	
Overall customer satisfaction	(1-10)	

Please provide any additional information regarding the vendor and/or the project (consider any significant accomplishments, anything you would do differently, challenges and risks, etc.).

Printed Name of Evaluator	Title	Phone Number	Email	Signature
Printed Name of Alternate Contact	Title	Phone Number	Email	Signature

Thank you for your time and effort in assisting us in this important endeavor.

Please return the completed survey to: ***<< The Vendor should enter a valid fax or email here >>***

MEDICAL SUBMITTAL FORM 6 – Mandatory Requirements

Section 1 - Bid Qualifications

No.	CRITERIA	RESPONSE
1.	Confirm you are not a broker or submitting a third-party proposal.	□ Yes □ No
2.	Confirm your firm has: • Provided claim administration for medical services and managed network services for at least one group of 20,000 or more eligible retirees for at least five years.	□ Yes □ No
	• Have five years of experience processing at least 125,000 claims per month.	□ Yes □ No
	• Have at least two million covered lives across your medical book of business.	□ Yes □ No
	• Have provided claims for a government employer or public retirement plan for medical services and managed network services for at least three years.	□ Yes □ No
	• Have Alaska clients in your book of business totaling a minimum of 10,000 lives.	□ Yes □ No
3.	Confirm that unless otherwise explained in this RFP, you agree that you will disclose all subcontractor arrangements, and any additional fees associated with the subcontractor arrangements, that involve the services provided to the State of Alaska.	□ Yes □ No
4.	Confirm that you will provide no less than 30-day notice to the State of Alaska for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign workers that will impact the State of Alaska.	□ Yes □ No
5.	Confirm that the contract with the State of Alaska will contain a mutual indemnification/hold harmless provision.	□ Yes □ No
6.	Confirm that all member claim records are the sole property of the State of Alaska. Sharing of the State of Alaska's data to outside entities must be disclosed and approved in writing in advance by the State of Alaska. All claims data obtained during the contract period and for up to seven years after the contract termination, is the property of the State of Alaska and must be available upon request.	□ Yes □ No
7.	Confirm you acknowledge you are compliant with all state and federal applicable regulations and are not currently restricted or prohibited from conducting business in all states where the State's participants reside or access care.	□ Yes □ No
8.	Confirm that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of the State of Alaska.	□ Yes □ No
9.	Confirm you agree the initial contract has a length of five (5) years beginning January 1, 2020 with up to five (5) years additional renewal options based on mutually agreed upon fees and terms.	□ Yes □ No
10.	Confirm you agree that bid proposal terms are guaranteed for the duration of the procurement process.	□ Yes □ No

Section 2 - Legal Responsibilities

No.	CRITERIA	RESPONSE
1.	Confirm you acknowledge that you are compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Addendum ("BAA") as provided by the State.	□ Yes □ No
2.	Confirm you agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the offeror and the State shall endeavor to meet and negotiate a reasonable outcome of said dispute. In no event shall the offeror undertake unilateral offset against any monies due and owed the State.	□ Yes □ No

No.	CRITERIA	RESPONSE
3.	Confirm you are in compliance with and will administer the proposed benefit plan(s) in accordance with all applicable legal requirements including: HIPAA, COBRA, DOL, ERISA, and state and local mandates.	□ Yes □ No
4.	Confirm that you meet all applicable HIPAA, EDI, privacy, security, and HITECH requirements and agree to hold the State of Alaska harmless for breaches that are the result of your or any subcontractor(s) actions. Further, you agree to: perform all of the duties associated with breach notification, assume financial responsibility for the breach notice, notify plan participants if there is a breach, and pay for 24 months of identity theft repair and credit monitoring services for impacted plan participants.	□ Yes □ No

Section 3 – Termination Requirements

No.	CRITERIA	RESPONSE
1.	Confirm you agree, in the event of contract termination, that you will cooperate with the State of Alaska, or their representative, in the prompt, accurate, and orderly transfer of the State of Alaska's plan experience. Claims and utilization information will be transferred to the State or its designated succeeding health plan/carrier within 30 days of the termination, at **no added fee**.	□ Yes □ No
2.	Confirm you agree the State of Alaska may terminate the contract at any time after the first complete plan year without cause, by giving 90 days' written notice. The State can terminate with cause with 30 days' notice unless proper remedy is provided by the vendor.	□ Yes □ No

Section 4 - Match Current Plan

No.	CRITERIA	RESPONSE
1.	Confirm you can, at a minimum, duplicate and administer the plan features and coverage of the State's current plan design(s) for each benefit plan, outlined in section 2.06 of the RFP, and will not require the State to alter any of the plan benefits in order to accommodate your claims administration system.	□ Yes □ No

Section 5 - Miscellaneous Services

No.	CRITERIA	RESPONSE
1.	Confirm that your firm can coordinate and administer an Employee Assistance Program (EAP) that can, at a minimum, match the current benefit level.	□ Yes □ No

Section 6 - Implementation

No.	CRITERIA	RESPONSE
1.	Confirm you can accept eligibility files in electronic 834 format.	□ Yes □ No

Section 7 – Eligibility Verification

No.	CRITERIA	RESPONSE
1.	Confirm you can verify retiree dependent student eligibility for dependent children between the ages of 19 and 23.	□ Yes □ No
2.	Confirm you can verify incapacitated dependent eligibility beginning at age 19.	□ Yes □ No

Section 8 - Member and Account Services

No.	CRITERIA	RESPONSE
1.	Confirm you agree to provide designated/dedicated account resources including, but not limited to: an implementation manager, strategic account executive, account manager, claims advocate and an underwriter/financial analyst.	□ Yes □ No
2.	Confirm you will maintain, at a minimum, offices in Juneau and Anchorage to provide dedicated customer service to members and providers served under the AlaskaCare plans.	□ Yes □ No
3.	Confirm you will maintain at least seven years of the State of Alaska's claims data (all fields indicated on the billing) and eligibility information at all times.	□ Yes □ No
4.	Confirm you will not automatically enroll the State in any programs that involve any type of communications with members without express written consent from the State.	□ Yes □ No
5.	Confirm the State will have a dedicated toll-free phone line(s) to answer member and provider inquiries.	□ Yes □ No
6.	Confirm your customer service representatives be available at a minimum Monday – Friday 8:00AM – 6:00PM Alaska time zone.	□ Yes □ No
7.	Confirm you agree to document 100% of the State's member service calls through call recordings/notes and acknowledge that the State reserves the right to access all recordings/notes at any time. Vendor agrees the State will have access to recordings within two business days of request and that transcripts will be provided as soon as administratively possible.	□ Yes □ No
8.	Confirm you agree to ad-hoc calls with the State to review member service issues, and you agree to allow the State to review member service quality issues to the resolution endpoint. In addition, confirm you agree to, at a minimum, quarterly in-person meetings with the account team to review overall performance and trends.	□ Yes □ No
9.	Confirm you agree to provide online, real-time, claim system access to the State or its designee, including access to historical claims data and eligibility data for up to three (3) years following termination of the agreement.	□ Yes □ No
10.	Confirm you will use call centers located within the United States (no outsourcing to non-U.S. based locations).	□ Yes □ No
11.	Confirm you agree to provide a dedicated call center for the AlaskaCare membership.	□ Yes □ No
12.	Confirm you agree to meet with both the State and their stakeholder groups on at least a quarterly basis for strategy sessions on plan design, emerging data trends, and to review utilization reports. These reports would include but are not limited to: medical and vision utilization, trend drivers, case management, customer service call center activity, status of appeals, etc.	□ Yes □ No

Section 9 - Information Technology

No.	CRITERIA	RESPONSE
1.	Confirm you agree to provide the reporting and data detail necessary for the State to manage the AlaskaCare program. Confirm you are able to provide custom regular and as-needed ad-hoc reporting.	□ Yes □ No
2.	Confirm you agree to release all detailed claims data and all encounter data to the State's data warehouse, and/or a designee of the State as needed.	□ Yes □ No
3.	Confirm you will perform comprehensive systems testing and quality assurance audits, with results reported to the State, prior to the contract effective date as part of the base administrative fees with no additional charge to the State.	□ Yes □ No
4.	Confirm you agree that upon determination and identification of system problems, programming problems, or transfer problems, the vendor shall notify the State immediately. The vendor shall also make every effort necessary to correct such problem immediately or as soon as possible, including but not limited to: working nights, weekends, and holidays, to minimize any negative impact to employees, retirees, or dependents, and to maintain continual operations of the program.	□ Yes □ No

No.	CRITERIA	RESPONSE
5.	Confirm you have a Computer Disaster Recovery Plan and can provide your most recent outside assessment of readiness.	□ Yes □ No

Section 10 - Coordination of Benefits

No.	CRITERIA	RESPONSE
1.	Confirm that you have reviewed, understand, and can administer the COB requirements for the State's membership according to current plan terms.	□ Yes □ No
2.	Confirm that you can coordinate benefit payments with Medicare for the retiree plans.	□ Yes □ No
3.	Confirm that you can estimate Medicare Part A and/or Part B coverage in instances where the member elects not to enroll in Medicare Part A and/or Part B.	□ Yes □ No

Section 11 - Audit Rights

No.	CRITERIA	RESPONSE
1.	Confirm you agree that once each year, or more frequently as reasonably determined by the State, or within two (2) years following termination of this agreement, the State's third party auditor(s) ("auditor"), as reasonably approved by the vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, health care benefits, clinical programs, subcontracted administrative services directly related to the State's member utilization and services, performance guarantees, and operational processes relating to the services provided to the State pursuant to this agreement to ensure vendor's compliance with the terms and conditions of this agreement, as the State deems appropriate.	□ Yes □ No

Section 12 - Appeals

No.	CRITERIA	RESPONSE
2.	Confirm you will follow the State's current appeals process for precertification review, claim review and/or billing appropriateness for the plan.	□ Yes □ No
3.	Confirm you agree to defend claims litigation based on decisions to deny coverage for clinical reasons, and that you will provide evidence-based guidelines for the denial of claims.	□ Yes □ No
4.	Confirm that you will administer the claims appeals process as outlined in the Summary of Benefits and Coverage (SBC).	□ Yes □ No
5.	Confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level or any other appeals as requested by the State.	□ Yes □ No
6.	Confirm you will coordinate external review requests with External Review Organizations (EROs).	□ Yes □ No

Section 13 - Banking

No.	CRITERIA	RESPONSE
1.	Confirm that you will set up the State's account structure based upon their requirements.	□ Yes □ No
2.	Confirm you will request an electronic transfer of funds from the State at regular intervals on a "checks cleared" basis and that the request will be by active employee medical claims, retiree medical, vision, and audio claims by retirement system.	□ Yes □ No

Section 14 – Offeror's Financial Terms Submitted with Pricing

No.	CRITERIA	RESPONSE
1.	Confirm that the Administrative Services Organization (ASO) rate includes the full list of core services required.	□ Yes □ No

No.	CRITERIA	RESPONSE
2.	Confirm that all rates provided for the services requested during the initial five-year contract will not be re-evaluated due to variations in enrollment below 25% of the enrollment identified in this RFP.	□ Yes □ No
3.	Confirm that your pricing includes your broadest network offering.	□ Yes □ No
4.	Confirm that your pricing includes a Medicare Direct network option to allow Medicare retirees with non-Medicare dependents to access network coverage.	□ Yes □ No
5.	Confirm that 15 months of claims runout is included in the ASO rate, and that the State will not be billed for these services after the contract termination date.	□ Yes □ No

MEDICAL SUBMITTAL FORM 7 – Contractual Requirements

The following are contractual expectations. The offeror must confirm that they can, or cannot, meet each requirement. A "no" response does not mean automatic rejection, but for each "no" response provide clarification (up to 200 word maximum) in the "Response Clarification and Explanation" section at the end of this document. The State reserves the right to seek additional clarification and negotiate terms regarding any offeror response.

Section 1 - Match Current Plan

The State seeks to replicate current design for the following AlaskaCare plans: employee medical and vision plans, defined benefit retiree medical plan, defined contribution retiree medical plan, and the vision and audio provisions in the retiree dental, vision, and audio plan.

No.	CRITERIA	RESPONSE
1.	The State has arrangements with carve-out vendors and hospital facilities for specific services and/or preferential pricing. Confirm you have reviewed these as outlined in "Other Vendor Services" in section 2.04 of the RFP, and that you will administer and coordinate these programs/arrangements.	□ Yes □ No
2.	Confirm that you can integrate and share electronic data files (including real-time eligibility) with all vendors associated with the State of Alaska, as outlined in "Other Vendor Services" in section 2.04 of the RFP.	□ Yes □ No
3.	Confirm that your firm can apply alternative reimbursement arrangements for out-of-network claims as directed by the State.	□ Yes □ No
4.	Confirm that your firm can reimburse out-of-network facilities with a percentage of Medicare, both in Alaska and the rest of the United States.	□ Yes □ No

Section 2 - Miscellaneous Services

No.	CRITERIA	RESPONSE
1.	Confirm you will provide vision claims invoices to the State within the medical claims reimbursement request.	□ Yes □ No
2.	Confirm that you can coordinate and administer a Flexible Spending Account (FSA) to include:	
	• Ongoing account recordkeeping as reported in files from State for members who have elected to participate in health care spending accounts.	□ Yes □ No
	• Claims administration for health care spending account.	□ Yes □ No
	• Reimbursement of flexible spending account claims, processed on a weekly basis via an ACH "push" arrangement.	□ Yes □ No
	• Do you subcontract this service?	□ Yes □ No
3.	Confirm that you can coordinate and administer a Health Reimbursement Arrangement (HRA) to include:	
	• Ongoing account recordkeeping.	□ Yes □ No
	• Claims administration for HRA	□ Yes □ No
	• Reimbursement of claims will be performed on a weekly basis via an ACH "push" arrangement	□ Yes □ No
	• No annual fees or installation fees will apply on a separate basis from the HRA administrative fees.	□ Yes □ No
	• Do you subcontract this service?	□ Yes □ No

No.	CRITERIA	RESPONSE
4.	Confirm that you can coordinate and administer a Health Savings Account (HSA) if the State were to implement one. • Do you subcontract this service?	□ Yes □ No □ Yes □ No
5.	Confirm you are able to administer COBRA continuation to include: • Initial COBRA notices for new eligible participants under the plan. • COBRA notification packets will be sent to individuals who have had a COBRA event due to loss of coverage under an AlaskaCare plan. • Billing and premium collection for members who elect to continue coverage through COBRA. • Premium remittance will be sent to the State monthly. • Eligibility to be shared with partner vendors on a monthly-basis. • Do you subcontract this service?	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No
6.	Confirm your ability to accept electronic fund transfer for direct pay retiree member's premium payments. (Retirees whose pension is not enough to cover the benefits and pay the difference directly.)	□ Yes □ No
7.	Confirm that your systems have the capabilities to administer a value-based plan design that provides incentives, such as plan design differentials, based on member compliance.	□ Yes □ No
8.	Confirm that your systems have the capabilities to track member eligibility for value-based plans based on their engagement in certain programs and activities.	□ Yes □ No
9.	Confirm you agree to allow for other Alaska public entities to participate in the State's contract terms (subject to mutually agreed upon requirements) with the chosen offeror.	□ Yes □ No

Section 3 - Implementation

No.	CRITERIA	RESPONSE
1.	Confirm you agree to start the process of implementation upon award date of services/coverages, and provide a detailed project management outline with milestones and roles/responsibilities.	□ Yes □ No
2.	Confirm the only information you require in order to establish the State of Alaska as a customer is the SPD, eligibility files for the most current month, and banking information (if necessary).	□ Yes □ No
3.	Confirm you will generate and mail ID cards within 3 days on an ongoing basis as new enrollees are reported eligible.	□ Yes □ No
4.	Confirm you agree to provide a one-time implementation credit to the State of $500,000 to cover expenses related to general implementation. The implementation credit can be used for services associated with ensuring proper implementation of the program including (but not limited to) pre-implementation audit, general implementation assistance, communications, etc.	□ Yes □ No
5.	Confirm you have a secure web-based eligibility system the State's staff may use to update eligibility.	□ Yes □ No

Section 4 - Member and Account Service

No.	CRITERIA	RESPONSE
1.	Are the plan participants able to access a web portal for: • Status of eligibility • Claim status • Electronic claims form • ID cards • Finding a network provider • Provider quality and outcomes information	 □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No

No.	CRITERIA	RESPONSE
	• Plan design including current deductible/out-of-pocket maximum accumulators	□ Yes □ No
	• Cost of services by a specific doctor	□ Yes □ No
	• Cost estimator of common services	□ Yes □ No
	• View/print EOBs	□ Yes □ No
2.	Confirm you agree to allow the State access to your member website with a dummy login prior to the go-live date.	□ Yes □ No
3.	Confirm you agree that all future edits required because of plan design changes implemented by the State shall, after testing, be completed by the vendor within 30 days of receiving notice unless agreed to by the State at no additional charge. If change is required due to vendor error, the change must occur within 3 business days unless other arrangements have been agreed upon by both the State and the vendor.	□ Yes □ No
4.	Confirm you agree the State reserves the right to review, edit, or customize any communication from the vendor to its membership, including prominently featuring the AlaskaCare logos.	□ Yes □ No
5.	Confirm you agree to provider communication pieces in any other language necessary to reach the members from the State.	□ Yes □ No
6.	Confirm you agree to survey the members for the State of Alaska to measure customer satisfaction, and report findings to the State on a quarterly basis.	□ Yes □ No
7.	Confirm you agree to provide members with concierge level customer service support.	□ Yes □ No
8.	Confirm you have a mobile app for participants to use.	□ Yes □ No

Section 5 – Explanation of Benefits (EOB)

No	CRITERIA	RESPONSE
1.	Does your EOB show:	
	• The negotiated charge?	□ Yes □ No
	• The actual charge?	□ Yes □ No
	• Both?	□ Yes □ No
2.	Does your EOB include the reason for denial or reduction of any line item charge?	□ Yes □ No
3.	Do you have the capability to customize EOB messages?	□ Yes □ No
4.	Do you have the capability to customize financial and service limit information that appears on your EOBs?	□ Yes □ No
5.	Are monetary adjustments (whether they are provider write-off or member responsibility) displayed on your EOBs?	□ Yes □ No
6.	Are any accumulator fields (such as YTD individual or family deductible maximum or YTD out-of-pocket expenses) displayed on your EOB?	□ Yes □ No
7.	Do you have the capabilities to provide an EOB specific to Medicare-eligible plan members?	□ Yes □ No

Section 6 - Information Technology

No.	CRITERIA	RESPONSE
1.	Confirm you will develop a custom data extract to be defined by the State including: the content, format, report timing, and frequency.	□ Yes □ No
2.	Does your firm have a data warehousing solution?	□ Yes □ No
3.	Confirm you will accept data transmissions from designated State vendors and agree there will be no additional fees to establish the interface and/or any other IT services in the initial set-up, or to accept changes to the file layout during the term(s) identified as part of the award. Vendor must reconcile each data feed and work with the appropriate vendors to keep the data accurate and consistent among all parties at no additional cost to the State, and will work with the State and its respective vendors to identify opportunities to improve data transmission requirements that will result in improved operational efficiencies and program effectiveness.	□ Yes □ No

No.	CRITERIA	RESPONSE
4.	Does your online system allow the State to assign different levels of security access internally?	□ Yes □ No
5.	Will the State have online access to retrieve routine claims and utilization reports?	□ Yes □ No
6.	Does your system have the capability to link accounts together for families that may have secondary coverage through another AlaskaCare plan?	□ Yes □ No
7.	Confirm you will provide all necessary data for the State to comply with or participate in programs (whether optional or mandated) implemented as part of any local, state or federal government health care reform legislation. Required data shall be provided at no additional cost to the State. This includes future program options or wrap plans that the State determines are advantageous to the State, if benefit plan and/or membership decide to participate.	□ Yes □ No

Section 7 – Eligibility Reporting

No.	CRITERIA	RESPONSE
1.	Confirm your system supports online real time eligibility inquiries by the State.	□ Yes □ No
2.	Confirm you can administer, at a minimum, 120-day retroactive enrollment adjustments.	□ Yes □ No

Section 8 – Network Services

No.	CRITERIA	RESPONSE
1.	Do you offer reciprocity arrangements for members who travel outside the service area and need: a. Emergency treatment? b. Non- Emergency treatment?	□ Yes □ No □ Yes □ No
2.	Do you anticipate a change in the size or location of your network in the next year that would affect the State's population?	□ Yes □ No
3.	Do you have facility contracts that renew with more than a medical CPI increase in the upcoming policy year?	□ Yes □ No
4.	With respect to your network in Alaska, do you: • Wholly own? • Partially own? • Lease?	□ Yes □ No □ Yes □ No □ Yes □ No
5.	Confirm that in-network providers are not allowed to balance bill.	□ Yes □ No
6.	Does your firm have value-based provider contracts in place for Alaska?	□ Yes □ No
7.	Do you agree to actively recruit and build your network offering in Alaska?	□ Yes □ No
8.	Confirm you will modify your network as requested by the State to address access issues and service provider areas where access is insufficient.	□ Yes □ No
9.	Do you have the ability support reference-based pricing?	□ Yes □ No
10.	Do you have the ability to implement a tiered network strategy?	□ Yes □ No
11.	Confirm that your organization can provide support with direct contracting. For example, carving-out providers from your network and supporting specific terms negotiated by the State.	□ Yes □ No
12.	Confirm you agree that any contracts directly established by the State will not impact the network discounts offered under this proposal.	□ Yes □ No
13.	Confirm at least 10% of your Alaska-based network agreements include value-based arrangements.	□ Yes □ No

Section 9 - Audit Rights

No.	CRITERIA	RESPONSE
1.	Confirm you agree to grant the right of the State or its representative(s) to audit claims at any time, during and up to, two years following termination of the business relationship with prior	□ Yes □ No

No.	CRITERIA	RESPONSE
	written notification. The State will have access to 100% of all valid claim records to complete the audit at no cost. You agree to provide all necessary claims details, data definitions, and reasonable support to complete an independent claim audit for each completed year under the contract in effect. The State will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space.	
2.	Confirm you agree audits will be based on either a 100% review of claims, or a statistically representative sample thereof, or a combination of methodologies as agreed to by the State and the vendor. Auditor's preliminary findings will be shared with the vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; vendor will produce financial impact reports for confirmed systemic errors. In the instance where auditor has reviewed 100% of claims and identified suspect claims, the vendor may elect to review a mutually-agreed upon representative sample of the suspect claims.	□ Yes □ No
3.	Confirm you agree the audit may include an onsite review of the sample claims by the auditor at the vendor's office. The auditor will provide the vendor with the sample claims thirty (30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days.	□ Yes □ No
4.	Confirm you agree the scope of audits may include up to three (3) benefit plan years as determined by the State.	□ Yes □ No
5.	Confirm you agree any and all costs and expenses of each party associated with the State's audit shall be borne by the party incurring the cost. The parties agree that the scope of audits by the State or auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of, and support for, such information. Audit materials or documentation provided by vendor will be confined to client-specific information.	□ Yes □ No
6.	If the audit discovers any validated overpayment of fees or claim payments by vendor or other errors that result in economic losses to the client for failure to meet all vendor guarantees or performance standards, confirm you agree vendor shall pay the amount owed to the client following completion of the audit, within 30 days of written confirmation from the State as to the agreed upon settlement terms and amounts.	□ Yes □ No

Section 10 - Appeals

No.	CRITERIA	RESPONSE
1.	Confirm you use medical professionals and/or outside consultants to review disputed claims for medical necessity and billing appropriateness.	□ Yes □ No
2.	Confirm you agree that the State reserves the right to review, edit, or customize appeal templates from the vendor to State's membership to ensure compliance with state law and due process requirements.	□ Yes □ No
3.	Confirm you have a dedicated appeals staff.	□ Yes □ No
4.	Confirm the State will have a single point of contact for appeals related inquiries.	□ Yes □ No
5.	Confirm that the State will have access to your medical director as questions arise on appeal decisions.	□ Yes □ No
6.	Does your EOB include: • Specific instructions on exactly how to appeal? • Specific information on the timeframes for appealing? • Ability for the State to customize language in the EOB?	□ Yes □ No □ Yes □ No □ Yes □ No

Section 11 - Financial

No.	CRITERIA	RESPONSE
1.	Will the State have the ability to retrieve online banking, accounting and financial reports?	□ Yes □ No
2.	Will you provide a temporary login/password for the State to evaluate the online financial tools available by your organization?	□ Yes □ No
3.	Will you support an All Payer Claims Database (APCD) claims data layout for details provided?	□ Yes □ No

Section 12 - Banking

No.	CRITERIA	RESPONSE
1.	Confirm you will establish a separate bank account on the State's behalf.	□ Yes □ No
2.	Confirm you will process claims and issue checks from the bank account you established on the State's behalf.	□ Yes □ No
3.	Confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers.	□ Yes □ No
4.	Do you require that self-funded plans use a specific bank for funding claims?	□ Yes □ No
5.	Do you require an imprest amount?	□ Yes □ No
6.	Is the frequency of ACH transfers for claim funding (mark all that apply): • Daily? • Every five days? • Monthly? • Other?	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No

Section 13 – Offeror's Financial Terms Submitted with Pricing

No.	CRITERIA	RESPONSE
1.	Confirm you agree renewal notification (starting with year six) will be at least 180 days in advance of the effective date and will include justification for any increase requested.	□ Yes □ No

Response Clarification and Explanation (add rows as necessary)

Section	No.	Clarification

MEDICAL SUBMITTAL FORM 8 – GeoAccess Analysis Active Employees

State of Alaska

GeoAccess: (GeoAccess analysis based on member zip codes in census file)

All reports are to be run using the census file provided. Results for this form should be run by active employees only. Do not exclude any zip codes or subscribers.

Use the following access criteria:

Provider Type	Urban/Suburban	Rural
Primary Care/Family Practice	2 providers within 10 miles	2 providers within 20 miles
Specialist	2 providers within 10 miles	2 providers within 20 miles
Hospital	1 provider within 10 miles	1 provider within 20 miles

Provide your GeoAccess analysis in your proposal showing the number of subscribers that are with and without desired access. GeoAccess analysis should include a list of locations (by city, county, zip code) and **number of subscribers <u>not</u> meeting the access criteria** along with the number of miles to the nearest in-network provider. In addition, please complete the GeoAccess summary table below for key locations and provide as an excel attachment to your response:

Census Data: Active Employees Only

Major/Town/City Zip Code	Provider Type	Total Members	Number of Members with Access	Number of Members without Access	Zip Code Considered Urban/Suburban or Rural?
	M.D., D.O.				
	All Other Primary Care				
	OB/GYN				
	Pediatrician				
	Specialty Providers				
	Free-Standing Hospitals				
	Urgent Care				

MEDICAL SUBMITTAL FORM 8 – GeoAccess Analysis Non-Medicare Retirees

State of Alaska

GeoAccess: (GeoAccess analysis based on member zip codes in census file)

All reports are to be run using the census file provided. Results should be run for non-Medicare retiree participants. Do not exclude any zip codes or subscribers.

Use the following access criteria:

Provider Type	Urban/Suburban	Rural
Primary Care/Family Practice	2 providers within 10 miles	2 providers within 20 miles
Specialist	2 providers within 10 miles	2 providers within 20 miles
Hospital	1 provider within 10 miles	1 provider within 20 miles

Provide your GeoAccess analysis in your proposal showing the number of subscribers that are with and without desired access. GeoAccess analysis should include a list of locations (by city, county, zip code) and **number of subscribers <u>not</u> meeting the access criteria** along with the number of miles to the nearest in-network provider. In addition, please complete the GeoAccess summary table below for key locations and provide as an excel attachment to your response:

Census Data: Non-Medicare Retirees Only

Major/Town/City Zip Code	Provider Type	Total Members	Number of Members with Access	Number of Members without Access	Zip Code Considered Urban/Suburban or Rural?
	M.D., D.O.				
	All Other Primary				
	OB/GYN				
	Pediatrician				
	Specialty Providers				
	Free-Standing				
	Urgent Care				

MEDICAL SUBMITTAL FORM 9 – Network Disruption Analysis Active Employees

Network Disruption Instructions:

A claim repricing file is included as an Excel attachment that includes a field for indicating if the provider/facility is currently in your proposed network. Offerors are to include a completed claims file in the same format with the submission of their response. Additionally, offerors are to complete the network disruption tables below. All responses will be verified by Segal through review of the submitted claims file. Segal reserves the right to seek clarification on the submitted pricing through the state 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.

Inpatient Facility Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# of Facilities[2]							
# of Claims							
Billed Charges $$							

Outpatient Facility Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# of Facilities[2]							
# of Claims							
Billed Charges $$							

Professional Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# of Providers[2]							
# of Claims							
Billed Charges $$							

[1] # of Records Used - is the count of Excel rows utilized in your analysis.

[2] # of Providers and/or Facilities- the provider counts should be based on unique tax IDs.
Bidder results should reflect the counts or dollars where a record is associated with an in-network provider in your network.

MEDICAL SUBMITTAL FORM 9 – Network Disruption Analysis Non-Medicare Retirees

State of Alaska Network Disruption:

A claim repricing file is included as an Excel attachment that includes a field for indicating if the provider/facility is currently in your proposed network. Offerors are to include a completed claims file in the same format with the submission of their response. Additionally, offerors are to complete the network disruption tables below. All responses will be verified by Segal through review of the submitted claims file. Segal reserves the right to seek clarification on the submitted pricing through the state 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.

Inpatient Facility Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# of Facilities[2]							
# of Claims							
Billed Charges $$							

Outpatient Facility Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# of Facilities[2]							
# of Claims							
Billed Charges $$							

Professional Baseline Data	Alaska					All Other States	Total
	995	996	997	998	999		
# of Records Used[1]							
# Providers[2]							
# of Claims							
Billed Charges $$							

[1] # of Records Used - is the count of Excel rows utilized in your analysis.
[2] # of Facilities and/or Providers - the provider counts should be based on unique tax IDs.

MEDICAL SUBMITTAL FORM 10 – Subcontractors

Please complete the below form if using subcontractors. During the Clarification Period (RFP Section 5.11), the State will require a signed written statement from each subcontractor that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to contract award, the State will also require evidence that each subcontractor possesses a valid Alaska business license. If no subcontractors will be used for a listed service or any other service, please type N/A in the appropriate cells.

	Subcontractor Name	Address	% of Work Performing
Claims Processing System			
Appeals			
Clinical Programs			
Customer Service			
Network Contracting			
Data Reporting			
Actuarial/Analytic Services			
Other Services (list these services)			

MEDICAL SUBMITTAL FORM 12 – Administrative Performance Guarantees

Please complete the following table:

Performance Guarantees	Measurement Frequency	Dollars at Risk (% or $)
1. Vendor attendance at requested meetings: • Attendance by vendor representatives when requested at meetings scheduled by the State during the contract period and implementation phase.	Quarterly	
2. Vendor call (or e-mail) return timeliness: • The State or designated consultant's calls (or e-mail) to vendor are returned within 24 business hours.	Quarterly	
3. Processing weekly eligibility updates: • All updates to eligibility or enrollment records will be made within 2 business days after the information is received by the vendor.	Monthly	
4. Telephone call availability or answering speed: • 90% of all calls are answered within 30 seconds. Telephone service is available between 8:00 AM (Alaska) and 6:00 PM (Alaska time) on business days.	Monthly	
5. Customer satisfaction: • Starting in the second year 90% customer satisfaction as determined by State annual survey (if conducted). Absent a State survey, determined by post-call vendor survey.	Monthly	
6. Telephone call on-hold (in queue) time: • An average of less than 2 minutes on hold before a human being answers.	Monthly	
7. Telephone abandonment rate: • An abandonment rate of less than 2.5% is maintained during standard business hours.	Monthly	
8. Claims financial accuracy: • 99% of claims dollars submitted for payment will be accurately processed and paid. Vendor must reimburse the State for all overpayments that are not recovered within 60 days after the overpayment is discovered. The State will assign its right to the vendor to collect any such overpayments.	Quarterly	
9. Turnaround time on claim payment: • 95% of all claims received will be completely processed (paid, denied, or pended for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 days of receipt.	Quarterly	
10. Claims processing accuracy: • 95% of all claims will be coded with no errors.	Annually	
11. Appeal reviews: • State to review TPA appeal files forwarded to Division in response to a level 3 filing. Will review to ensure they meet minimum Alaska due process requirements. Findings to be reviewed with TPA. Penalty if less than 95% meet standard.	Annually	

Performance Guarantees	Measurement Frequency	Dollars at Risk (% or $)
12. Implementation: • Successful implementation is defined by key milestones. Include measurable milestones in your proposal.	Annually	
13. Implementation customer satisfaction: • Based on customer satisfaction survey, achieve all satisfaction of 80% or greater by the end of the second quarter.	Annually	
		% of Admin Exp.
Total Dollars at Risk		Total $

MEDICAL SUBMITTAL FORM 12 – Clinical Performance Guarantees

Please include your proposed clinical performance guarantees.