State of Alaska RFP 2013-0200-1396

4 Healthcare Management

4.1 Company Profile

4.1.1 General

4.1.1.1 Describe your company's ownership structure. Explain why your organization is best suited to provide Healthcare Management services.

Unlimited.

4.1.1.2 Describe how your company meets and exceeds the minimum requirements listed in Section 2.7 of the RFP.

Unlimited.

4.1.1.3 Provide client references for whom you provide (or have provided) the same services you are proposing to the State that meet the following qualifications. The same reference may be used to meet one or more qualifications but five distinct references must be provided.

- A client with more than 6,000 employee participants for at least 5 years;
- A client with at least 20,000 retiree participants for at least 5 years;
- A client you have had for two years or less;
- A client whose contract has ended with you in the last two years; and
- A governmental client for at least 3 years.

Report by Column.

	Client 1	Client 2	Client 3	Client 4	Client 5
Name of client	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Type of business	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Beginning year of providing service to client	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Number of participants (total Lives)	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Name, address and telephone number of the designated client representative	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Types of coverage or plans provided; and	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Reason for Termination (if applicable)	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*

4.1.1.4 Describe a situation in which you brought a client's healthcare plan trend down. This client should be similar to the State of Alaska in size, as well as in industry.

Unlimited.

4.1.2 Account Management Team

4.1.2.1 Please submit a written narrative providing a thorough description of the proposed account management structure. Your narrative must include the following:

I. An organizational chart depicting the account management structure.
II. The individuals who will comprise the account management team.
III. For each individual on the proposed account management team:
    a. name
    b. title
    c. physical work location where normally based
    d. years of industry experience
    e. years with organization
    f. level of educational attainment
    g. resume
    h. years in current position
    i. level and scope of decision making authority.
IV. How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.
V. Maximum number of accounts assigned to each member of the account management team.
VI. List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to Healthcare Management component.

Unlimited.

4.1.3 Organizational Capacity

4.1.3.1 Confirm you, as the Offeror, have reviewed and understand the information presented in the Introduction section of the RFP.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

4.1.3.2 Identify and describe how all aspects of the work for each function identified below will be organized and staffed.

1. Company Profile
    a. HIPAA Compliance
    b. Communications
    c. Information Technology
    d. Integration with Other Vendors
2. Patient Value Chain
    a. Customer Service
    b. Establishing Population Needs
        i. Identification
        ii. Health Risk Assessment

        iii. Biometrics
    c. Outreach
    d. Incentives
    e. Participation
    f. Effectiveness
    g. Healthcare Management Services
        i. Wellness Services
        ii. Nurse Call Line
        iii. Disease Management Programs
        iv. Maternity Management
        v. Employee Assistance Program (EAP)
    h. Quality Control
        i. Performance Guarantees
    i. Data Analysis
        i. Data Collection
        ii. Reporting
    j. Financial
3. State Objectives
    a. Plan Design
    b. Policy Development
    c. Innovation
    d. Performance Incentives

In responding to this question you must include the following information:

a. A work flow chart depicting how the work associated with each function will be performed and a narrative describing the processes depicted in each flow chart. In your narrative please specifically address, for each function:
    i. The role of customer service and communications.
    ii. Special expertise, if any, that you can provide the State with respect to each function.
    iii. Your experience and background in performing each specific function.
    iv. How your system technologies uniquely position you to perform each specific function.
    v. What innovation you can provide to the State with respect to each specific function.
    vi. How you will coordinate with other Contractors who may be awarded Contracts under this RFP.
    vii. If applicable, specify how the process will be different for members outside of Alaska.
b. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
c. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venture and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
d. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
e. Describe your organization’s process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.

f. Please include an organizational chart depicting all personnel or positions that will be assigned to accomplish each function.
g. Please identify the geographic location where the work associated with each identified function will be performed, including which functions will be performed exclusively in Alaska.
h. For any function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each function.
i. Please identify the proposed point-of-contact for each function.
j. Please identify customer service hours of operation for each function. Specify hours of operation by Alaska Standard Time and the applicable time zone where the function will be performed if not in Alaska.
k. Please identify for which functions you will provide onsite support. For example, open enrollment meetings and health fairs.
l. If the Project Team includes the role of a Medical Director, or similar position, please provide the following information:
    a. The role of the Medical Director in each function.
    b. A description of how the Medical Director will support the medical management process and assigned staff.
    c. Whether the Medical Director will be located in Alaska.
    d. Whether the Medical Director is/will be licensed as a physician in the State of Alaska.
    e. If the Medical Director is/will not be licensed as a physician in the State of Alaska, is the Medical Director licensed as a physician elsewhere? If so, where?
    f. Whether the Medical Director will be subject to the review and approval of the Project Director.

Unlimited.

4.1.3.3 Provide a copy of your standard Administrative Services Organization contract.

Single, Pull-down list.
1: Attached,
2: Not Attached

4.1.4 Implementation Plan

4.1.4.1 Identify and describe, by function, how you will execute a successful implementation for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Healthcare Management component. For each function, please provide:

I. A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.
II. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
III. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.

IV. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
V. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
VI. An organizational chart depicting the implementation management team structure.
VII. Whether you will provide an Alaska-based implementation project manager during the term of the implementation.
VIII. The individuals who will comprise the implementation management team.
IX. For each individual on the proposed implementation management team:
    a. name
    b. title
    c. physical work location where normally based
    d. years of industry experience
    e. years with organization
    f. level of educational attainment
    g. resume
    h. years in current position
    i. level and scope of decision making authority
    j. whether the individual management team member will be exclusively assigned to the implementation until completion. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the implementation.
X. The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.
XI. For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.
XII. The proposed point-of-contact for each implementation function.
XIII. Timeline for implementation
XIV. How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the State.

Unlimited.

4.1.4.2 Will you provide welcome kits as part of the implementation? If so, please identify and describe all information that will be contained in the welcome kits. If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.1.4.3 Please confirm that your cost proposal includes the cost of all implementation expenses. If not, please identify all additional costs on the rate sheet.

Unlimited.

4.1.4.4 Please confirm that you will provide run-out administration, including communications and data support for transition to a new Contractor for a period of 12 months following contract termination. If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.1.4.5 Within your implementation team, is employee compensation tied directly to performance?

Unlimited.

4.1.4.6 Please outline your procedures for loading patient payment histories from the prior carrier. If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.1.5 HIPAA Compliance

4.1.5.1 Confirm your organization is 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.

Unlimited.

4.1.5.2 Describe how you maintain confidentiality of patient and plan data.

Unlimited.

4.1.5.3 Confirm you are currently receiving eligibility files in the HIPAA 834 format

Unlimited.

4.1.5.4 Are your eligibility and claim systems compliant with recently updated HIPAA regulations?

Unlimited.

4.1.5.5 Please list the dates in which your eligibility and claims systems were reviewed or validated against the updated HIPAA regulations.

Unlimited.

4.1.5.6 Was an outside auditor/reviewer employed for HIPAA review/validations of these two systems?

Unlimited.

4.1.5.7 How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Unlimited.

4.1.5.8 Confirm your ability to administer HIPAA creditable coverage notices.

Unlimited.

4.1.6 Communications

4.1.6.1 Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

4.1.6.2 Can you provide communication materials in an electronic and editable format for use by the State in their communications? If there is an additional cost, please indicate the cost in the rate sheet.

Unlimited.

4.1.6.3 Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. If you cannot confirm, please explain.

Unlimited.

4.1.6.4 Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as plan participant communication materials, plan documents, etc.

Unlimited.

4.1.6.5 Is the creation, customization, production, and distribution of the materials itemized below included in your cost proposal?

I. If there is an additional cost for any of the items listed below, please indicate each additional cost on the rate sheet.
II. Will each of the items listed below be made available online?
III. Please identify any additional communication and/or educational materials not listed below that are included in your cost proposal, and provide an example of each where possible.
IV. Please identify any additional communication and/or education materials not listed below that you can provide for an additional fee. Please indicate each additional cost on the rate sheet.

	Can Provide?	Included in Fees?	Can Customize?	Included in Fees? If no, include fee on rate sheet
Educational Flyers	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Brochures	*Single, Pull-down list.* 1: Yes,	*Single, Pull-down list.* 1: Yes,	*Single, Pull-down list.* 1: Yes,	*Single, Pull-down list.* 1: Yes, 2: No

	2: No	2: No	2: No	
Activities related documents (monthly health logs, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
On-line wellness portal	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Printed Newsletters	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
General Letters and Correspondence Sent to Employees	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Healthcare reminders (preventive screenings)	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	
Other: *describe*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No

4.1.6.6 What is the average number of work days from placing an order to time of delivery for the following communication materials?

	Average Days to delivery
Letters & General Correspondence	*Decimal.*
Brochures	*Decimal.*
Flyers	*Decimal.*
Newsletters	*Decimal.*
Activities-related documents	*Decimal.*

4.1.7 Information Technology

4.1.7.1 Describe how your company will use its systems technologies to perform each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Healthcare Management component.

Unlimited.

4.1.7.2 Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational?

Unlimited.

4.1.7.3 Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

Unlimited.

4.1.7.4 Are all data feeds for set-up and on-going maintenance included in your pricing? If not, please include the fees on the rate sheet.

Unlimited.

4.1.7.5 Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Unlimited.

4.1.7.6 Describe your system access security process with members, providers and the State.

Unlimited.

4.1.7.7 Describe the advantages of your Internet home page, including access and capability to communicate with the State and members on information regarding:

a. Eligibility (name, address, covered dependents, etc.)
b. Wellness Portal
c. Health Risk Assessment
d. Health improvement and education information
e. Webinars

Unlimited.

4.1.7.8 Describe what types of information are available through your wellness portal.

Unlimited.

4.1.7.9 Is the wellness portal managed by a subcontractor or joint venturer?

Unlimited.

4.1.7.10 Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail.

Unlimited.

4.1.7.11 Describe your company's use of current system technologies to notify customers of issues that relate to them.

Unlimited.

4.1.7.12 Indicate services you offer to members and providers via e-mail and electronically.

Unlimited.

4.1.7.13 Describe electronic service methods you use to educate members in accounts you currently manage of similar size to the State of Alaska about health care issues.

Unlimited.

4.1.7.14 Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

Unlimited.

4.1.7.15 Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Unlimited.

4.1.7.16 Does the online system allow the State to assign different levels of access internally?

Unlimited.

4.1.8 Integration with Other Vendors

4.1.8.1 Describe your procedures for implementation of ongoing treatment plans.

Unlimited.

4.1.8.2 Are you able to accept electronic feeds of data or referrals from other vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Pull-down list.
1: Yes, included in base pricing,
2: Yes, for an additional fee (indicated on rate sheet),
3: Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet),
4: No

4.1.8.3 Are you able to provide electronic feeds of participation data to an outside data aggregator or vendor partners? If there is an additional cost for providing or sharing the data, please indicate the cost on the rate sheet.

Unlimited.

4.1.8.4 How often can you export data files to vendor partners? If there is an additional cost, please indicate the cost on the rate sheet

Unlimited.

4.1.8.5 Are you willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization data? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Radio group.
1: Yes, no additional cost,
2: Yes, additional cost (indicated on the rate sheet),
3: No

4.1.8.6 Does your program/system have the capability to share data with the following vendors or programs?

Multi, Checkboxes.
1: Biometrics,
2: Case Management,
3: Demand Management/Nurse Line,
4: Disease Management,
5: EAP/Behavioral health,
6: Health Advocacy/Health Coach,
7: Health Plans/TPA,
8: Health Risk Appraisal,
9: Healthcare savings/FSA,
10: Healthcare savings/FSA,
11: Maternity Management,
12: Mental Health / Substance Abuse,
13: Nurse and/or doctor line,
14: On site clinics,
15: PBM,
16: Providers,
17: Utilization Management,
18: Wellness/Lifestyle management,
19: Other, please specify: [500 words]

4.1.8.7 Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

Unlimited.

4.1.8.8 Does your system flag a member if they are enrolled in another vendor partner program so that members are not outreached to when already participating?

Unlimited.

4.1.8.9 Does your system make automated referrals to other care management programs (wellness, CM, maternity, health advocacy, EAP, quality, etc.)?

Unlimited.

4.1.8.10 Describe your plans for integrating the services described in one program, such as the wellness program, with other programs such as disease management, utilization management, case management, claims processing and customer service. Please identify any difficulties you foresee in integrating these activities and your proposed solutions.

Unlimited.

4.1.8.11 Explain how you can coordinate with an external weight management program, such as Weight Watchers At Work.

500 words.

4.1.8.12 Describe your procedures for transition of ongoing management cases to a new vendor. Unlimited.

Unlimited.

4.2 Patient Value Chain

4.2.1 Customer Service

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.1.1 Will you provide the State with unit(s) dedicated to customer service? Please describe each healthcare management function supported by these customer service unit(s).

Unlimited.

4.2.1.2 Where will the dedicated office(s) be located and will those offices provide customer service for all healthcare management functions under this RFP?

Unlimited.

4.2.1.3 Please identify whether you will maintain, at a minimum, offices in Juneau and Anchorage to provide dedicated customer service to AlaskaCare members and providers served under the healthcare management function.

Unlimited.

4.2.1.4 List how many customer service representatives will be dedicated to each program.

Unlimited.

4.2.1.5 Describe your training program for customer service employees.

Unlimited.

4.2.1.6 Explain any incentive programs you employ to retain competent customer service employees.

Unlimited.

4.2.1.7 What is the average years of experience for your customer service staff?

Unlimited.

4.2.1.8 What is the average length of employment for your customer service staff?

Unlimited.

4.2.1.9 How many dedicated toll-free phone lines will be made available to answer member and provider inquiries?

Unlimited.

4.2.1.10 How many dedicated toll free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

Unlimited.

4.2.1.11 During what hours/days of week will toll free phone lines be staffed?

Unlimited.

4.2.1.12 Provide an explanation of how you define “after-hours.” Explain your process for delivery of services on nights, weekends, and holidays.

Unlimited.

4.2.1.13 Describe how emergency after-hours calls will be handled.

Unlimited.

4.2.1.14 Is there a voice mail system or capability for callers to leave messages after normal business hours? During hours?

Unlimited.

4.2.1.15 Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service?

Unlimited.

4.2.1.16 Please describe how you would handle a call from a member who does not speak English.

Unlimited.

4.2.1.17 Are all calls logged into your tracking system?

Unlimited.

4.2.1.18 If no, what percentage of calls are logged into your tracking system?

Unlimited.

4.2.1.19 Please check all items below which pertain to calls handled by the customer service representatives:

Multi, Checkboxes.
1: All calls are recorded,
2: Customer service representatives document all calls,
3: Customer service representatives can make adjustments to claims during a call,
4: Calls are documented verbatim,
5: Calls are documented in summarization

4.2.1.20 If your customer service unit uses a dedicated on-line call tracking and documentation system, identify whether the following characteristics are tracked:

Multi, Checkboxes.
1: Date of initial call,
2: Date inquiry closed,
3: Representative who handled the call,
4: Call status,
5: If and where issue was referred for handling,
6: Reason for call,
7: What was communicated to member

4.2.1.21 What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Unlimited.

4.2.1.22 Do customer service representatives handle both member calls and provider calls?

Unlimited.

4.2.1.23 Identify the typical work and training experience required of your customer service supervisors and/or managers.

Unlimited.

4.2.1.24 What is the current ratio of customer service representatives to supervisors and managers.

Unlimited.

4.2.1.25 What is the ratio of customer service representatives to covered lives in your organization's programs?

Unlimited.

4.2.1.26 Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

Unlimited.

4.2.1.27 Provide the turnover rate of your call center representatives for the past three calendar years.

Unlimited.

4.2.1.28 Using current calendar year data, please provide the following information for each customer service office that will have responsibility for this account:

	Standard Target	Average Statistics
Answer speed (xx seconds)	*Unlimited.*	*Unlimited.*
Wait time (xx seconds)	*Unlimited.*	*Unlimited.*
Abandonment rate (xx.xx%)	*Unlimited.*	*Unlimited.*

4.2.1.29 Provide your standard wait times for triage and assessment, crisis counseling, urgent care, and routine care:

	Standard Wait Time
Triage and Assessment	*500 words.*
Crisis Counseling	*500 words.*
Urgent Care	*500 words.*
Routine Care	*500 words.*

4.2.2 Establishing Population Needs

4.2.2.1 Identification

4.2.2.1.1 Please describe how your organization will identify population specific health issues and design or modify existing healthcare management programs to meet the specific needs of the State. Include the type of data you will be relying on to make determinations of population health, and what type of data you expect to collect from the population once the program is underway.

Unlimited.

4.2.2.1.2 Describe how you will identify participants from the population for healthcare management services and indicate if you use any of the resources listed below:

Multi, Checkboxes.
1: Behavioral health referrals,
2: Biometric data,
3: Case management referrals,
4: EAP referrals,
5: External vendor partner referrals,
6: Health advocacy referrals,
7: Health Risk Assessments,
8: Lab data,
9: Medical claims,
10: Nurse line referrals,
11: On site clinic referrals,
12: Physician/Provider referrals,
13: Rx claims,
14: Self referrals,

15: Utilization management referrals,
16: Other, please specify: [500 words]

4.2.2.1.3 Does your organization utilize predictive modeling technology to identify participants?

Unlimited.

4.2.2.1.4 Does your organization stratify the total population by risk level?

Unlimited.

4.2.2.1.5 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive).

	Percent of Members	Comments
Identified	*Percent.*	*Unlimited.*
Outreached To	*Percent.*	*Unlimited.*
Reached	*Percent.*	*Unlimited.*
Opted Out	*Percent.*	*Unlimited.*
Enrolled	*Percent.*	*Unlimited.*
Dropped Out	*Percent.*	*Unlimited.*
Completed program – goals met	*Percent.*	*Unlimited.*

4.2.2.1.6 Does your organization stratify only the Health Risk Assessment (HRA) participants by risk level?

Unlimited.

4.2.2.1.7 Do you stratify participants in a client group with your book of business or is it client specific?

Unlimited.

4.2.2.1.8 Are intervention services linked to HRA results?

Unlimited.

4.2.2.1.9 Are intervention services linked to biometrics results?

Unlimited.

4.2.2.1.10 Describe how healthcare management program managers have access to the claims payment information either internally or by data feed from the claims payer to view member activity and costs?

Unlimited.

4.2.2.2 Health Risk Assessment

4.2.2.2.1 Confirm you offer a Health Risk Assessment (HRA).

Single, Radio group.
1: Confirmed,
2: Not Confirmed

4.2.2.2.2 Can your HRA be purchased independent of other programs?

Single, Radio group.
1: Yes,
2: No

4.2.2.2.3 How long have you offered this HRA?

Single, Pull-down list.
1: 2 years or less,
2: 2 to 5 years,
3: 5 to 7 years,
4: 7 to 10 years,
5: 10 years or more

4.2.2.2.4 Is your HRA proprietary or was it created externally (i.e. University of Michigan)?

Unlimited.

4.2.2.2.5 Confirm you have attached a copy of your HRA.

Single, Radio group.
1: Confirmed,
2: Not confirmed

4.2.2.2.6 Is your HRA administered internally or do you use an outside vendor?

Single, Radio group.
1: Internally,
2: External vendor, (specify),
3: Combination of internally and outside vendor

4.2.2.2.7 To how many clients do you provide HRA services?

Decimal.

4.2.2.2.8 How is information about the HRA delivered to participants?

Multi, Checkboxes.
1: Brochures,
2: Email,
3: Face to face,
4: Mail,
5: Payroll stuffers,

6: Posters,
7: Website,
8: Other, please specify: [500 words]

4.2.2.2.9 Are standard communications materials regarding the HRA included in your base fee? Provide samples.

Single, Radio group.
1: Yes,
2: No

4.2.2.2.10 What types of risk factors are included in your HRA? (Check all that apply)

Multi, Checkboxes.
1: Age,
2: Blood glucose,
3: Blood pressure,
4: Cholesterol, including LDL and HDL,
5: Chronic illnesses,
6: Family disease history,
7: Gender,
8: Health perception,
9: Life and job satisfaction,
10: Nutrition,
11: Patient disease history,
12: Physical activity,
13: Safety,
14: Sleep,
15: Stress,
16: Substance abuse,
17: Tobacco use,
18: Triglycerides,
19: Waist circumference measurement,
20: Other, please specify: [500 words]

4.2.2.2.11 Is there an extra fee for customization? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Radio group.
1: Yes (indicated on rate sheet),
2: No

4.2.2.2.12 What categories of information does the HRA evaluate? (Check all that apply)

Multi, Checkboxes.
1: Biometric measurements, e.g. BMI, blood pressure,
2: Health risk and behaviors,
3: Job satisfaction,
4: Personal medical conditions,
5: Preventive services,
6: Quality of life,
7: Safety

4.2.2.2.13 Does the HRA evaluate member readiness to change?

Single, Radio group.
1: Yes,
2: No

4.2.2.2.14 How long does it typically take to complete your HRA?

Single, Pull-down list.
1: 10 minutes or less,
2: 10 to 15 minutes,
3: 15 to 30 minutes,
4: 30 to 45 minutes,
5: 45 minutes or more

4.2.2.2.15 What is the range of the number of questions in your HRA?

Single, Pull-down list.
1: 0 - 25 questions,
2: 26 - 50 questions,
3: 50+ questions,
4: 100+ questions

4.2.2.2.16 Is your HRA available in paper and/or electronically?

Single, Radio group.
1: Paper,
2: Electronic,
3: Both

4.2.2.2.17 Do you have the capability to upload biophysical metrics automatically into your HRA?

Single, Radio group.
1: Yes,
2: No

4.2.2.2.18 How often is your HRA revised?

Single, Radio group.
1: Every 2 plus years,
2: Every 2 years,
3: Annually,
4: Semi-annually,
5: Quarterly,
6: As needed,
7: Other, please specify: [500 words]

4.2.2.2.19 In the most recent calendar year, what percent of your total eligible membership completed the HRA?

Percent.

4.2.2.2.20 On average, what percentage of your covered population participates in a HRA?

Single, Pull-down list.
1: 5 percent or less,
2: 5 to 10 percent,
3: 10 to 20 percent,
4: 20 to 30 percent,
5: 30 to 40 percent,
6: 40 to 50 percent,
7: 50 to 75 percent,

8: 75 to 95 percent,
9: Greater than 95 percent

4.2.2.2.21 Which of the following services do you integrate your HRA program with? (Check all that apply)

Multi, Checkboxes.
1: Case Management,
2: Disease Management,
3: EAP/Behavioral Health,
4: Fitness,
5: Health advocates,
6: Health coaches,
7: Health plan/administrator,
8: Incentives,
9: Nurse Line,
10: Onsite clinics,
11: Wellness/ Lifestyle Management,
12: Biometric Screening,
13: Other, please specify: [500 words],
14: No integration

4.2.2.2.22 Does the HRA evaluate the predictability of the following: (Check all that apply)

Multi, Checkboxes.
1: Disease morbidity - potential for progression of disease,
2: Cost - individuals most likely to incur the highest costs,
3: Other, please specify: [500 words],
4: Absenteeism,
5: Presenteeism,
6: No integration

4.2.2.2.23 Please indicate the type of feedback employees receive upon completion of the HRA. (Check all that apply)

Multi, Checkboxes.
1: Individual written paper report to all respondents,
2: Individual written paper report to high-risk respondents only,
3: Individual electronic report to all respondents,
4: Individual electronic report to high-risk respondents only,
5: Customized plan of action for all respondents,
6: Customized plan of action for high-risk respondents only

4.2.2.2.24 Please indicate the type of feedback that is received by the State. (Check all that apply)

Multi, Checkboxes.
1: Number of respondents,
2: Number of respondents by risk level,
3: Aggregate report indicating areas of risk within the population,
4: Website access/usage,
5: Website maintenance and availability

4.2.2.2.25 Does the State receive aggregated and de-identified reporting on overall HRA results? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Pull-down list.
1: Yes, included in fees,
2: Yes, at an additional fee (indicated on rate sheet),

4.2.2.2.26 Are you able to electronically transfer HRA results in the event of a vendor change?

Single, Pull-down list.
1: Yes, included in pricing,
2: Yes, at an extra charge,
3: No

4.2.2.2.27 Describe other dedicated or customized customer services you are prepared to offer the State.

Unlimited.

4.2.2.3 Biometrics

4.2.2.3.1 Confirm you offer a medical (biometric) screening program.

Single, Radio group.
1: Yes,
2: No

4.2.2.3.2 Can your medical (biometric) screenings be purchased independent of other programs?

Single, Radio group.
1: Yes,
2: No

4.2.2.3.3 How long have you provided this service?

Single, Pull-down list.
1: 2 years or less,
2: 2 to 5 years,
3: 5 to 7 years,
4: 7 to 10 years,
5: 10 years or more

4.2.2.3.4 Are your medical (biometric) screening programs administered internally or do you use an outside vendor?

Single, Radio group.
1: Internally,
2: External vendor, (specify),
3: Combination of internally and outside vendor

4.2.2.3.5 How many total covered lives do your medical (biometric) screening programs support?

Decimal.

4.2.2.3.6 To how many clients do you provide medical (biometric) screening services?

Decimal.

4.2.2.3.7 In which capacities do you offer medical (biometric) screening programs? (Check all that apply)

Multi, Checkboxes.
1: Mail,
2: On-site client locations,
3: Off-site

4.2.2.3.8 How is information about the medical (biometric) screenings delivered to participants?

Multi, Checkboxes.
1: Brochures,
2: Email,
3: Face to face,
4: Mail,
5: Payroll stuffers,
6: Posters,
7: Website,
8: Other, please specify: [500 words]

4.2.2.3.9 How do you collect biometric data?

Multi, Checkboxes.
1: Mail / home-kits,
2: Onsite,
3: Off-site / lab vendor partner,
4: Venipuncture,
5: Finger-stick,
6: Mouth swab,
7: Urine,
8: Other, please specify: [500 words]

4.2.2.3.10 How can a member's healthcare provider obtain results?

Unlimited.

4.2.2.3.11 How do you receive biometric results?

Multi, Checkboxes.
1: Data entry of physician reported info via fax,
2: Self reported,
3: File upload from lab data or from screening event,
4: Other, please specify: [500 words]

4.2.2.3.12 Do you provide standard communications materials regarding the medical screening as part of the fees? Please describe what is provided.

Single, Radio group.
1: Yes,
2: No

4.2.2.3.13 What measurements are available in your medical (biometric) screenings programs?

Multi, Checkboxes.
1: Blood glucose,
2: Blood pressure,
3: Body fat percentage,
4: Breast Cancer-Mammogram,
5: Cervical Cancer-PAP Test,

6: Cholesterol-Total, LDL, HDL,
7: Height/Weight/Body Mass Index,
8: Lung Cancer,
9: Other, please specify: [500 words],
10: Prostate Cancer-PSA Test,
11: Tuberculosis testing,
12: Tobacco Use-Saliva, Blood, Breath Analyzer,
13: Triglycerides,
14: Waist circumference,
15: Other Conditions, please specify: [500 words]

4.2.2.3.14 Is there an extra fee for customization? If there is an additional cost, please indicate it on the rate sheet.

Single, Radio group.
1: Yes,
2: No

4.2.2.3.15 On average, what percentage of your covered population participates in medical (biometric) screenings?

Single, Pull-down list.
1: 5 percent or less,
2: 5 to 10 percent,
3: 10 to 20 percent,
4: 20 to 30 percent,
5: 30 to 40 percent,
6: 40 to 50 percent,
7: 50 to 75 percent,
8: 75 to 95 percent,
9: Greater than 95 percent

4.2.2.3.16 Does the biometric screening program evaluate the predictability of the following: (Check all that apply)

Multi, Checkboxes.
1: Disease morbidity - potential for progression of disease,
2: Cost - individuals most likely to incur the highest costs,
3: Other, please specify: [500 words],
4: Absenteeism,
5: Presenteeism,
6: No integration

4.2.2.3.17 Are you able to electronically transfer biometrics results in the event of a vendor change?

Single, Pull-down list.
1: Yes, included in pricing,
2: Yes, at an extra charge,
3: No

4.2.3 Outreach

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.3.1 Please describe how you communicate and provide outreach to plan members. Specifically include the type of communications used to target specific portions of the population and the frequency of those communications.

Unlimited.

4.2.3.2 Do you incorporate social networking into your program? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Radio group.
1: Yes, included in base pricing,
2: Yes, for an additional fee (indicated on rate sheet),
3: No

4.2.3.3 Are reminders sent on a routine schedule to members and/or participants to motivate appropriate health actions (e.g., obtain certain tests, schedule follow-up exams, etc)?

Single, Radio group.
1: Yes, to all members,
2: Yes, to participants only,
3: No reminders sent

4.2.3.4 Do you participate in on-site health events, such as health fairs, as part of your healthcare management programs? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Radio group.
1: Yes, included in base pricing,
2: Yes, for an additional fee (indicated on rate sheet),
3: No

4.2.3.5 Which of the following do you consider your program to be?

Single, Pull-down list.
1: Opt-in -patients must sign up to participate,
2: Opt-out - patients are assumed to be participating unless they actively declare that they are opting out,
3: A combination of opt-in and opt-out

4.2.3.6 If a participant opts out of the program, how long will it be until they are contacted again?

Single, Pull-down list.
1: 1 month,
2: 3 months,
3: 6 months,
4: 1 year,
5: Never

4.2.4 Incentives

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.4.1 Describe any incentive awards you provide or administer to increase enrollment. Identify any additional costs associated with this on the rate sheet.

Unlimited.

4.2.4.2 Can you administer client-specific (custom) incentives? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.4.3 Are you able to provide incentive administration for members with more than one condition? For example: Member in weight management and stress management can receive 2 incentives for coaching received on both conditions.

Unlimited.

4.2.4.4 Please describe the incentive program you would propose for the State? (8 sentences or less).

500 words.

4.2.5 Participation

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.5.1 How do you define participation for your current clients?

Single, Radio group.
1: Identified members are considered participants unless they have actively communicated that they do not want further contact,
2: Participation is defined as anyone identified as being eligible,
3: Participation is defined as anyone receiving educational information and/or working with a manager,
4: Participation is defined as anyone who has a condition covered by the program,
5: Participation is defined as working with a manager on a routine basis,
6: Other: [500 words]

4.2.5.2 In the most recent calendar year, what percentage of those members that were referred to or identified for services were actively engaged to participate based on your definition above?

Single, Pull-down list.
1: 5 percent or less,
2: 5 to 10 percent,
3: 10 to 15 percent,
4: 15 to 20 percent,
5: 20 to 30 percent,
6: 30 to 50 percent,
7: 50 to 70 percent,
8: 70 to 90 percent,
9: 90 to 100 percent

4.2.5.3 What is the average frequency or length of participation?

Unlimited.

4.2.5.4 What is the typical drop-out disenrollment rate for enrollees?

Percent of active disenrollment: Please specify	*500 words.*
Percent of passive disenrollment: Please specify	*500 words.*
We do not track this: Please specify	*500 words.*

4.2.5.5 How often do you report participation rates to the client?

Unlimited.

4.2.5.6 If you provide tobacco cessation services, please provide your tobacco cessation program's quit rate:

6 month:	*500 words.*
12 month:	*500 words.*

4.2.5.7 Does your tobacco cessation program include nicotine replacement therapy?

Unlimited.

4.2.5.8 Please describe any methods or efforts specific to the State’s population that your organization would recommend to increase participation.

Unlimited.

4.2.6 Effectiveness

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.6.1 Describe how you will evaluate the effectiveness and efficiency of each program in the following areas:

Clinical outcomes
Costs avoided
Behavior Change
Improved health knowledge
Reduced risk
Appropriate utilization
Member satisfaction
Return on investment
Other, please specify

Unlimited.

4.2.6.2 Please list the average annual ROI for clients of similar size for the following years:

2009	*Unlimited.*
2010	*Unlimited.*
2011	*Unlimited.*

4.2.6.3 Are you able to measure ROI for each health care management program?

Unlimited.

4.2.6.4 If yes to the previous question, on average, what range (%) of ROI is each program producing and what is the process to develop the ROI?

Unlimited.

4.2.6.5 Are any of your ROI guaranteed savings dependent on an incentive, client-offered or otherwise? Please provide details.

Unlimited.

4.2.6.6 How often do you solicit program participants' feedback and satisfaction?

Single, Radio group.
1: Annually,
2: Semiannually,
3: Quarterly,
4: Monthly,
5: Continuously,
6: Randomly,
7: Other. Please specify: [500 words],
8: Do not survey satisfaction

4.2.6.7 Please describe the results of your most recent member satisfaction surveys.

Unlimited.

4.2.6.8 How often do you conduct client satisfaction surveys?

Single, Pull-down list.
1: Ongoing,
2: Monthly,
3: Quarterly,
4: Semi-Annually,
5: Annually,
6: We do not conduct Client satisfaction surveys

4.2.6.9 Please describe the results of your most recent client satisfaction surveys.

Unlimited.

4.2.6.10 Explain how your organization will determine whether the program produces cost savings for the State. Describe the types of annual program evaluations you will prepare.

Unlimited.

4.2.7 Healthcare Management Services

4.2.7.1 Wellness Services

For **EACH** of the wellness programs you are proposing for the State, please provide the following information:

4.2.7.1.1 Please identify and describe in detail each service you provide through your wellness program.

Unlimited.

4.2.7.1.2 Please indicate whether your wellness program is available only in its entirety or whether the State can select which aspects of the wellness program it wishes to implement (customization). If customization is allowed, please identify how customization is priced.

Unlimited.

4.2.7.1.3 How is information about each program delivered to participants?

Unlimited.

4.2.7.1.4 Are standard communication materials regarding each program included in your base fee? Provide samples.

Unlimited.

4.2.7.1.5 Describe where offices(s) for each program will be located and the specific services managed at each location.

Unlimited.

4.2.7.1.6 Describe how wellness employees utilize member claims payment and utilization management information either internally or by data feed from the claims payer to initiate and provide services under each program.

Unlimited.

4.2.7.1.7 How many years has your organization provided each wellness program?

Unlimited.

4.2.7.1.8 How many clients do you currently serve within each wellness program?

Unlimited.

4.2.7.1.9 What is the size of the target client for each wellness program?

Unlimited.

4.2.7.1.10 How many total covered lives does each wellness program support?

Unlimited.

4.2.7.1.11 List how many staff members will be dedicated to each wellness program.

Unlimited.

4.2.7.1.12 Describe which wellness programs (if any) are available for children under 18 years of age?

Unlimited.

4.2.7.1.13 What is the average caseload for each wellness manager within each program?

Unlimited.

4.2.7.1.14 Will services under each program be available to members for at least 8 hours each day during Alaska Standard Time? Indicate the hours of operation for each service.

Unlimited.

4.2.7.1.15 Which days of the week will each services under each program be available?

Unlimited.

4.2.7.1.16 Is there a ceiling on the number of telephonic coaching cases per program you will manage for the State? If yes, what is that limit (per program)?

Unlimited.

4.2.7.1.17 Indicate any accreditations you currently hold SPECIFIC to your wellness programs.

Unlimited.

4.2.7.1.18 Describe the minimum required credentials for employees providing services in each program.

Unlimited.

4.2.7.1.19 Describe your training program for employees in each program.

Unlimited.

4.2.7.1.20 Please indicate, for each program, what percent of staff members have a clinical degree by type (i.e., Registered Nurse, Physical Therapist, Dietician, Exercise Physiologist, Nutritionist, Personal Trainer).

Unlimited.

4.2.7.1.21 Is your organization willing to modify aspects of the wellness program per direction from the Project Director?

Unlimited.

4.2.7.1.22 Do you include gym memberships as part of your wellness offering?

Unlimited.

4.2.7.1.23 Can you provide onsite fitness programs?

Unlimited.

4.2.7.2 Nurse Call Line

4.2.7.2.1 Please identify and describe each service you provide through your nurse call line program.

Unlimited.

4.2.7.2.2 Do you provide nurse call line services as a stand-alone program?

Unlimited.

4.2.7.2.3 Describe where all functions associated with this unit are located.

Unlimited.

4.2.7.2.4 Do you provide all nurse line services internally or are any services subcontracted?

Unlimited.

4.2.7.2.5 How many years has your organization provided nurse call line services?

Unlimited.

4.2.7.2.6 How many total covered lives does your nurse call line program support?

Unlimited.

4.2.7.2.7 How many clients do you currently service in your nurse call line program?

Unlimited.

4.2.7.2.8 Indicate any accreditations you currently hold SPECIFIC to the nurse call line program.

Unlimited.

4.2.7.2.9 Is your organization willing to modify aspects of the nurse call line program per direction from the Project Director?

Unlimited.

4.2.7.2.10 List how many staff members will be dedicated to the State's nurse call line.

Unlimited.

4.2.7.2.11 Describe the minimum required credentials of a nurse call line employee.

Unlimited.

4.2.7.2.12 Please indicate what percentage of the staff members in the nurse call line unit have a clinical degree.

Unlimited.

4.2.7.2.13 During what hours/days of week will toll free phone lines be staffed?

Unlimited.

4.2.7.2.14 How are calls "after-hours" of operation handled?

Unlimited.

4.2.7.2.15 On average, how many calls per week does the nurse call line receive in a typical population?

Unlimited.

4.2.7.2.16 What is the average length of time for a call?

Unlimited.

4.2.7.2.17 What percentage of members access the nurse call line annually in a typical population?

Single, Pull-down list.
1: 5 percent or less,
2: 5 to 10 percent,
3: 10 to 15 percent,
4: 15 to 20 percent,
5: 20 to 30 percent,
6: 30 to 50 percent,
7: 50 to 70 percent,

8: 70 to 90 percent,
9: 90 to 100 percent

4.2.7.2.18 What percentage of calls result in an emergency room visit?

Unlimited.

4.2.7.2.19 What percentage of calls result in avoidance of an emergency room visit?

Unlimited.

4.2.7.2.20 Does you nurse call line have access to see which programs members are currently participating in and can they make referrals to these programs as appropriate?

Unlimited.

4.2.7.2.21 Do you report on diversion of care?

Unlimited.

4.2.7.2.22 Please explain how you evaluate the ROI for this program.

Unlimited.

4.2.7.3 Disease Management Programs

4.2.7.3.1 Please identify and describe each service provided through your disease management program.

Unlimited.

4.2.7.3.2 How many years has your organization provided a disease management program?

Unlimited.

4.2.7.3.3 How many total covered lives does your disease management program support?

Unlimited.

4.2.7.3.4 What percentage of members is managed in your disease management program in a typical population?

Unlimited.

4.2.7.3.5 How many clients do you currently service in your disease management program?

Unlimited.

4.2.7.3.6 Indicate any accreditations you currently hold SPECIFIC to your disease management program.

Unlimited.

4.2.7.3.7 Indicate which conditions/diseases are routinely managed in your disease management program.

Unlimited.

4.2.7.3.8 Describe which conditions and associated program services (if any) are available for children under 18 years of age ?

Unlimited.

4.2.7.3.9 Indicate whether all conditions must be included in disease management or whether the State can customize the list of conditions to suit its population?

Unlimited.

4.2.7.3.10 Is your organization willing to modify aspects of the disease management program per direction from the Project Director?

Unlimited.

4.2.7.3.11 Describe where the dedicated offices(s) will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Unlimited.

4.2.7.3.12 List how many staff members will be dedicated to the disease management program.

Unlimited.

4.2.7.3.13 What is the average caseload for disease management nurses/coaches?

Unlimited.

4.2.7.3.14 Describe the minimum required credentials of a disease management nurse.

Unlimited.

4.2.7.3.15 What percentage of disease management staff has a disease management certification such as CDE?

Unlimited.

4.2.7.3.16 Describe your training program for disease management employees.

Unlimited.

4.2.7.3.17 Explain any incentive programs you employ to retain competent disease management employees?

Unlimited.

4.2.7.3.18 During what hours/days of is the disease management program available to members?

Unlimited.

4.2.7.3.19 How are calls “after-hours” of operation handled?

Unlimited.

4.2.7.3.20 Is there a voice mail system or capability for callers to leave messages after normal business hours?

Unlimited.

4.2.7.3.21 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive).

	Percent of Members	Comments
Identified	*Percent.*	*Unlimited.*
Outreached To	*Percent.*	*Unlimited.*
Reached	*Percent.*	*Unlimited.*
Opted Out	*Percent.*	*Unlimited.*
Enrolled	*Percent.*	*Unlimited.*
Dropped Out	*Percent.*	*Unlimited.*
Completed program – goals met	*Percent.*	*Unlimited.*

4.2.7.3.22 What is the average length of time a case stays open?

Unlimited.

4.2.7.3.23 Are you able to warm transfer members to other vendors? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.7.3.24 Describe your procedures for transition of ongoing management cases to a new vendor.

Unlimited.

4.2.7.3.25 Is there a ceiling on the number of telephonic coaching cases you will manage for this client? If yes, what is that limit?

Unlimited.

4.2.7.3.26 Is there a limit on the number of RN engaged cases?

Unlimited.

4.2.7.3.27 Does your program include an Electronic Medical Record/Personal Health Record? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.7.4 Maternity Management

4.2.7.4.1 Please identify and describe the services you provide through your maternity management program.

Unlimited.

4.2.7.4.2 How many years has your organization provided a maternity management program?

Unlimited.

4.2.7.4.3 How many total covered lives does your maternity management program support?

Unlimited.

4.2.7.4.4 What percentage of members is in your maternity management program in a typical population?

Unlimited.

4.2.7.4.5 How many clients do you currently service in your maternity management program?

Unlimited.

4.2.7.4.6 Indicate any accreditations you currently hold SPECIFIC to your maternity management program.

Unlimited.

4.2.7.4.7 Indicate which of the following components are included in your maternity program? (check all that apply)?

Multi, Checkboxes.
1: All pregnancies, regardless of risk level, routinely work with a nurse care manager,
2: All pregnancies receive multiple screenings and assessments throughout the pregnancy,
3: All pregnancies receive routine educational mailings,
4: Educational mailings are customized based on risk factors to all pregnant members,
5: Educational mailings are customized based on risk factors to high risk pregnancies,
6: High-risk pregnancies receive multiple screenings and assessments throughout the pregnancy,

7: High-risk pregnancies receive routine educational mailings,
8: High-risk pregnancies routinely work with a nurse care manger,
9: Post-partum assessment and education for all pregnancies,
10: Post-partum assessment and education for high risk pregnancies

4.2.7.4.8 Describe where the dedicated offices(s) will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Unlimited.

4.2.7.4.9 List how many staff members will be dedicated to the maternity management program.

Unlimited.

4.2.7.4.10 What is the average caseload for maternity management nurses/coaches?

Unlimited.

4.2.7.4.11 Describe the minimum required credentials of a maternity management nurse.

Unlimited.

4.2.7.4.12 Describe your training program for maternity management employees.

Unlimited.

4.2.7.4.13 Explain any incentive programs you employ to retain competent maternity management employees?

Unlimited.

4.2.7.4.14 During what hours/days of is the maternity management program available to members?

Unlimited.

4.2.7.4.15 How are calls “after-hours” of operation handled?

Unlimited.

4.2.7.4.16 Is there a voice mail system or capability for callers to leave messages after normal business hours?

Unlimited.

4.2.7.4.17 Is there a ceiling on the number of maternity management cases you will manage for the State? If so, what is that limit?

Unlimited.

4.2.7.4.18 Does your program include an Electronic Medical Record/Personal Health Record? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.7.4.19 In general, how often are pregnant participants contacted by telephone by a nurse?

Single, Pull-down list.
1: Once per pregnancy,
2: Once each trimester,
3: Once each month,
4: Bi-weekly,
5: Weekly,
6: Other, please specify: [500 words]

4.2.7.4.20 Describe the interventions provided for members identified as low-risk.

Unlimited.

4.2.7.4.21 Describe the interventions provided for members identified as medium-risk.

Unlimited.

4.2.7.4.22 Describe the interventions provided for members identified as high-risk.

Unlimited.

4.2.7.4.23 Does your maternity management staff have ready access to a High Risk Obstetrician or Neonatologist for consults?

Unlimited.

4.2.7.4.24 If a member is actively engaged in maternity management and is admitted to the hospital, does the maternity manager continue to monitor the care and provide authorizations for inpatient care?

Unlimited.

4.2.7.4.25 What percentage of all pregnancies are managed in your maternity program in a typical employee population?

Unlimited.

4.2.7.4.26 What metrics do you report on for both pregnant participants and pregnant non-participants?

Unlimited.

4.2.7.5 Employee Assistance Program (EAP)

4.2.7.5.1 Please identify and describe the services you provide in your EAP.

Unlimited.

4.2.7.5.2 How many years has your organization provided an EAP?

Unlimited.

4.2.7.5.3 How many total covered lives does your EAP support?

Unlimited.

4.2.7.5.4 What percentage of members participates in your EAP in a typical population?

Unlimited.

4.2.7.5.5 How many clients do you currently service in your EAP?

Unlimited.

4.2.7.5.6 Indicate any accreditations you currently hold SPECIFIC to your EAP program.

Unlimited.

4.2.7.5.7 Is your employee assistance program included in or separate from your managed mental health program?

Unlimited.

4.2.7.5.8 Do you provide all EAP services internally or are some services subcontracted?

Unlimited.

4.2.7.5.9 Is your organization willing to modify aspects of the EAP program per direction from the Project Director?

Unlimited.

4.2.7.5.10 How many hours of training/onsite services are provided in the contract?

Unlimited.

4.2.7.5.11 Describe where the dedicated offices(s), if any, will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Unlimited.

4.2.7.5.12 List how many staff members will be dedicated to the State’s EAP plans.

Unlimited.

4.2.7.5.13 Describe your training program for EAP employees.

Unlimited.

4.2.7.5.14 Are client specific toll-free numbers available?

Unlimited.

4.2.7.5.15 Who is the member's first point of telephone contact?

Unlimited.

4.2.7.5.16 What are minimum credentials of staff assigned to the 24-hour intake line?

Unlimited.

4.2.7.5.17 Describe your organization's assessment and referral services, specifically outlining the procedures used. Explain your review criteria and how they were developed.

Unlimited.

4.2.7.5.18 Describe your treatment protocol for critical incidence intervention. Define the resources and treatment options that will be available to employees in the event of a crisis.

Unlimited.

4.2.7.5.19 Describe how you would deliver crisis intervention services to five employees in Kotzebue, AK and the time frame for such delivery starting from the time of initial outreach

Unlimited.

4.2.7.5.20 Describe the services and training/workshops you can provide the State through local network practitioners for promotion of mental wellness and prevention of mental health problems and substance abuse. This includes but is not limited to supervisory training of State employees to identify, document, and refer substance abuse cases for proper treatment.

Unlimited.

4.2.7.5.21 Describe how you will coordinate EAP services with Managed Mental Health services including handling transition of member care from EAP to MMH when appropriate.

Unlimited.

4.2.7.5.22 Provide the total number of Alaska contracted EAP practitioners in your current network, by location.

Unlimited.

4.2.7.5.23 Explain how providers are selected and screened for proficiency in their specialty and provide the average experience level of the various mental health professionals.

Unlimited.

4.2.7.5.24 How much notice is a provider contractually required to give if he/she elects to terminate contract with your network?

Unlimited.

4.2.7.5.25 Provide the total number of contracted EAP practitioners in your current network in the other 49 states.

Unlimited.

4.2.7.5.26 Indicate whether the network(s) is owned by you or by another organization. Describe your relationship with that network, if it is not owned by you.

Unlimited.

4.2.7.5.27 How quickly is a member informed when his/her provider has left the network?

Unlimited.

4.2.7.5.28 What percentage of members participate in the EAP in a typical employee population?

Unlimited.

4.2.7.5.29 For the EAP benefit, please indicate the average number of face-to-face visits per unique episode of care within the last 12 months?

Unlimited.

4.2.8 Quality Control (use tables provided in Attachment G3)

4.2.8.1 Please explain in detail how you will evaluate and report to the State your performance under the Contract. Specifically, identify and describe, by function, how each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the HealthCare Management component will be evaluated for effectiveness and efficiency. For each function, please provide the following evaluative information:

- A detailed description of each performance standard you will utilize to evaluate each functional component for effectiveness and efficiency.
- The benchmark measurement for each identified performance standard for each functional component.
- The frequency of reporting to the State your evaluation of each identified performance standard for each functional component based on the standards and benchmarks you utilized to determine effectiveness and efficiency.
- Which standards you are willing to subject to penalty for failure to meet.

- Whether the evaluation of each standard will be conducted by your organization or will be conducted by an independent external organization.

Unlimited.

4.2.8.2 Are you willing to place fees at risk for meeting certain performance standards and guarantee outcomes under the Contract?

Single, Pull-down list.
1: Yes,
2: No

4.2.8.3 Are you willing to guarantee savings in this proposal? If so, please explain.

Unlimited.

4.2.8.4 When are performance penalties paid out?

Unlimited.

4.2.8.5 Can tracking and reporting of the performance standards be based on State-specific data?

Unlimited.

4.2.8.6 Please confirm that you will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate. State personnel or outside auditors that the State selects may perform these audits, including audits that may take place after the end of the contract period.

Unlimited.

4.2.8.7 Please confirm that you will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits.

Unlimited.

4.2.8.8 Please indicate whether or not you agree with the following statements regarding Audits.

	Agree
You will allow auditing of your operations as they relate to the administration and servicing of this account.	*Single, Pull-down list.* 1: Agree, 2: Disagree
Your organization will not charge for services rendered in conjunction with the audit.	*Single, Pull-down list.* 1: Agree, 2: Disagree
If problems are discovered, follow-up audits will be paid by your organization.	*Single, Pull-down list.*

	1: Agree, 2: Disagree

4.2.8.9 Do you have a dedicated internal audit staff?

Single, Radio group.
1: Yes,
2: No

4.2.8.10 What percentage of member calls is monitored?

Unlimited.

4.2.8.11 How long are recorded calls maintained?

Unlimited.

4.2.9 Data Analysis

4.2.9.1 Data Collection

4.2.9.1.1 Provide a brief example of when you shared participation data or referrals to a data aggregator or vendor partner in any care management area (case management, disease management, wellness, etc).

500 words.

4.2.9.1.2 Provide a brief example of when you accepted participation data or referrals from a data aggregator or vendor partner (case management, disease management, wellness, etc).

500 words.

4.2.9.1.3 Explain whether your organization will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis. Indicate if you are paid to provide this data.

500 words.

4.2.9.1.4 Do you utilize a data warehouse for reporting and claim and trend analysis?

Unlimited.

4.2.9.1.5 If yes, please provide the name of the warehouse and indicate if the State will have access to data and reporting. If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.9.1.6 Describe your organization's data warehousing and population health analytical services, including software used.

Unlimited.

4.2.9.1.7 What resources do you provide from a health data analyst perspective to support your clients?

Unlimited.

4.2.9.2 Data Reporting

4.2.9.2.1 Provide a list and detailed description (including frequency) of the reporting package available as part of the standard fees (at no additional cost)

Unlimited.

4.2.9.2.2 Does the client receive aggregated and de-identified reporting on overall medical (biometric) screening results and primary disease burdens regardless of number of participants and number of locations? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.9.2.3 Are you able to accommodate requests for ad-hoc or customized reporting (including utilization information) at no cost to the State? If there is an additional cost, please indicate the cost on the rate sheet

Unlimited.

4.2.9.2.4 If you are able to accommodate ad- hoc or customized reporting, what is the normal turnaround time to fulfill such request.

Unlimited.

4.2.9.2.5 Describe any custom reporting and data dashboards you have created for your clients, be specific and how they integrated into the full suite of services being proposed.

Unlimited.

4.2.9.2.6 Are reports available via the web?

Unlimited.

4.2.9.2.7 If you are able to provide electronic feeds of medical (biometric) screening data is there an extra fee for this? If there is an additional cost, please indicate the cost on the rate sheet.

Unlimited.

4.2.9.2.8 Describe the available reporting specifically relating to each program including the types of data and information included.

Unlimited.

4.2.9.2.9 How frequently are reports available?

Single, Pull-down list.
1: Monthly,
2: Quarterly,
3: Semi-annually,
4: Annually,
5: Other, please specify: [500 words]

4.2.9.2.10 Are reports available via the web? If there is an additional cost, please indicate the cost on the rate sheet

Single, Pull-down list.
1: Yes, included in base pricing,
2: Yes, for an additional fee (indicated on rate sheet),
3: No

4.2.9.2.11 Is there an additional fee for customization? If there is an additional cost, please indicate the cost on the rate sheet.

Single, Pull-down list.
1: Yes (indicated on rate sheet),
2: No

4.2.9.2.12 How often do you report participation rates to the client?

Unlimited.

4.2.10 Financial

4.2.10.1 Provide a sample of your administrative fee invoice.

Single, Pull-down list.
1: Attached,
2: Not Attached

4.3 State Objectives

4.3.1 Plan Design

4.3.1.1 Please describe how you can assist the State with identifying possible plan enhancements that would support the states objectives as identified in Section 1.0 of the RFP.

Unlimited.

4.3.2 Policy Development

4.3.2.1 Please describe how you can support the State in policy development through the use of data driven analysis and best practice recommendations. Please include any additional resources your organization can provide.

Unlimited.

4.3.3 Innovation

4.3.3.1 Briefly describe the four most important ways you propose to assist the State in controlling health costs in Alaska now and in the future.

Unlimited.

4.3.3.2 Please provide a white paper with information on innovative steps your organization is prepared to implement in order to assist the State is achieving its vision as stated in Section 1.0 of the RFP. Include any programs or innovations that have proven successful with other similar clients. Focus on cost containment and cutting edge health care support, as well as integration with other key vendor partners.

Single, Pull-down list.
1: Attached,
2: Not Attached

4.3.3.3 How is your organization leveraging Patient Centered Medical Homes? What are the outcomes of your programs?

Unlimited.

4.3.3.4 How is your organization supporting the creation of Accountable Care Organizations?

Unlimited.

4.3.3.5 Is your organization planning to or participating in any private exchanges today? If so, which ones?

Unlimited.

4.3.3.6 Is your organization planning to participate in the public/State exchanges? If so, which states?

Unlimited.

4.3.4 Performance Incentives

4.3.4.1 In accordance with Section 3.2 of the RFP, please describe in detail any proposals you are including with your cost proposal relative to fee increments for accomplishing state objectives as outlined in Section 1.0 of the RFP such as:

a. Increased Utilization Of Preventive Care Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if utilization of preventive care among the Employee population increased by x% over the prior fiscal year.
b. Increased Participation in Wellness and Disease Management Programs Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if participation in the wellness and disease management programs among the Employee population increased by x% over the prior fiscal year.

Note that these are examples and the State is willing to review other proposed performance incentives.

Unlimited.

4.4 Cost

4.4.1 Fees

4.4.1.1 Confirm you have submitted a cost proposal based upon an administrative fee charge on a per Employee and per Retiree per month basis.

Unlimited.

4.4.1.2 Confirm you have completed the rate table, and included any additional costs identified within the questionnaire.

Unlimited.

4.4.1.3 Confirm that your rates are guaranteed for at least 3 years.

Unlimited.

4.4.1.4 You understand that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees you input in other sections within this RFP and/or may disqualify your offer from being considered.

Unlimited.

4.4.1.5 Healthcare Management Pricing Tables
Please confirm you have completed the Excel worksheets in Attachment F3 and provided the completed worksheets as an attachment in section 4.5 Required Documents. Detailed instructions are provided in the worksheet.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

State of Alaska RFP 2013-0200-1396

4.5 Response Documents - Healthcare Management

4.5.1 Please complete an attach the following file labeled "Attachment F3 - Healthcare Management Pricing Tables and Examples.xlsx"

Single, Pull-down list.
Answer and attachment required
1: Attached,
2: Not Attached

Attached Document: Attachment F3 - Healthcare Management Pricing Tables and Examples.xlsx

4.5.2 Please complete an attach the following file labeled "Attachment I3 - Healthcare Management Implementation and Performance Guarantees.xlsx"

Single, Pull-down list.
Answer and attachment required
1: Attached,
2: Not Attached

Attached Document: Attachment I3 - Healthcare Management Implementation and Performance Guarantees.xlsx

4.6 Reference Documents - Healthcare Management

4.6.1 Attachment G3 - Healthcare Management Scoring Methodology.docx

Document.

Attached Document: Attachment G3 - Healthcare Management Scoring Methodology.docx

4.6.2 Attachment H3 - Healthcare Management Scoring Methodology Example.xlsx

Document.

Attached Document: Attachment H3 - Healthcare Management Scoring Methodology Example.xlsx