**FA2 Attachment S-1: Plan Information Amendments 2 and 4**

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete each cell with the requested information. Items in the response column with the words **"Choose an Item"** contain a drop down list of options. Please select a response from those options as applicable.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I.** | **GENERAL PLAN INFORMATION** | |  | |
|  |  | **Response** | | |
| 1. | Offeror's Legal Name | Click here to enter text. | | |
| 2. | Plan Name | Click here to enter text. | | |
| 3. | Proposed Plan Type | **EPO-SF** | | |
| 4. | Address | Click here to enter text. | | |
| 5. | City | Click here to enter text. | | |
| 6. | State | Click here to enter text. | | |
| 7. | Zip | Click here to enter text. | | |
| 8. | Web Address | Click here to enter text. | | |
| 9. | Operational Date | Click here to enter a date. | | |
| 10. | Corporate Tax Status | Choose an item. | | |
| 11. | Federal Employer Identification Number | Click here to enter text. | | |
| 12. | Ownership/Controlling Interest | Click here to enter text. | | |
| 13. | NCQA Accreditation Status | Choose an item. | | |
| 14. | JCAHO Accreditation | Choose an item. | | |
| 15. | URAC Accreditation |  | | |
|  | Health Plan | Choose an item. | | |
|  | Health Network | Choose an item. | | |
|  | Health Utilization Management | Choose an item. | | |
| 16. | Commercial Group Membership | Click here to enter text. | | |
| **II.** | **PLAN DESIGN** | | | |
|  | Offerors must adhere to the proposed plan designs shown in **"FA2 Attachment S-3: EPO Plan Design"** in preparing the quote. | | | **Select Response** |
| 1. | Confirm that the proposal is issued in accordance with the specifications, assumptions and information included in this Request for Proposal, the accompanying worksheets and standard services addressed in the Information Questionnaire. If "No,” indicate deviations in "**FA2 Attachment S-2: Explanations and Deviations**" worksheet. | | | Choose an item. |
| 2. | Review and detail deviations from the proposed plan design shown in the worksheet, "**FA2 Attachment S-3: EPO Plan Design**.” | | | Choose an item. |
| 3. | Include a concise description of how Offeror covers transitional conditions, such as pregnancy, chemotherapy, etc., if a new Participant is receiving treatment from a non-participating provider. Labelas **"Response** **FA2 Attachment S-1: Transitional Care Information.”** | | | Choose an item. |

**III. MEDICAL DELIVERY SYSTEM**

|  |  |  |
| --- | --- | --- |
| 1. | Please describe the proposed geographical service area. | Click here to enter text. |
| 2. | Provide a map of the proposed geographical service area. Labelas **"Response** **~~FA1~~ FA2 Attachment S-1: Service Area Map.”** | Choose an item. |
| 3. | Please provide the website address (URL) for your provider directory and its password, if necessary. | Click here to enter text. |

**Participants' Access to Providers**

The State would like to determine the availability of key EPO healthcare providers to its employee and retiree population. Please prepare GeoAccess® GeoNetworks® report(s) for each network and/or plan type that you are proposing, using census data provided by the State and the parameters in the table below. Provide the reports using two separate formats: 1. using current EPO enrollment, and 2. using entire census population. Note that it is important that you follow the exact parameters. The report should show hospital and provider availability by physician specialty for each zip code (or community). Report output is required for those with access and those without access, based upon the stipulated parameters. The report output should show the average distance to each provider group. See the sections entitled "**FA2 Attachment S-5: Access to Adult PCPS**,” "**FA2 Attachment S-6: Access to Pediatricians**,” "**FA2 Attachment S-7: Access to OB/GYN**,” and "**FA2 Attachment S-8: Access to Hospitals**" for the required format of the output. In addition to the hard copy report, the data must be supplied in electronic format that has read/write capabilities. **Do not send the data in a read-only file.**

Use only physicians accepting new patients in your GeoAccess® GeoNetworks® provider file. The census data needed to perform this mapping is available for download upon execution of the Non-Disclosure Agreement (see RFP Section 1.37). Label the completed GeoAccess® GeoNetworks® report as **Response FA2 Attachment S‑1: GeoAccess® GeoNetworks® Report**. Attachment S-1 can be provided electronically on CD/DVD. The electronic version should include a system-generated PDF file and an Excel file.

|  |  |  |  |
| --- | --- | --- | --- |
| **Practice Specialty** |  | **Number of**  **Providers Available** | **Miles from**  **Employees Residence** |
| Adult Physicians (Family Practice, General Practice, General Internal Medicine) | | 2 | 8 |
| General Pediatricians | | 2 | 8 |
| Obstetricians/Gynecologists | | 2 | 8 |
| Acute Care Hospitals | | 1 | 10 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Select Response** |
| 1. | Has the GeoAccess® GeoNetworks® reporting been completed using the requested parameters? | | | Choose an item. |
| 2. | Please note the geo-mapping method used: | | | Choose an item. |
| 3. | Was GeoAccess® GeoNetworks® Release 3.0, 2012 used to create the Accessibility Analysis? | | | Choose an item. |

**IV. ADMINISTRATIVE AND OPERATIONAL ISSUES**

|  |  |  |
| --- | --- | --- |
| 1. | List the location(s) of your service centers (separately identify claims processing centers and customer service centers if in different locations) that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location. Use the "FA2 Attachment S‑2: Explanations and Deviations" worksheet if you need more space. | |
|  | Service Center Location(s) | Geographic Region(s) Covered |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Select Response** |
| 2. | Please attach a copy of your standard report suite, including a plan experience report, a summary report of Wellness activities and performance metrics that would be provided to the State at the end of each quarter and the end of each fiscal year at no additional cost. At a minimum, your package should include the reports shown in the Reporting section of the Compliance Checklist. Label as **"Response FA2 Attachment S-1: Management Reporting Package.”** | | | Choose an item. |
| 3. | Offeror agrees to provide at least one fully insured conversion plan option. | | | Choose an item. |

**V. REFERENCES**

Please complete the following tables with the requested reference information.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | Please provide three of your employer client references of similar size (a minimum of 50,000 covered lives or your largest) offering EPO services in the area that will be serving most of the State's employees. | | | |
|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|  | Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | # EPO Members Enrolled | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Description of Services provided | Click here to enter text. | Click here to enter text. | Click here to enter text. |

| 2. | Please provide three of your terminated employer clients of similar size (a minimum of 50,000 covered lives or your largest) that offered EPO services in the area that will be serving most of the State's employees. | | | |
| --- | --- | --- | --- | --- |
|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|  | Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | # EPO Members Enrolled at Date of Termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Termination Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Reason for Termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3. | Please provide your three largest employer client references in the EPO service area that will be serving most of the State's employees. | | | |
|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|  | Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | # EPO Members Enrolled | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Description of Services Provided | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**VI. CONTACT INFORMATION**

|  |  |  |
| --- | --- | --- |
|  | **Primary contact of person authorized to execute this proposal** | |
|  | Name | Click here to enter text. |
|  | Title | Click here to enter text. |
|  | Address | Click here to enter text. |
|  | City | Click here to enter text. |
|  | State | Click here to enter text. |
|  | Zip Code | Click here to enter text. |
|  | Telephone # | Click here to enter text. |
|  | Cell Phone # | Click here to enter text. |
|  | E-mail Address | Click here to enter text. |

## FA2 Attachment S-2: Explanations and Deviations

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** All deviations from the specifications of the Request for Proposal (RFP) must be clearly defined using this worksheet. Explanations must be numbered to correspond to the question number and section number to which it pertains. If additional space is required, submit a separate attachment labeled **“FA2 Attachment S-2b: Explanations and Deviations”** using the same table format. **Most importantly, keep all explanations brief.**  In the absence of any identified deviations, your organization will be bound to the terms of the RFP.

| **Section # / Question #** | **Indicate "Explanation" or "Deviation"** | **Offeror Response** |
| --- | --- | --- |
| Click here | Choose | Click here to enter text. |
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Please indicate if **“FA2 Attachment S-2b: Explanations and Deviations”** is provided: **Choose an item.**

## FA2 Attachment S-3: EPO-SF Plan Design

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Any deviations between the State's proposed plan design and the proposed plan design of the Offeror must be noted in the space provided below. If there are no deviations in the Offeror's proposed plan design, please enter the phrase **"No Deviations"** in the space provided.

| **TYPE OF SERVICE** | **PLAN DESIGN** | **DEVIATIONS** | |
| --- | --- | --- | --- |
| **MAJOR MEDICAL** | |  | |
| **Annual Deductible** |  |  | |
| Individual | None | Click here | |
| Family | None | Click here | |
| **Yearly Maximum  Out-of-Pocket Costs** |  |  | |
| **Coinsurance OOP** |  |  | |
| Individual | None | Click here | |
| Family | None | Click here | |
| **Copayments** |  |  | |
| Individual | $1,500 | Click here | |
| Family | $3,000 | Click here | |
| **Total Medical OOP** |  |  | |
| Individual | $1,500 | Click here | |
| Family | $3,000 | Click here | |
| Lifetime Benefit Maximum | Unlimited | Click here | |
| **Dependent Coverage** | Dependents are eligible for coverage according to the definition of "dependent child" located in Section 1.2 of this RFP. | No deviations will be considered. | |
| **Medicare COB** | Retirees or their dependent(s) must enroll in Medicare Parts A & B upon becoming eligible for Medicare due to age or disability. If the Medicare eligible State retiree and their dependent(s) fail to enroll in Medicare, the Medicare eligible State retiree and their dependent(s) will be responsible for any claim expenses that would have been paid under Medicare Parts A or B, had they enrolled in Medicare. If a retiree or covered dependent's Medicare eligibility is due to ESRD, they must sign up for both Medicare Parts A & B as soon as they are eligible. | No deviations will be considered. | |
| **Non-Medicare COB** | When the State's plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the State's plan. | No deviations will be considered. | |
| **Are referrals required in this plan?** | No referrals in this plan | No deviations will be considered. | |
| **Mandated Benefits** | All mandated benefits, unless otherwise directed by the State. | No deviations will be considered. | |
| **HOSPITAL INPATIENT SERVICES (Preauthorization Required)** | |  | |
| Inpatient Care | 100% of allowed benefit | Click here | |
| Hospitalization | 100% of allowed benefit | Click here | |
| Acute Inpatient Rehab  for Stroke and Traumatic Brain Injury Patients when Medically Necessary | 100% of allowed benefit | Click here | |
| Anesthesia \* | 100% of allowed benefit | Click here | |
| Surgery | 100% of allowed benefit | Click here | |
| Acute Inpatient Rehab  (pre-cert required , must be medically necessary) | 100% of allowed benefit | Click here | |
| Organ Transplant | 100% of allowed benefit | Click here | |
| **HOSPITAL OUTPATIENT SERVICES (Preauthorization Required)** | |  | |
| Chemotherapy/Radiation | 100% of allowed benefit | Click here | |
| Diagnostic Lab Work and X‑rays\*\* | 100% of allowed benefit | Click here | |
| Outpatient surgery | 100% of allowed benefit | Click here | |
| Anesthesia \* | 100% of allowed benefit | Click here | |
| Observation – up to 23 hours and 59 minutes - presented via Emergency Department | 100% of allowed benefit after $75 facility copay and $75 physician copay | Click here | |
| Observation – 24 hours or more - presented via Emergency Department | 100% of allowed benefit | Click here | |
| **THERAPIES (Preauthorization required)** | |  | |
| Benefit Therapies | 100% of allowed benefit after $30 copay | Click here | |
| Physical Therapy (PT) and Occupational Therapy (OT) | ~~PO~~PT/OT services must be pre-certified after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy | Click here | |
| Speech Therapy | Must be pre-certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits. | Click here | |
| **COMMON AND PREVENTIVE SERVICES** | |  | |
| Physician Office Visits - Primary Care | 100% after $15 copay | Click here | |
| Physician Office Visits - Specialist | 100% after $30 copay | Click here | |
| Preventive Health Office Visit and Associated Lab (Adult and Child) | 100% of allowed benefit | Click here | |
| Routine annual GYN Exam (including PAP test) | 100% of allowed benefit | Click here | |
| Hearing Examinations | 100% after $15 copay – PCP or $30 copay – Specialist | Click here | |
| Hearing Aids | 100% of allowed benefit for Basic Model Hearing Aid.  Includes Maryland mandated benefit for hearing aids for minor children (ages 0-18) effective 01/01/02, including hearing aids per each impaired ear for minor children. | No deviations will be considered. | |
| Immunizations | 100% of allowed benefit  Immunizations are only covered as recommended by the U.S. Preventive Services Task Force. The immunization benefit covers immunizations required for participation in school athletics and Lyme Disease immunizations when medically necessary. | Click here | |
| Flu Shots | 100% of allowed benefit | No deviations will be considered. | |
| Mammography Preventive | 100% of allowed benefit Screening: one mammogram per plan year (35+). | Click here | |
| Mammography Diagnostic | 100% of allowed benefit No age or frequency limitation on diagnostic mammograms. | Click here | |
| Physical Exams | 100% of allowed benefit  One exam per plan year for all members and their dependents age 3 and older. | Click here | |
|  |
| Well Baby Care | 100% of allowed benefit  Birth – 36 months: 12 visits total | Click here | |
|  |
| STI Screening and Counseling (Including HPV DNA and HIV) | 100% of allowed benefit  Counseling and screening for sexually active women as mandated by PPACA. | Click here | |
| Norplant Surgery Only | 100% of allowed benefit | Click here | |
| Allergy Testing | 100% after $15 copay – PCP; $30 copay – Specialist | Click here | |
| **EMERGENCY TREATMENT** | |  | |
| Ambulance Services  (Emergency and Non-Emergency transport) | 100% of allowed benefit | Click here | |
| Emergency Room (ER) Services - In and Out of Network | 100% of allowed benefit after $150 copay ($75 for facility and $75 for physician)  Copays are waived if admitted.  If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, plus the two $75 copays. | Click here | |
| Urgent Care Office Visit | 100% of allowed benefit after $30 copay | Click here | |
| **MATERNITY BENEFITS** | |  | |
| Maternity Benefits | 100% of allowed benefit | Click here | |
| Prenatal Care | 100% of allowed benefit | Click here | |
| Newborn Care | 100% of allowed benefit | Click here | |
| **OTHER SERVICES AND SUPPLIES** | |  | |
| Breastfeeding Support, Supplies and Counseling (per birth) | 100% of allowed benefit | Click here | |
| Covers the cost of rental/purchase of certain breastfeeding equipment through Carrier’s DME partner(s). |
| Acupuncture Services for Chronic Pain Management | 100% after $30 copay | Click here | |
| Chiropractic Services | 100% after $30 copay | Click here | |
| Cardiac Rehabilitation | 100% of allowed benefit | Click here | |
| Dental Services | Not covered except as a result of accident or injury or as mandated by Maryland or federal law | No deviations will be considered. | |
| Diabetic Nutritional Counseling, as mandated by Maryland Law | 100% of allowed benefit | Click here | |
| Durable Medical Equipment  Must be medically necessary as determined by the attending physician | 100% of allowed benefit | Click here | |
| Extended Care Facilities | 100% of allowed benefit  Skilled nursing care and extended care facility benefits are limited to 180 days per calendar year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered. | Click here | |
| Contraception and Contraceptive Counseling | 100% of allowed benefit | Click here | |
| Family Planning and Fertility Testing | 100% of allowed benefit | Click here | |
| Hospice Care | 100% of allowed benefit | Click here | |
| Home Healthcare | 100% of allowed benefit  Home Healthcare benefits are limited to 120 days per plan year | Click here | |
|  |
| In-Vitro Fertilization (IVF) and Artificial Insemination(per MD mandate) | 100% of allowed benefit  IVF and AI benefits are limited to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth. Not covered following reversal of elective sterilization. | Click here | |
|  |
| Medical Supplies | 100% of allowed benefit  Includes, but is not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law. | Click here | |
|  |
| **MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES** | | | |
| Inpatient Hospital Care | 100% of allowed benefit | No deviations will be considered. | |
| Partial Hospitalization Services | 100% of allowed benefit | No deviations will be considered. | |
| Outpatient Services (Including Intensive Outpatient Services) | 100% after $15 copay | Click here | |
| Residential Crisis Services | 100% of allowed benefit | Click here | |
| Private Duty Nursing | 100% of allowed benefit | Click here | |
| Surgical Second Opinion | 100% of allowed benefit | Click here | |
| Whole Blood Charges | 100% of allowed benefit | Click here | |
| **VISION SERVICES** |  |  |  |
| Vision - Medical (services related to the medical health of the eye) | 100% after $15 copay (PCP) or $30 copay (specialist) | Click here | |
| Vision - Routine Exam (per plan year – waived for children through age 18)) | 100% after $15 copay (PCP) or $30 copay (specialist) | Click here | |
| Prescription Lenses/frames or contact lenses (per plan year) | Single vision: $28.80, Bifocal (single): $48.60, Bifocal (double): $88.20, Trifocal: $70.20, Aphakic: Glass - $54, Plastic - $126, Aspheric - $162. No limits for children through age 18 | Click here | |
| Frames (per plan year) | Up to $45 - No limits for children through age 18. | Click here | |
| Contact Lenses (per plan year) | Per pair, in lieu of frames & lenses: Medically necessary - $201.60, Cosmetic - $50.40 - No limits for children through age 18. | Click here | |

\* Silent Pay-Up Inpatient/Outpatient Surgery: If a participant uses an in-network hospital and an in-network physician/surgeon for in- or out-patient surgery, then the Plan must pay out-of-network anesthesiologists and radiologists at 100% of the billed amount (not 100% of the allowed amount). No deviations permitted.

\*\* Laboratory testing services related to diabetes, hypertension, coronary artery disease, asthma and COPD are paid at 100%, including test strips for diabetics.

## FA2 Attachment S-4: Participating Physicians

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:**

1. Please define your organization’s criteria for designating high quality, high efficiency and low cost (QEC) physicians (e.g., tiered or centers of excellence “providers of distinction,” “premium providers,” Patient-Centered Medical Homes):

|  |
| --- |
| Click here |

1. Please provide the total number of participating physicians by specialty and, of those physicians, the number designated as high quality, high efficiency and low cost (QEC):

| **County/**  **Metro Area** | **Category** | **Family Practice, General Practice** | **General Internal Medicine** | **General Pediatrics** | **Obstetrics/ Gynecology** | **All Other Specialists** | **Total Physicians** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Central Maryland** | |  |  |  |  |  |  |
| Anne Arundel County | Total # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Baltimore City | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Baltimore County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Carroll County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Harford County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Howard County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| **Eastern Shore** | |  |  |  |  |  |  |
| Caroline County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Cecil County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Dorchester County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Kent County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Queen Anne's County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Somerset County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Talbot County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Wicomico County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
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| Worcester County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| **Southern Maryland** | |  |  |  |  |  |  |
| Calvert County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Charles County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| St. Mary's County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| **Washington Metro** | |  |  |  |  |  |  |
| District of Columbia | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Montgomery County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Prince George's County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| **Western Maryland** | |  |  |  |  |  |  |
| Allegany County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Frederick County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Garrett County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| Washington County | # of physicians | Click here | Click here | Click here | Click here | Click here | Click here |
| # of QEC physicians | Click here | Click here | Click here | Click here | Click here | Click here |

**Instructions:** For the states and locations shown below, list the total number of participating providers by specialty.

| **State** | **Participating Physicians including Family Practice, General Internal Medicine** | **Pediatricians** | **OB/GYN** | **Hospitals** |
| --- | --- | --- | --- | --- |
| Alabama | Click here | Click here | Click here | Click here |
| Alaska | Click here | Click here | Click here | Click here |
| Arizona | Click here | Click here | Click here | Click here |
| Arkansas | Click here | Click here | Click here | Click here |
| California | Click here | Click here | Click here | Click here |
| Colorado | Click here | Click here | Click here | Click here |
| Connecticut | Click here | Click here | Click here | Click here |
| Delaware | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | Click here | Click here | Click here |
| Florida | Click here | Click here | Click here | Click here |
| Georgia | Click here | Click here | Click here | Click here |
| Hawaii | Click here | Click here | Click here | Click here |
| Idaho | Click here | Click here | Click here | Click here |
| Illinois | Click here | Click here | Click here | Click here |
| Indiana | Click here | Click here | Click here | Click here |
| Iowa | Click here | Click here | Click here | Click here |
| Kansas | Click here | Click here | Click here | Click here |
| Kentucky | Click here | Click here | Click here | Click here |
| Louisiana | Click here | Click here | Click here | Click here |
| Maine | Click here | Click here | Click here | Click here |
| Massachusetts | Click here | Click here | Click here | Click here |
| Michigan | Click here | Click here | Click here | Click here |
| Minnesota | Click here | Click here | Click here | Click here |
| Mississippi | Click here | Click here | Click here | Click here |
| Missouri | Click here | Click here | Click here | Click here |
| Montana | Click here | Click here | Click here | Click here |
| Nebraska | Click here | Click here | Click here | Click here |
| Nevada | Click here | Click here | Click here | Click here |
| New Hampshire | Click here | Click here | Click here | Click here |
| New Jersey | Click here | Click here | Click here | Click here |
| New Mexico | Click here | Click here | Click here | Click here |
| New York | Click here | Click here | Click here | Click here |
| North Carolina | Click here | Click here | Click here | Click here |
| North Dakota | Click here | Click here | Click here | Click here |
| Ohio | Click here | Click here | Click here | Click here |
| Oklahoma | Click here | Click here | Click here | Click here |
| Oregon | Click here | Click here | Click here | Click here |
| Pennsylvania | Click here | Click here | Click here | Click here |
| Rhode Island | Click here | Click here | Click here | Click here |
| South Carolina | Click here | Click here | Click here | Click here |
| South Dakota | Click here | Click here | Click here | Click here |
| Tennessee | Click here | Click here | Click here | Click here |
| Texas | Click here | Click here | Click here | Click here |
| Utah | Click here | Click here | Click here | Click here |
| Vermont | Click here | Click here | Click here | Click here |
| Virginia | Click here | Click here | Click here | Click here |
| Washington | Click here | Click here | Click here | Click here |
| West Virginia | Click here | Click here | Click here | Click here |
| Wisconsin | Click here | Click here | Click here | Click here |
| Wyoming | Click here | Click here | Click here | Click here |
| **Total** | **Click here** | **Click here** | **Click here** | **Click here** |

## FA2 Attachment S-5: Access to Adult PCPs

**Instructions:** Provide access two ways: 1) all employees and retirees currently in EPO and 2) all employees and retirees. Matches must be determined based on criteria outlined in Section III Participants Access to Providers in **"Attachment S-1: Plan Information.”**

A. For Response Attachment S-1: GeoAccess® GeoNetworks® Report, please provide the following report format for Access to Adult Primary Care Physicians:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Zip Code** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
|  |  |  |  |  |  |  |
| **SAMPLE FORMAT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

B. Also provide subtotals for (1.) All employees and retirees currently in EPO by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 3206 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 6056 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 6960 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1062 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 1314 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1593 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **20191** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 419 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 414 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 578 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 310 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 483 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 600 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 402 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1756 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 543 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **5505** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 375 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 246 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 332 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **953** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 330 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1477 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 3258 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **5065** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 1107 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 640 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 185 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1193 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **3125** | Click here | Click here | Click here | Click here |

C. Also provide subtotals for (2.) All employees and retirees by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 10035 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 18927 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 21493 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 3522 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 3884 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 5005 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **62866** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 912 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 1279 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 1229 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 811 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 1191 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 1382 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 930 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 3937 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 1283 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **12954** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 1080 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 882 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 1233 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **3195** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 1353 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 5432 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 8625 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **15410** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 3559 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 2115 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 743 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 3625 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **10042** | Click here | Click here | Click here | Click here |

## FA2 Attachment S-6: Access to Pediatricians

**Instructions:** Provide access two ways: (1) all employees and retirees currently in EPO and (2) all employees and retirees. Matches must be determined based on criteria outlined in Section III Participants Access to Providers in **"Attachment S-1: Plan Information.”**

A. For Response Attachment S-1: GeoAccess® GeoNetworks® Report, please provide the following report format for Access to Pediatricians:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Zip Code** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
|  |  |  |  |  |  |  |
| **SAMPLE FORMAT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

B. Also provide subtotals for (1.) All employees and retirees currently in EPO by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 3206 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 6056 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 6960 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1062 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 1314 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1593 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **20191** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 419 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 414 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 578 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 310 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 483 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 600 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 402 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1756 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 543 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **5505** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 375 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 246 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 332 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **953** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 330 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1477 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 3258 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **5065** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 1107 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 640 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 185 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1193 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **3125** | Click here | Click here | Click here | Click here |

C. Also provide subtotals for (2.) All employees and retirees by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 10035 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 18927 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 21493 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 3522 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 3884 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 5005 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **62866** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 912 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 1279 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 1229 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 811 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 1191 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 1382 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 930 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 3937 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 1283 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **12954** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 1080 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 882 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 1233 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **3195** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 1353 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 5432 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 8625 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **15410** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 3559 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 2115 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 743 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 3625 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **10042** | Click here | Click here | Click here | Click here |

## FA2 Attachment S-7: Access to OB/GYN

**Instructions:** Provide access two ways: (1) all employees and retirees currently in EPO and (2) all employees and retirees. Matches must be determined based on criteria outlined in Section III Participants Access to Providers in **"Attachment S-1: Plan Information.”**

A. For Response Attachment S-1: GeoAccess® GeoNetworks® Report, please provide the following report format for Access to OB/GYN Physicians:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Zip Code** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
|  |  |  |  |  |  |  |
| **SAMPLE FORMAT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

B. Also provide subtotals for (1.) All employees and retirees currently in EPO by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 3206 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 6056 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 6960 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1062 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 1314 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1593 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **20191** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 419 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 414 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 578 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 310 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 483 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 600 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 402 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1756 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 543 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **5505** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 375 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 246 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 332 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **953** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 330 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1477 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 3258 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **5065** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 1107 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 640 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 185 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1193 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **3125** | Click here | Click here | Click here | Click here |

C. Also provide subtotals for (2.) All employees and retirees by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 10035 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 18927 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 21493 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 3522 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 3884 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 5005 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **62866** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 912 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 1279 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 1229 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 811 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 1191 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 1382 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 930 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 3937 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 1283 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **12954** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 1080 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 882 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 1233 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **3195** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 1353 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 5432 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 8625 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **15410** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 3559 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 2115 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 743 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 3625 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **10042** | Click here | Click here | Click here | Click here |

## FA2 Attachment S-8: Access to Hospitals

**Instructions:** Provide access two ways: (1) all employees and retirees currently in EPO and (2) all employees and retirees. Matches must be determined based on criteria outlined in Section III Participants Access to Providers in **"Attachment S-1: Plan Information.”**

A. For Response Attachment S-1: GeoAccess® GeoNetworks® Report, please provide the following report format for Access to Hospitals:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Zip Code** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
|  |  |  |  |  |  |  |
| **SAMPLE FORMAT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

B. Also provide subtotals for (1.) All employees and retirees currently in EPO by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 3206 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 6056 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 6960 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1062 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 1314 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1593 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **20191** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 419 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 414 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 578 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 310 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 483 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 600 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 402 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1756 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 543 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **5505** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 375 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 246 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 332 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **953** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 330 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1477 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 3258 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **5065** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 1107 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 640 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 185 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1193 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **3125** | Click here | Click here | Click here | Click here |

C. Also provide subtotals for (2.) All employees and retirees by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area  (Subtotal by County)** | **Average Distance to Adult PCPs** | **Total Number of Employees / Retirees** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Anne Arundel County | Click here | 10035 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 18927 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 21493 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 3522 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 3884 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 5005 | Click here | Click here | Click here | Click here |
| **Central Maryland** | Click here | **62866** | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 912 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 1279 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 1229 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 811 | Click here | Click here | Click here | Click here |
| Queen Anne's County | Click here | 1191 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 1382 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 930 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 3937 | Click here | Click here | Click here | Click here |
| Worcester County | Click here | 1283 | Click here | Click here | Click here | Click here |
| **Eastern Shore** | Click here | **12954** | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 1080 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 882 | Click here | Click here | Click here | Click here |
| St. Mary's County | Click here | 1233 | Click here | Click here | Click here | Click here |
| **Southern Maryland** | Click here | **3195** | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | 1353 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 5432 | Click here | Click here | Click here | Click here |
| Prince George's County | Click here | 8625 | Click here | Click here | Click here | Click here |
| **Washington Metro** | Click here | **15410** | Click here | Click here | Click here | Click here |
| Allegany County | Click here | 3559 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 2115 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 743 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 3625 | Click here | Click here | Click here | Click here |
| **Western Maryland** | Click here | **10042** | Click here | Click here | Click here | Click here |

## FA2 Attachment S-9: Compliance Checklist Amendments 2 and 4

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete each item with the requested information. Items in the response column with the words **"Choose”** contain a drop down list of options. Please select a response from those options as applicable. NOTE: All "No" responses must be addressed in **"FA2 Attachment S-2: Explanations and Deviations.”**

| **Compliance Checklist** | | | | | | **Contractor's Response** |
| --- | --- | --- | --- | --- | --- | --- |
| **Yes or No\*** |
| **CUSTOMER SERVICE** | | | | | |  |
|  | | Contractor agrees to permit all eligible Members, as determined by the State, to obtain health insurance benefits for themselves and their eligible Dependents. | | | | Choose |
|  | | ~~Contractor agrees to provide a post-COBRA fully insured conversion plan to terminated participants.~~ | | | | ~~Choose~~ |
|  | | Contractor agrees that no administrative functions required under this contract may be performed offshore. | | | | Choose |
|  | | Contractor agrees to establish and provide a dedicated, state-of-the-art customer service operation (including a toll-free dedicated line) that is available to plan Participants (both in-state and out-of state) 24/7, staffed by live customer service representatives during the core hours, 7 am – 11 pm Eastern Time, seven days a week at no additional charge. | | | | Choose |
|  | | This toll-free customer service line will be supported during the hours stated above by an automated voice-response system 24 hours a day, seven days a week. Participants (both in-state and out-of state) can access this system directly to request and receive service authorizations or other pertinent data. This operation should comply with Performance Standards #1 and #2, in **"FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
|  | | During call center hours, as indicated above, the customer service phone intake system should be an automatic answering system that picks up within 10 seconds and directs Participants into a queue to be serviced, with an available opt-out to a live representative at any time during the call. | | | | Choose |
|  | | Automated call answer system will provide estimated wait time until live operator pick-up to Participant. | | | | Choose |
|  | | Contractor agrees to resolve a minimum of 85% of member calls on the first call to the customer service line. | | | | Choose |
|  | | The member services operation must include: | | | |  |
| a.) Knowledgeable staff available to answer questions on plan eligibility, plan guidelines, benefit levels, disease management, wellness healthy activities, and claims procedures. | | | | Choose |
| b.) The ability to maintain an eligibility file that identifies eligible Participants as well as certain other pertinent information regarding Participants. | | | | Choose |
| c.) A system for providing Explanations Of Benefits to eligible Participants detailing payments to facilities and providers for services rendered and the amounts applicable to each service. | | | | Choose |
| d.) A procedure for handling emergency requests and non-office hour admissions. | | | | Choose |
| e.) An integrated claims and customer service system enabling both claims and service team members to view all screens. | | | | Choose |
| f.) Adequate access to the customer service system for individuals with disabilities. (TTY and online access for deaf, full-service phone access for blind) | | | | Choose |
| g.) The ability to track healthy activities, as well as disease management and tobacco cessation activities, completed, as outlined in Section 3.3 General Requirements for All Functional Areas, and advise Member of outstanding activities still needed to meet to avoid premium surcharges. | | | | Choose |
|  | | Contractor agrees to accurately convert State data files, including the State master enrollment file and any other relevant files to the Contractor's data system. | | | | Choose |
|  | | Contractor agrees to offer support services for the 2014 Open Enrollment period (for the plan year beginning January 1, 2015) and all subsequent open enrollments during the contract term. Contractor will provide services in accordance with Performance Standard #5, in **"FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
|  | | Contractor will provide representatives to attend Benefit Fairs, who will be trained on the State-specific benefit plans, in accordance with Performance Standard #5, in **"FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
|  | | Contractor agrees to maintain and verify documentation of disabled status for dependents of eligible State participants. Contractor must verify disabled status every two years, or in the event of a total and permanent disability, once per contract period. If no documentation is received within the required timeframe, Contractor must notify the State of Maryland within 10 calendar days. | | | | Choose |
|  | | Contractor agrees to share the expenses for producing and distributing all State of Maryland Open Enrollment materials, including but not limited to the Benefits Guide, universal enrollment forms, and other notices or information included in the enrollment kits. The total cost will be shared equally among all benefit plans. For 2013 Open Enrollment, each State vendor's share was approximately $19,000 per plan. The Contractor’s share will vary based on the number of vendors and if there are fewer vendors in future years, the pro-rated amounts will increase. | | | | Choose |
|  | | Contractor agrees to assume a share of the cost of an annual State-conducted Participant satisfaction survey on its health plan. Approximate cost is $5,000 per year per plan. The Contractor’s share will vary based on the number of vendors and if there are fewer vendors in future years, the pro-rated amounts will increase. | | | | Choose |
|  | | | Contractor shall prepare and provide identification cards and a detailed plan description document to Members. ID cards are to be mailed to members at least ten business days before the program is operational. ID cards must be mailed to new members within three business days of notification by the State or receipt of the add/change/delete enrollment file that reflects the new enrollment, whichever is earlier. The detailed plan description/Evidence of Coverage will be provided electronically (and via paper upon request). | | | Choose |
|  | | | Contractor shall provide an electronic version of the detailed plan description/summary of coverage/evidence of coverage to the employee benefits compliance manager no later than 45 days in advance of the first day of the plan year. | | | Choose |
|  | | | Contractor will use a unique identification number (that is not the Social Security number) on all Participant communications, including, but not limited to, membership cards, EOBs, etc. | | | Choose |
|  | | | Upon request, Contractor will submit forms for the State's approval, and print forms with the State's logo for claims submission. | | | Choose |
|  | | The State of Maryland reserves the right to accept or decline the Contractor’s designated account manager for any reason at any time. | | | | Choose |
|  | | Contractor will provide a dedicated, but not exclusive, account management team for the State, directly employed by the Contractor. | | | | Choose |
|  | | Contractors Plan representatives will return all messages received from the State’s Department of Budget and Management/Employee Benefits Division (whether voice mail, e‑mail or other communication method) promptly. Messages received before noon will be replied to the same day. Messages received after noon will be replied to by noon of the following business day. | | | | Choose |
|  | | Contractor will provide a designated eligibility manager for the State. | | | | Choose |
|  | | Contractor will provide a designated billing manager for the State. | | | | Choose |
|  | | Contractor will provide a dedicated claims supervisor to assist with internal claims eligibility audits conducted quarterly and on an annual look-back basis. | | | | Choose |
|  | | Contractor will provide a dedicated (but not exclusive) claim processing unit for the State. | | | | Choose |
|  | | The State of Maryland reserves the right to accept or decline the Contractor’s designated claim supervisor, claim processor and claim facility for any reason at any time. | | | | Choose |
|  | | Contractor will attend quarterly meetings to discuss plan administration and any other concerns the State may have. Meetings will be set with the State in advance on a designated day each quarter. The content of the meeting will include but not be limited to unusual claims utilization trends, disease state prevalence, operational performance, disease management progress, wellness tracking and customer service issues. | | | | Choose |
|  | | Contractor agrees to review drafts of the plan description as requested by the State contained in the State's annual Benefits Guide, at no extra cost. | | | | Choose |
|  | | Contractor agrees to provide certificate/evidence of coverage documents by State directed deadline in accordance with Performance Standard #17 in “**~~FA1~~** FA2 Attachment S-12: Performance Guarantees.” | | | | Choose |
|  | | Contractor agrees to meet or exceed established performance standards as described in "**FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
| **NETWORK COMPLIANCE/REIMBURSEMENT** | | | | | |  |
|  | | Contractor agrees to provide Participant support services live and online for selecting and/or locating network physicians and for answering provider credentialing questions that Participants may have. | | | | Choose |
|  | | Contractor agrees to provide online tools for comparing procedure costs by provider/facility. | | | | Choose |
|  | | Contractor agrees to provide online access to up-to-date network provider listings and locations to assist Participants with provider selection, including quality performance and outcome ratings, and other services with regard to provider selection. | | | | Choose |
|  | | Contractor agrees to notify plan Participants, in writing with at least 60 days advance notice, in the event that the contract for a Participant's network physician terminates for any reason. The State will review and approve the communications provided to State Participants for this purpose. | | | | Choose |
|  | | Contractor agrees to notify the State, in writing with at least 75 days advance notice, in the event that the contract for a practice group, or a physician terminates for any reason. | | | | Choose |
|  | | Contractor has a procedure in place to allow the State and/or plan Participants to nominate providers to be considered for inclusion in the network panel, and if included, made available to Participants. | | | | Choose |
|  | | Contractor's physician and hospital contracts have a "continuation of care" clause that says if a physician or hospital cancels or fails to renew their contract, that care which began with a network provider will continue to be provided and reimbursed as a network provider until 90 days after discharge. | | | | Choose |
|  | | Contractor has, and will maintain, a process for Participants to contact customer service to find out the maximum allowance for a specific procedure in advance of having the procedure done. | | | | Choose |
|  | | Contractor confirms that procedures are in place for ensuring that a network provider does not bill participants and/or the plan sponsor any amount in excess of the network allowance. | | | | Choose |
|  | | Contractor's contracts with network providers prohibit providers from balance billing patients above the network allowance. | | | | Choose |
|  | | Contractor will guarantee that a participant will not be liable for any amounts over and above the scheduled plan of benefits in the event a healthcare provider is not paid accurately for services rendered. | | | | Choose |
|  | | Contractor guarantees that the network allowance will always be the basis for determining the member's liability (coinsurance, etc.), if applicable, for in-network services rendered. | | | | Choose |
|  | | Contractor shall provide and maintain a broad-based national network. | | | | Choose |
|  | | Contractor agrees that the State reserves the right to explore the Contractor’s tiered network, and if decided, implement this structure in future plan years. | | | | Choose |
| **VALUE BASED BENEFIT DESIGN AND ADMINISTRATION** | | | | | |  |
|  | | Contractor agrees to monitor variations in outcomes and quality for procedures performed in hospitals within their networks and develop and or expand Centers of Excellence. The Contractor agrees to develop strategies for guiding State Health Plan participants to those hospitals with high quality performance ratings for those identified procedures. The Contractor agrees that procedures and services associated with its Centers of Excellence programs are bundled with regard to reimbursement. | | | | Choose |
|  | | Contractor agrees to the performance metrics and the shared incentive structure of the Value Based Benefit Design. See Attachment "**Attachment S-13: Performance Metrics.”** | | | | Choose |
|  | | Contractor agrees to provide routine education to network providers regarding the plan's policies and procedures, including but not limited to disease management, wellness, and outcome incentives, through a manual, periodic newsletters, and special meetings, as needed. | | | | Choose |
|  | | The Contractor agrees to participate in a pilot shared savings model and understands by Year 3 of the Contract, the State will identify certain episodes of care/and or conditions (up to 5) that will be included in the pilot. Contractors constraining costs below benchmarks established by The State and achieve outcomes consistent with prior experience will share in the savings. Contractor understands savings would be shared retrospectively based on cost and quality. | | | | Choose |
|  | | The Contractor agrees to develop a list of medical services that produce high value medical outcomes and offer recommendations to the State for administering incentives that reward high value choices. Contractor agrees to quantify and detail the criteria and benchmark or studies used to develop the list and modify the list as needed based on the most current information available. | | | | Choose |
| **AUDITS** | | | | | |  |
|  | | | The Contractor agrees to perform regular hospital records (including clinical and billing issues) audits on all hospital admissions exceeding $25,000 in paid claims, subject to a minimum of 2% of all hospital claims, and report audit results and recoveries to the State. Such audits will be performed in accordance with Performance Standard #12, in **"FA2 Attachment S-12: Performance Guarantees.”** | | | Choose |
|  | | | The Contractor agrees to have an annual audit performed by an independent audit firm of its handling of the Department’s critical functions and/or sensitive information, which is identified as Insurance Claims Processing Services (collectively referred to as the “Information Functions and/or Processes”). Such audits shall be performed in accordance with audit guidance: *Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy* *(SOC 2)* as published by the American Institute of Certified Public Accountants (AICPA) and as updated from time to time, or according to the most current audit guidance promulgated by the AICPA or similarly-recognized professional organization, as agreed to by the Department, to assess the security of outsourced client functions or data (collectively, the “Guidance”). Copies of such audits will be provided to DBM annually. | | | Choose |
|  | | | The Contractor agrees to provide the State or its designated representative the right to audit the performance of the plan and services provided (including quality of care and HIPAA compliance). Contractor will make available all services, records and access to the auditors at no extra charge. Contractor will be given two months written advance notice of an impending audit. The State or its designated representative will audit operations at least once annually. | | | Choose |
|  | | The Contractor agrees to provide the State the right to audit self-insured claims against the State’s eligibility system. Contractor will designate a supervisor – level contact from both its enrollment and claims units who will be responsible and accountable for ensuring timely response to the Department’s Audit Unit to support its efforts to collect ineligible payments from either the Contractor or the individual. Such audits will occur within the plan year with a final reconciliation to occur no later than 90 days following the plan year end , in accordance with Performance Standard #19, in **" ~~FA1~~ FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
|  | | Contractor agrees to maintain eligibility reconciliations between Contractor files and State eligibility files. | | | | Choose |
| **HIPAA** (Business Associate Agreement) (Terms herein shall have meaning provided in 45 CFR, Parts 160, 162 and 164.) | | | | | |  |
|  | The Contractor agrees to comply with HIPAA security regulations, 45 CFR Part 164, subpart C, including the following: | | | | |  |
| a.) The Contractor agrees to develop and implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that the Contractor creates, receives, maintains or transmits in the Contractor's administration of the plan, as required by the HIPAA security standards. | | | | | Choose |
| b.) The Contractor agrees to comply with the HIPAA security standards. | | | | | Choose |
| c.) The Contractor agrees to maintain documentation of the policies and procedures and safeguards implemented to comply with the HIPAA security standards. | | | | | Choose |
| d.) In compliance with 45 CFR 164.308(b), the Contractor agrees to ensure, through written contract, that any agent, including a subcontractor to whom the Contractor provides electronic PHI, agrees to implement reasonable and appropriate safeguards. | | | | | Choose |
| e.) The Contractor agrees to report to the State within ten days any security incident of which the Contractor becomes aware during the term of the Contract and any mitigation or remedial plans to address such security incidents. | | | | | Choose |
| f.) The Contractor agrees to make the Contractor's policies and procedures, and its documentation required by the HIPAA security standards, available to the State and the Department of Health and Human Services for purposes of determining if the plan complies with the HIPAA security standards. | | | | | Choose |
|  | The Contractor agrees to comply with HIPAA privacy standards, 45 CFR Parts 160 and 164, including the following: | | | | |  |
| a.) The Contractor shall not use or disclose PHI except to fulfill the requirements of this RFP and the contract, or as required by law. In doing so, the Contractor shall use, disclose or request the minimum amount of PHI necessary and act in compliance with §164.502(b) as if a covered entity. Further, the Contractor shall use limited data sets when possible and comply with DHHS guidance in determining minimum necessary standards to accomplish intended use, purpose or disclosure as if a covered entity. | | | | | Choose |
| b.) The Contractor shall implement and use appropriate and reasonable administrative, physical and technical safeguards to prevent Use or Disclosure of PHI other than (1) as provided in this RFP and the contract, (2) permitted by the HIPAA Privacy Regulation for a Covered Entity, and (3) permitted by the Medical Records Act. In the event that the HIPAA Privacy Regulation and the Medical Records Act conflict regarding the degree of protection provided for PHI, the Contractor shall comply with the more restrictive protection requirements. | | | | | Choose |
| c.) The Contractor shall report to the State any Use or Disclosure of PHI that is not permitted within 10 days of when the Contractor becomes aware of such Use and Disclosure. | | | | | Choose |
| d.) The Contractor shall use reasonable efforts to mitigate the effect of any Use or Disclosure of PHI known to Contractor that is not permitted. | | | | | Choose |
| e.) The Contractor shall comply with the administrative requirements of 45 CFR § 164.530 as if the Contractor were the Covered Entity in relation to the plan. | | | | | Choose |
| f.) In compliance with 45 CFR § 164.504(e)(5), the Contractor shall ensure, through written contract, that any agent, including a subcontractor to whom it provides PHI received from, created by, or received by the Contractor, agrees to the same restrictions and conditions that apply to the Contractor with respect to such information. This obligation shall apply in connection with PHI created, retained, used, disclosed, or transmitted in connection with the plan(s) administered by the Contractor. | | | | | Choose |
| g.) The Contractor shall provide a Notice of Privacy Practices to all individuals enrolled in the plan in compliance with 45 CFR §164.520 as if the Contractor were the Covered Entity with regard to the plan.  (1) This Notice of Privacy Practices shall comply with the requirements of 45 CFR §164.520 as if the Contractor were the Covered Entity with regard to the plan.  (2) A copy of this Notice of Privacy Practices shall be provided to the State with certification that the notice has been provided to the Members. | | | | | Choose |
| h.) The Contractor shall permit an individual enrolled in the plan to request restricted Uses and Disclosures of PHI related to that individual in accordance with 45 CFR §164.522(a)(1)(i). The Contractor shall comply with 45 CFR §164.522(a)(1)(iii)-(iv) and HITECH §13.405(a) in the event that a request for restricted Uses and Disclosures is granted as if the Contractor were the Covered Entity with regard to the plan. The Contractor may refuse such request to restrict Uses and Disclosures or terminate a restriction on Uses and Disclosures provided that the Contractor complies with the provisions of 45 CFR §164.122(a)(1)(ii), §164.522(a)(2)-(3) and HITECH §13.405(a) as if the Contractor were the Covered Entity with regard to the plan. | | | | | Choose |
| i.) The Contractor shall accommodate reasonable requests by individuals enrolled in the plan or by the State on behalf of such individuals to receive confidential communications in compliance with 45 CFR §164.522(b)(ii) as if the Contractor were the Covered Entity with regard to the plan. The Contractor may condition providing confidential communications as permitted by 45 CFR §164.522(b)(2). | | | | | Choose |
| j.) The Contractor shall maintain PHI in a Designated Record Set and make available to an individual the PHI relating to that individual in compliance with 45 CFR §164.524 and the HITECH Act as if the Contractor were the Covered Entity with regard to the plan. | | | | | Choose |
| k.) The Contractor shall make available for amendment and amend PHI at the request of the State or the individual to whom the PHI relates in compliance with 45 CFR §164.526 as if the Contractor were the Covered Entity with regard to the plan. | | | | | Choose |
| l.) Contractor shall document and track Disclosures and provide an accounting of Disclosures of PHI to the individual about whom it relates in compliance with 45 CFR §165.528 and the HITECH Act as if the Contractor were the Covered Entity with regard to the plan. | | | | | Choose |
| m.) The Contractor shall make the Contractor’s internal practices, books and records, including privacy and confidentiality policies and procedures and PHI, available to the State and the Federal Department of Health and Human Services, for purposes of determining whether the State is compliant with the HIPAA Privacy Regulation in the administration of the plan. | | | | | Choose |
| n.) Upon termination of the Contract, for any reason, the Contractor shall maintain all records created under the Contract as required by the Contract and shall extend the protections of the HIPAA privacy standards to the PHI contained in those records for so long as the Contractor maintains the PHI. All such records containing PHI shall be destroyed at the expiration of the record retention period required by the Contract or, if retained by the Contractor, protected, used and disclosed only in accordance with this RFP and the Contract. | | | | | Choose |
| o.) The Contractor shall provide a certification to the State that the Contractor's HIPAA Privacy Standards obligations have been met, to occur no more frequently than quarterly, upon the State's request for certification. | | | | | Choose |
| p.) The Contractor shall disclose PHI to the State and to the State's agents for the State's use in treatment, payment and healthcare operations related to the plan, and the State's other related plans. | | | | | Choose |
| q.) The Contractor may Disclose PHI as required by law in compliance with 45 CFR §164.512. | | | | | Choose |
| r.) The Contractor may Use and Disclose PHI to conduct data aggregation services as permitted by 45 CFR §164.501 and §164.504(e)(2)(i)(B). | | | | | Choose |
| s.) The Contractor may Use and Disclose PHI for the proper management and administration of the Contractor or to carry out its legal responsibilities as permitted by 45 CFR §164.504(e)(4), provided that: (a) such Uses and Disclosures would be permitted by the HIPAA Privacy Regulation if the Contractor were a Covered Entity regulated by the HIPAA Privacy Regulation and (b) the Contractor obtains reasonable written assurances from the person, agency, or entity to which such Disclosures are made that all PHI will remain confidential and be Used or Disclosed further only as required by law, for the purposes of Disclosure by the Contractor, and the person, agent or entity notifies the Contractor of any instances in which the confidentiality of the PHI has been breached. | | | | | Choose |
| t.) The Contractor may Use or Disclose PHI to report violations of the law to appropriate State and Federal authorities consistent with 45 CFR §164.502(j). | | | | | Choose |
| u.) The Contractor may Disclose PHI in response to an authorization executed by the individual who is the subject of the PHI or that individual's personal representative in accordance with 45 CFR §502(g) and 45 CFR §164.508. | | | | | Choose |
|  | The Contractor shall comply with 45 CFR 164.508(a)(4) and §13405(d)(1) and (2) of the HITECH Act as if it were a covered entity in connection with the benefit plan administered by the Contractor pursuant to this RFP and Contract. The Contractor shall prohibit its business associates, agents and subcontractors who receive, use, disclose, create, retain, maintain, or transmit PHI from receiving remuneration in exchange for PHI on the same terms. | | | | | Choose |
|  | The Contractor shall comply with the limitations on marketing and fundraising communications provided in 45 CFR 164.508(a)(3) and §13406 of the HITECH Act as if it were a covered entity in connection with the benefits plan. | | | | | Choose |
|  | **Breaches of Unsecured PHI** | | | | |  |
| a.) A breach shall be treated as discovered in the terms described in 45 CFR §164.410. | | | | | Choose |
| b.) Notice to the Department | | | | | Choose |
| (1) The Contractor shall promptly notify the Department of a breach of unsecured PHI in its possession following the first day on which the Contractor (or Contractor's employee, officer, agent or subcontractor) knows of such breach or following the first day on which Contractor (or Contractor's employee, officer, agent or subcontractor) should have known of such breach. Such notice shall occur without unreasonable delay and in no event more than 30 days following discovery of the breach. Such notice shall occur even if the breach is not of a Member of the State's Plan. | | | | | Choose |
| (2) In the event that Contractor determines that there is a low probability that the unauthorized access, acquisition, use, or disclosure has compromised the security or privacy of the protected health information based on a risk assessment conducted pursuant 45 CFR §164.402(2), Contractor shall promptly notify the Department of the event and the basis for that determination. Such notice shall occur as soon as is reasonable but in no event more than 30 days following discovery of the unauthorized access, acquisition, use or disclosure of PHI of a Participant. Such determination shall be in writing and signed by an appropriate officer or employee of Contractor. | | | | | Choose |
| (3) Contractor's notice to the Department pursuant to this section concerning breaches shall include, at a minimum: | | | | |  |
| (i) the number of individuals overall affected by the breach and the number of Participants in the State's Plan affected by the breach; | | | | | Choose |
| (ii) if applicable, the identification of each State Plan Participant whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or otherwise the subject of the breach; | | | | | Choose |
| (iii) a description of what happened, the date of the breach, if known, and the date of the discovery of the breach; | | | | | Choose |
| (iv) a brief description of the types of unsecured PHI that were involved in the breach (such as name, social security number, date of birth, claims or healthcare services information, etc.); | | | | | Choose |
| (v) identification of an individual who can provide additional information concerning the breach; and | | | | | Choose |
| (vi) a brief description of the steps Contractor is taking to mitigate the breach, investigate the breach, and to protect against further breaches. | | | | | Choose |
| (4) Contractor's notice to the Department pursuant to this section may be provided on a rolling basis, with information provided to the Department as it becomes available. | | | | | Choose |
| c.) Notice to Participants. | | | | |  |
| (1) Contractor shall provide notice to affected members and to the media in the form, content, manner, method, and timing required to meet the requirements of §§13400-13402 of the HI TECH Act and 45 CFR §§164.404 and 164.406, applied as if Contractor were a covered entity in connection with the group plan(s) administered by Contractor pursuant to the Underlying Agreement. | | | | | Choose |
| (2) The notice(s) required by this section may not be issued until the Department has reviewed and approved the notice(s). Such approval may not be unreasonably delayed or withheld. | | | | | Choose |
| d.) Contractor may delay the notice(s) required pursuant to sections 164.404(b) and 164.406(b) only if permitted pursuant to 45 CFR §164.412. | | | | | Choose |
| e.) In the event of an unauthorized use or disclosure of PHI or a breach of Unsecured PHI, Contractor shall use reasonable efforts to mitigate any harmful effects of said disclosure that are known to it. | | | | | Choose |
| f.) Notices to DHHS. | | | | |  |
| (1) In the event of a breach described in 45 CFR §164.408(b), Contractor shall provide to Department all information required by that subsection to be submitted to the Secretary of DHHS. The information shall be provided without unreasonable delay and in no event more than 30 days following discovery of the breach. Upon request, Contractor shall submit the required breach notice to the Secretary of DHHS on behalf of the Department, the State, the group plan(s), and the Program. | | | | | Choose |
| (2) Contractor shall maintain a log of breaches described in 45 CFR §164.408(c) and that affect members and the group plan(s) administered by Contractor pursuant to the Underlying Agreement. | | | | | Choose |
| g.) In fulfilling its obligations pursuant under this Contract in connection with 45 CFR §164.530, Contractor shall address the provisions of 45 CFR Part 164, subpart D in the manner provided in 45 CFR §164.414, as if Contractor were a covered entity in connection with the benefits plan administered by the Contractor pursuant to this Contract and RFP. | | | | | Choose |
| h.) Contractor agrees to review any guidance from DHHS specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals. BA further agrees, to the extent practical, appropriate and reasonable, to incorporate such guidance into its administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI. | | | | | Choose |
| i.) Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Contractor, agrees to provide notice of a breach and the information necessary for the Contractor to comply with its notice requirements in sections (a) through (h) above. | | | | | Choose |
|  | **Electronic Health Records** | | | | |  |
| a.) Contractor shall notify the Department if and when Contractor uses or maintains electronic health record(s) with respect to PHI. | | | | | Choose |
| b.) As of the applicable effective date identified in HI-TECH §13405(c )(4), when complying with the obligations to respond to requests for an accounting under 45 CFR §164.528, Contractor shall respond to requests for an accounting of disclosures of PHI, in compliance with the requirements of §13405( c)(1) and (3) of the HITECH Act and any regulations promulgated by the Secretary of DHHS pursuant to §13405( c)(2) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI. | | | | | Choose |
| c.) When complying with the obligation to provide access to PHI under 45 CFR §164.524, Contractor shall respond to requests for access to PHI in compliance with the requirements of §13405(e) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI. | | | | | Choose |
|  | The Contractor agrees to provide all HIPAA certificates of creditable coverage, at no extra cost, within the timeframe required by the regulations (see 45 CFR §146.115). | | | | | Choose |
|  | The Contractor confirms that its proposal, and plan design offered, is in compliance with all federal and state laws and regulations that pertain to employee benefit plans. | | | | | Choose |
|  | The Contractor understands, has the necessary systems capability and complies with HIPAA's administrative simplification standards related to electronic data interchange (EDI), including the code set/transactions requests of 45 CFR Part 162. | | | | | Choose |
|  | The Contractor requires any agents/subcontractors it brings onto the project(s) covered by this RFP to comply with the HIPAA standards for EDI. | | | | | Choose |
| **SPECIAL PROVISIONS** | | | | | |  |
|  | | Contractor will provide at least six months’ advance notice of any planned systems upgrades or changes (to include claims, customer service, eligibility, corporate operating system). | | | | Choose |
|  | | Contractor agrees to retain records in excess of the period required by the Contract, if required by State and Federal regulations for health plans. | | | | Choose |
|  | | Contractor must unconditionally agree to provide coverage to all Participants enrolled on the Program effective date. | | | | Choose |
|  | | Contractor agrees to provide necessary legal defense in the event of litigation resulting from Contractor error, omission, etc. | | | | Choose |
|  | | Contractor agrees to cover all costs associated with legal defense in the event of litigation. | | | | Choose |
|  | | In the event of a change in vendors or expiration of this contract, at the termination or expiration of this contract, the vendor selected will be responsible for incurred claims up to the termination or expiration date for up to 12 months following the end of the contract term. | | | | Choose |
|  | | All claim records and eligibility data used by the Contractor in its role as claim administrator shall remain the property of the State as plan sponsor and plan administrator. | | | | Choose |
|  | | Contractor agrees to prepare and file all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts, required state filings, and development of booklet/certificate formats. | | | | Choose |
|  | | Contractor agrees to monitor federal and state legislation affecting the delivery of medical benefits under the plan and to report to the State on those issues in a timely fashion prior to the effective date of any mandated plan changes. | | | | Choose |
|  | | Contractor will absorb the cost of programming to meet any benefit design changes. | | | | Choose |
|  | | Member service operations must include an information system capable of electronically transmitting, receiving, and updating Participant profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.) on a daily basis. | | | | Choose |
|  | | Contractor agrees to accept prescription claims data from State’s PBM at a frequency necessary to properly and fully manage wellness and disease management obligations. | | | | Choose |
|  | | Contractor agrees to share claims data on participants who enroll in another Contractor’s plan during the annual Open Enrollment in order to ensure continuity of the State’s wellness and disease management objectives. | | | | Choose |
|  | | All electronic file transfers shall be exchanged using a point to point VPN connection approved by the State of Maryland, Department of Budget and Management, Office of Information Technology. | | | | Choose |
|  | | Contractor will use a unique identification number (that is not a Social Security number) on all Participant communications, including, but not limited to, membership cards, EOBs, etc. | | | | Choose |
|  | | Contractor agrees to maintain a claims fraud detection and prevention program and will notify the State within 10 business days of any suspected fraud and the steps Contractor has taken to remedy and investigate. Contractor will provide the State with its current procedures and any updates as they occur, but no less frequently than annually. | | | | Choose |
| **HEALTHCARE REFORM** | | | | | |  |
|  | | Contractor agrees that it will use an effective internal claims appeals process pursuant to PPACA (§ 2719 of the Public Health Service Act) and the regulations promulgated thereto, including: | | | | Choose |
| a) Incorporating the procedures of the Department of Labor claims procedure regulation; | | | | Choose |
| b) Providing appropriate and timely notice to members regarding benefit determinations; | | | | Choose |
| c) Providing appropriate and timely notice to members regarding available internal and external appeals processes; | | | | Choose |
| d) Allowing members to review their file, present evidence and testimony as part of the appeals process; and | | | | Choose |
| e) Updating its claims and procedures in accordance with any standards established by the Secretary of Labor. | | | | Choose |
|  | | Medical Loss Ratio Requirement  Contractor agrees to comply with PPACA(§ 2719 of the Public Health Service Act) and the regulations promulgated thereto, including: | | | | Choose |
|  | | a) Contractor agrees to spend at least 85% of premiums charged under this Contract on healthcare benefits and quality improvement activities rather than on administrative costs or as retained profits in accordance with PPACA .  b) Contractor agrees to provide DBM and each enrollee a notice (in a form prescribed by HHS) at the time a rebate is provided to DBM, that includes the following information: (i) a general description of the MLR concept, (ii) the purpose of setting the MLR standard, (iii) the applicable MLR standard, (iv) the Contractor’s MLR, (v) the Contractor’s aggregate premium revenue minus applicable taxes and fees, (vi) the rebate percentage and amount owed to enrollees, and (vii) verification that the total aggregated rebate is being provided to DBM.  c) Contractor agrees to pay 100% of any such rebate to DBM  d) DBM will use the amount of the rebate that is proportionate to the total amount of premium paid by all enrollees under the policy, for the benefit of enrollees in one of the ways described in 45 CFR §158.242(b)(1), at the option of the DBM. | | | | Choose |
|  | | Contractor has disclosed their claims appeals (claims decision or coverage) protocols as well as actual response time statistics for the most recent year. Label as **"Response FA2 Attachment S-1: Claims Appeal Protocol.”** | | | | Choose |
| **CLAIM PROCESSING** | | | | | |  |
|  | | Contractor agrees that all claims will be paid in accordance with the benefit program described in **"FA2 Attachment S-3: EPO Plan Design"** in this Request for Proposal | | | | Choose |
|  | | Contractor has procedures in place for recovery of claims processing errors identified by, but not limited to, Contractor audits, EBD, claims eligibility, and its external Contractor audits. | | | | Choose |
|  | | Contractor also agrees to promptly refund to the State of Maryland any claims overpayments identified in the audits, regardless of timing. | | | | Choose |
|  | | Contractor agrees to have a process for resolving complaints in place and operable on the date of contract commencement. The State expects that an expeditious, written resolution will normally be mailed within 10 workdays of receipt of any complaint other than claims appeals. | | | | Choose |
|  | | Contractor agrees to use the current NAIC 120-1 Model COB Contract Provisions for determining when to pay as primary coverage. | | | | Choose |
|  | | Notwithstanding anything in the attachments to the contrary, Contractor agrees to administer the plan to provide Coordination of Benefits (COB) under a pay and pursue basis with other employee, retiree, and dependent medical coverage, including Medicare and Medicaid, in accordance with current NAIC 120-1 Model COB Provisions | | | | Choose |
|  | | Contractor will verify and update Participant records with information on other coverage at least annually, and more frequently if notified by the State or Participants. | | | | Choose |
|  | | As a secondary payer, your non-Medicare COB will be based on the coinsurance in effect on the secondary payer plan and adjudicated based on the allowed amount of the secondary payer plan. | | | | Choose |
|  | | As a secondary payer, your Medicare COB will be based on the coinsurance in effect on the secondary payer plan, adjudicated based on Medicare's allowed amount and the assumption that the Participant has enrolled in Parts A and B. | | | | Choose |
|  | | Contractor agrees to comply with all applicable rules and requirements of The Medicare, Medicaid, and SCHIP Extension Act of 2012, S. 2499 (Public Law No: 110-173 and submit data on behalf of the plan as required. | | | | Choose |
|  | | Contractor agrees to use its UCR profiles, reduced network fees, or those of the primary carrier in determining its level of reimbursement when it is the secondary payor in a COB situation. | | | | Choose |
|  | | To the extent permitted under state law, no fault auto insurance, governmental plans (Medicare, Medicaid) coordination and negligent third party subrogation will be included in the contract. | | | | Choose |
|  | | Contractor agrees to process claims either by a paper process or electronic process in accordance with Performance Standards #9through #11, in **"FA2 Attachment S-12: Performance Guarantees.”** | | | | Choose |
|  | | Contractor will have a pre-authorization procedure in place for referrals to non-network providers in those circumstances in which a network provider is not available to provide specific services. | | | | Choose |
|  | | Contractor will obtain the advice and consultation of qualified experts (internal or external, as needed) to review unusual charges or claims at no additional cost to the State. | | | | Choose |
|  | | Contractor will have the following policies and procedures in its Care Management processes for the State: | | | | Choose |
| a.) Pre-certification / Prior authorization | | | | Choose |
| b.) Concurrent and Review and discharge planning for inpatient admissions. | | | | Choose |
| c.) Retrospective Clinical Review | | | | Choose |
| d.) Second Surgical Opinions, as directed by the State. | | | | Choose |
| e.) Large Case Management provided, on a voluntary basis, to all members with the potential to benefit from the program. This includes not only members with select diagnoses, but also those who meet certain situational criteria. Potential candidates for case management include, but are not limited to: (1) Catastrophic conditions such as High risk obstetrics/neonatal, HIV/AIDS, Amputation, Asthma/COPD, Cardiovascular disease, Severe burns, Cerebrovascular accident with deficits, Infectious disease, Oncology including all metastatic cancer, complications of diabetes, traumatic injuries, neuromuscular disease, low back pain, end stage renal disease; (2) Members with complex care coordination needs; (3) High dollar cases (>$100,000 incurred / year); (4) 3 or more ER visits within 6-month period for same or related condition; (5) 2 unscheduled admissions within 6-month period; (6) Inpatient length of stay > 10 days; (7) Inpatient rehabilitation or skilled nursing facility admission; (8) Home healthcare services beyond 50% of benefit level; (9) Home healthcare services beyond 30 days for one episode of care; (10) Members with 3 or more providers; (11) Prescriptions for controlled substances from more than 3 providers. | | | | Choose |
| f.) System with ability to provide utilization statistics and savings reports, including utilization trends, care management interventions, and clinical and financial outcomes of not just individual claims but also episodes of care. | | | | Choose |
| g.) Use of an automated system for identification, tracking and management of care management activities. System is fully integrated with claims processing and benefits system, if separately maintained. Medical necessity and length of stay criteria is integrated within the system and Contractor's UR staff has access to online diagnostic and procedure codes. | | | | Choose |
| h.) DRG validation | | | | Choose |
| j.) Responses on all UR prior authorization/pre-certification requests are made to the attending physician, hospital, patient, and claim administrator within 24 hours of initial request. | | | | Choose |
| k.) A written appeals process, with a multi-level process for adverse UR review decisions. First-level appeals shall be available on an expedited basis (within 24 hours of request); second-level appeals shall be specialty-matched, with a decision rendered within 72 hours of receipt of all pertinent clinical information. | | | | Choose |
| l.) Medical director/physician advisor participates in day-to-day operations and is easily available to care management staff for consultation. | | | | Choose |
| m.) Licensed care management staff have an average 5 years of clinical experience and a licensed clinician provides oversight to all non-clinical support staff participating in care management activities. | | | | Choose |
| n.) Documented comprehensive training program for all new care management hires, including non-clinical support staff. | | | | Choose |
| o.) Contractor agrees to provide telephonic outreach services for the following designated chronic conditions – asthma, COPD, CAD, CHF, diabetes, hypertension, hyperlipidemia, musculoskeletal/low back pain, and others designated by the State. | | | | Choose |
| p.) Contractor agrees to provide telephonic counseling services to participants with designated chronic conditions in the high and medium acuity/severity level. | | | | Choose |
| q.) Contractor agrees to track and from time to time report all telephonic outreach to eligible and targeted participants for proper adherence to the Contractor’s engagement guidelines including – meeting appointments for counseling calls, following treatment and medication compliance, adherence of participants to all healthy activities requirements in the Value Based Benefit Design. | | | | Choose |
| r.) Contractor agrees to ~~conform~~perform disease management and case management programs to facilitate cross referral and data integration to facilitate care coordination. | | | | Choose |
|  | | Contractor agrees not to make payment for hospital facility, professional and other related services, when the delivery of those services results in a preventable medical error. | | | | Choose |
| **REPORTING** | | | | | |  |
|  | | | | **General Reporting Requirements** | |  |
|  | | | | Contractor agrees to provide the State online access to all standard reports | | Choose |
|  | | | | Contractor agrees to provide the State ad hoc reporting including but not limited to reporting required for Wellness and Disease Management Tracking including outcomes and quality of care, as requested by the State, for no additional charge. | | Choose |
|  | | | | Contractor agrees to provide reporting and data to the State and its Contractors as required to support plan management and the development of wellness and disease management, and additional strategic initiatives. | | Choose |
|  | | | | Contractor agrees to deliver the required management information reporting in format specified by the State that provides utilization, claims reporting, and administrative services data by subgroup and total to the State of Maryland. The required subgroups are: State actives, State retirees under 65, State retirees 65 and over, Direct Pay, and Satellite Accounts. Contractor also agrees to provide monthly claims and enrollment in these specified subgroups and in total. | | Choose |
|  | | | | The State requires a number of regular monthly, quarterly and annual claim reports. The Contractor will provide these reports electronically to both the State and the State's benefit consultant by 6:00 p.m. on the 10th business day of the month following the end of the calendar month/quarter/year. | | Choose |
|  | | | | Contractor will provide Ad Hoc reporting flexibility at no additional charge. | | Choose |
|  | | | | Wellness and Disease Management Reports | |  |
|  | | | | Quarterly | |  |
|  | | | | Disease Management activity reports showing: | |  |
|  | | | | 1. Total number of participants identified as eligible for telephonic outreach by chronic condition and by severity level e.g. moderate or high severity | | Choose |
|  | | | | 1. Total number of eligible participants who were “reached” telephonically by chronic condition and severity level | | Choose |
|  | | | | 1. Total number of those eligible who were “reached” telephonically who “consented” to engage in telephonic counseling | | Choose |
|  | | | | 1. Total number of those eligible who were “reached” telephonically who “declined” to engage in telephonic counseling | | Choose |
|  | | | | 1. Total number of those eligible who were “not reached” telephonically | | Choose |
|  | | | | 1. Total number of those who “consented” who completed at least 1 counseling call | | Choose |
|  | | | | 1. Total number of those who “consented” who completed 2-3 calls, 4+ calls | | Choose |
|  | | | | 1. Total number of those who completed or graduated from the program | | Choose |
|  | | | | 1. Total number who dropped out before completing the program requirements | | Choose |
|  | | | | 1. Total number of cases that were closed without making any live contact | | Choose |
|  | | | | Wellness Program (i.e. tobacco cessation, weight management, nutrition education) activity reports: | |  |
|  | | | | 1. Total number of participants who enrolled in the program | | Choose |
|  | | | | 1. Total number of participants who completed the program | | Choose |
|  | | | | 1. Total number of participants who enrolled in the program but did not complete the program | | Choose |
|  | | | | Annually | |  |
|  | | | | Disease Management clinical reports showing: | |  |
|  | | | | 1. Treatment compliance rates for all participants (show percentage and actual counts) by condition (i.e. asthma, COPD, diabetes, hypertension, hyperlipidemia, CAD) for all condition related tests and exam based on evidenced based medical recommendations. | | Choose |
|  | | | | 1. For diabetics show the number of participants with Hb A1c rates < 7, those >8 but < 9, and those > 10. | | Choose |
|  | | | | 1. For diabetic show the number of participants with blood pressure of < 140/90 | | Choose |
|  | | | | 1. For hyperlipidemia report the number of participants with cholesterol levels <220mb/dl and >250mb/dl | | Choose |
|  | | | | 1. For all participants with a chronic condition show the progress in closing gaps in care i.e. medical adherence, physician visits, treatment compliance | | Choose |
|  | | | | 1. For those with chronic conditions, report the number of ER visits related to the condition | | Choose |
|  | | | | 1. For those with chronic conditions report: number of hospital admissions and those hospitalizations that were readmissions related to a prior condition related episode of care | | Choose |
|  | | | | ROI overall and by specific Wellness and/or Disease Management Program describing program components, improvements, and specific clinical and financial outcomes for each component of the program and the overall program. | | Choose |
|  | | | | **Value Based Benefit Plan Design Reporting Requirements** | |  |
|  | | | | 2015 baseline data metrics (including metrics in Attachment ~~P~~S-13: Performance Metrics, for each performance metric by March 30, 2016. | | Choose |
|  | | | | Reporting on each performance metric Attachment ~~P~~S-13, Performance Metrics, showing current as well as historical, within 3 months of the close of the plan year. | | Choose |
|  | | | | Contractor will provide an electronic file which reports on each participant’s compliance with requirements for healthy activities and participation in disease management and tobacco cessation programs. This data will be used by the State to identify each participant’s eligibility for copay waivers and premium surcharges. The report will be based on participant’s compliance with the requirements during the previous plan year and must be delivered by July 1 of the following year. | | Choose |
|  | | | | **Program Reports** | |  |
|  | | | | **Monthly** | |  |
|  | | | | A monthly paid claim report showing paid claims, number of enrolled employees/retirees, number of enrolled participants (including employees/retirees and their dependents) for the following groups: State actives, State retirees, Direct Pay, and Satellite Account. | | Choose |
|  | | | | Contractor shall supply on a monthly basis a full file of all claim activity to the State's data warehouse vendor. This file shall include member SSNs. This file shall be transmitted electronically to a designated VPN connection. | | Choose |
|  | | | | **Quarterly** | |  |
|  | | | | Contractor must self-report on each of the Performance Guarantee measurements as defined in Quarterly Plan Performance Measurement Report Card to the State on a calendar quarter basis, in the format requested. See Performance Standard #5, in "~~FA1~~ **FA2** Attachment S-12: Performance Guarantees.” | | Choose |
|  | | | A quarterly paid claim report showing paid claims, number of enrolled employees/retirees, number of enrolled participants (including employees/retirees and their deerforamnce pendents) for the following groups: State actives, State retirees, Direct Pay, and Satellite Account. | | | Choose |
|  | | | | **Annually** | |  |
|  | | | | A rate renewal report, as required by Performance Standard #8 in "Attachment S 12: Performance Guarantees,” including, but not limited to: | |  |
|  | | | | a.) Projection of incurred claim costs for renewal year; | | Choose |
|  | | | | b.) Estimate of IBNR reserves at end of current year, including the most recent 36 months of incurred/paid triangular reports; | | Choose |
|  | | | | c.) Complete documentation of the methodology and assumptions used to develop the projected costs; | | Choose |
|  | | | | d.) Disclosure of supporting data used in calculations, including monthly paid claims and enrollment, large claims analysis, trend analysis, demographic analysis, etc.; | | Choose |
|  | | | | Annually in and out-of-network utilization showing information noted above by in and out-of-network. | | Choose |
|  | | | | Explanations for any unusual trend results (high/low relative to the market). | | Choose |
| **IMPLEMENTATION SCHEDULE** | | | | | |  |
|  | | | | | Contractor agrees to comply with the implementation schedule as outlined in the RFP. | Choose |
| **PAYMENT SPECIFICATIONS** | | | | | |  |
|  | | | Contractors will conform to the State's payment procedures outlined in Section 3.5, Payment and Invoice Specifications, of the RFP. | | | Choose |
|  | | | **Claims** | | |  |
|  | | | Contractor will submit for each claim invoiced, a 100-character record with claims detail. The file containing these records must equal the amount invoiced and be submitted within 48 hours of invoice submission. An example is in "Attachment E.” | | | Choose |
|  | | | Contractor agrees to accept adjustments based on the reconciliation of State's invoice amount and 100-character file (Attachment E). Applicable adjustments will be made to a subsequent invoice. | | | Choose |
|  | | | **Non-Claims (Administrative)** | | |  |
|  | | | Contractor agrees to accept monthly payments of administration fees based on the State's enrollment provided by the State on a self-administered basis. | | | Choose |
|  | | | Contractor agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State and limited to premium, administrative fees, claims, shared savings and/or other incentive payments. | | | Choose |
|  | | | All vendors that are awarded a contract must contractually agree to provide “run-out” claims processing services at the level of service and price that are comparable to pre-termination services, for no less than 12 months at termination of the new agreement. | | | Choose |
|  | | | Contractor agrees that, upon contract termination or expiration, the cost of any work required by a new administrator to bring records in unsatisfactory condition up to date shall be the obligation of its firm and such expenses shall be reimbursed by its firm within three (3) months of the end of the contract term. | | | Choose |
|  | | | Contractor agrees to transfer enrollment data, claim information and other administrative records to any carrier/TPA who replaces it, at no charge. | | | Choose |
|  | | | Contractor agrees to receive enrollment data, claim information and other administrative records from the carrier/TPA they are replacing, at no charge. | | | Choose |
|  | | | Contractor agrees to confirm bank transfers as they occur. | | | Choose |

## FA2 Attachment S-10: Questionnaire Amendment 2

**NOTE: Answers that are not concise and directly relevant may receive a lower score.**

| **Question** | | | | | | | **Offeror’s Response** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL** | | | | | | |  |
|  | | Describe your company's experience in providing medical group benefits through an EPO. | | | | | Click here to enter text. |
|  | | How long have you offered EPO plans to Maryland based clients? | | | | | Click here to enter text. |
|  | | Is your organization compliant with all applicable HIPAA administrative simplification rules? | | | | | Choose an item. |
|  | | a.) Will your organization be involved in any acquisitions or mergers within the next 12 months? | | | | | Choose an item. |
| If yes, please describe. | | | | | Click here to enter text. |
| b) Has your organization been involved in any recent acquisitions or mergers? | | | | |  |
| Within the last year? | | | | | Choose an item. |
| 1-2 years ago? | | | | | Choose an item. |
| 2-5 years ago? | | | | | Choose an item. |
| None in the last five years | | | | | Choose an item. |
| If yes, please describe. | | | | | Click here to enter text. |
|  | | Confirm that your organization has Errors and Omissions Insurance and Commercial General Liability Insurance. | | | | | Please submit a copy of your certificate(s) of insurance indicating coverage limits and label as **“Response Attachment: Certificates of Insurance.”** |
| E & O | | | | | Choose an item. |
| Commercial General Liability | | | | | Choose an item. |
|  | | Provide a copy of your most recent *financial* ratings and complete the following table. | | | | |  |
| **1. A.M. Best** | | | | |  |
| Current Financial Rating | | | | | Click here to enter text. |
| Date of Rating | | | | | Click here to enter text. |
| Prior Financial Rating | | | | | Click here to enter text. |
| Date of rating | | | | | Click here to enter text. |
| **2. Standard & Poor's** | | | | |  |
| Current Financial Rating | | | | | Click here to enter text. |
| Date of Rating | | | | | Click here to enter text. |
| Prior Financial Rating | | | | | Click here to enter text. |
| Date of rating | | | | | Click here to enter text. |
| **3. Fitch** | | | | |  |
| Current Financial Rating | | | | | Click here to enter text. |
| Date of Rating | | | | | Click here to enter text. |
| Prior Financial Rating | | | | | Click here to enter text. |
| Date of rating | | | | | Click here to enter text. |
|  | | Provide a sample of a new member communications package. | | | | | Please submit a sample of a new member communications package and label as **“Response Attachment: Member Communications Package.”** |
|  | | Provide the following aggregate claims information for 2011 and 2012: | | | | |  |
|  | | **Calendar Year 2011** | | | | |  |
|  | | Total claim dollars paid under all health plans administered or insured | | | | | Click here to enter text. |
|  | | Total members covered under all health plans administered or insured | | | | | Click here to enter text. |
|  | | Total claim dollars paid under all EPO plans administered or insured | | | | | Click here to enter text. |
|  | | Total members covered under all EPO plans administered or insured | | | | | Click here to enter text. |
|  | | Total claim dollars paid under health plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total members covered under all health plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total claim dollars paid under all EPO plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total members covered under all EPO plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | **Calendar Year 2012** | | | | |  |
|  | | Total claim dollars paid under all health plans administered or insured | | | | | Click here to enter text. |
|  | | Total members covered under all health plans administered or insured | | | | | Click here to enter text. |
|  | | Total claim dollars paid under all EPO plans administered or insured | | | | | Click here to enter text. |
|  | | Total members covered under all EPO plans administered or insured | | | | | Click here to enter text. |
|  | | Total claim dollars paid under health plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total members covered under all health plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total claim dollars paid under all EPO/POS plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Total members covered under all EPO/POS plans administered or insured in the State of Maryland | | | | | Click here to enter text. |
|  | | Provide a profile of your EPO business for each of the most recent three calendar years. | | | | |  |
|  | | **Calendar Year 2011** | | | | |  |
|  | | Total premium volume | | | | | Click here to enter text. |
|  | | Total number of clients | | | | | Click here to enter text. |
|  | | Total number of participants covered | | | | | Click here to enter text. |
|  | | Number of public sector clients | | | | | Click here to enter text. |
|  | | Average size of public sector clients | | | | | Click here to enter text. |
|  | | Number of public sector participants | | | | | Click here to enter text. |
|  | | Number of claims handled | | | | | Click here to enter text. |
|  | | Number of plans terminated | | | | | Click here to enter text. |
|  | | Average size of terminated plans | | | | | Click here to enter text. |
|  | | **Calendar Year 2012** | | | | |  |
|  | | Total premium volume | | | | | Click here to enter text. |
|  | | Total number of clients | | | | | Click here to enter text. |
|  | | Total number of participants covered | | | | | Click here to enter text. |
|  | | Number of public sector clients | | | | | Click here to enter text. |
|  | | Average size of public sector clients | | | | | Click here to enter text. |
|  | | Number of public sector participants | | | | | Click here to enter text. |
|  | | Number of claims handled | | | | | Click here to enter text. |
|  | | Number of plans terminated | | | | | Click here to enter text. |
|  | | Average size of terminated plans | | | | | Click here to enter text. |
|  | | **Calendar Year 2013 YTD** | | | | |  |
|  | | Total premium volume | | | | | Click here to enter text. |
|  | | Total number of clients | | | | | Click here to enter text. |
|  | | Total number of participants covered | | | | | Click here to enter text. |
|  | | Number of public sector clients | | | | | Click here to enter text. |
|  | | Average size of public sector clients | | | | | Click here to enter text. |
|  | | Number of public sector participants | | | | | Click here to enter text. |
|  | | Number of claims handled | | | | | Click here to enter text. |
|  | | Number of plans terminated | | | | | Click here to enter text. |
|  | | Average size of terminated plans | | | | | Click here to enter text. |
| **PROVIDER/NETWORK ACCESS** | | | | | | |  |
|  | | Please describe your capabilities in the following areas: | | | | |  |
| Capability to institute episodes of care pricing and what are the criteria? | | | | | Choose an item. |
| Capabilities to administer reference based pricing? | | | | | Choose an item. |
| Expanding capability to do predictive modeling and data mining? | | | | | Choose an item. |
| Collecting and tracking laboratory testing and results? | | | | | Choose an item. |
|  | | Can a plan sponsor or plan participant nominate providers to be considered for inclusion in the network panel? | | | | | Choose an item. |
| If yes, what steps would be required to be taken by the plan sponsor and/or participant? | | | | | Click here to enter text. |
|  | | Does your provider directory list whether each provider's office is accessible to the handicapped? | | | | | Choose an item. |
|  | | Are you anticipating any material changes (+/- 5%) in network size (for either hospitals or providers) in the network area serving State of Maryland employees and retirees during the next 12 months? | | | | | Choose an item. |
|  | | Identify the annual percentage increase in payments (on a per unit of service basis) made to contracted providers for 2012 and estimated for 2013 and 2014. | | | | |  |
| **Calendar Year 2012** | | | | |  |
| Family Practice | | | | | Click here to enter text. |
| Specialists | | | | | Click here to enter text. |
| Hospital Inpatient | | | | | Click here to enter text. |
| Hospital Outpatient | | | | | Click here to enter text. |
| Lab | | | | | Click here to enter text. |
| X-ray | | | | | Click here to enter text. |
| Chiropractic | | | | | Click here to enter text. |
| PT, OT, ST | | | | | Click here to enter text. |
| Other | | | | | Click here to enter text. |
| Overall % Increase (all services) | | | | | Click here to enter text. |
| **Calendar Year 2013 (estimated)** | | | | |  |
| Family Practice | | | | | Click here to enter text. |
| Specialists | | | | | Click here to enter text. |
| Hospital Inpatient | | | | | Click here to enter text. |
| Hospital Outpatient | | | | | Click here to enter text. |
| Lab | | | | | Click here to enter text. |
| X-ray | | | | | Click here to enter text. |
| chiropractic | | | | | Click here to enter text. |
| PT, OT, ST | | | | | Click here to enter text. |
| Other | | | | | Click here to enter text. |
| Overall % Increase (all services) | | | | | Click here to enter text. |
| **Calendar Year 2014 (anticipated)** | | | | |  |
| Family Practice | | | | | Click here to enter text. |
| Specialists | | | | | Click here to enter text. |
| Hospital Inpatient | | | | | Click here to enter text. |
| Hospital Outpatient | | | | | Click here to enter text. |
| Lab | | | | | Click here to enter text. |
| X-ray | | | | | Click here to enter text. |
| chiropractic | | | | | Click here to enter text. |
| PT, OT, ST | | | | | Click here to enter text. |
| Other | | | | | Click here to enter text. |
| Overall % Increase (all services) | | | | | Click here to enter text. |
| **WELLNESS PROGRAM CAPABILITIES** | | | | | | |  |
|  | Describe the types of value based or incentive based plan designs that your organization routinely administers. | | | | | | Click here to enter text. |
|  | Describe any current program offerings your organization has for alternative services such as health/fitness promotions, health assessment/screening, wellness, etc., which will be providedto the State in support of its wellness and DM goals noted in this RFP | | | | | | Click here to enter text. |
| Blood pressure screening | | | | | | Click here to enter text. |
| Bone density tests | | | | | | Click here to enter text. |
| Cholesterol checking | | | | | | Click here to enter text. |
| Flu shots | | | | | | Click here to enter text. |
| Hearing tests | | | | | | Click here to enter text. |
| Mammograms | | | | | | Click here to enter text. |
| Alcohol and other substance abuse | | | | | | Click here to enter text. |
| Back care and injury prevention | | | | | | Click here to enter text. |
| Eating disorders | | | | | | Click here to enter text. |
| Fitness | | | | | | Click here to enter text. |
| HIV/AIDS prevention | | | | | | Click here to enter text. |
| Nutrition | | | | | | Click here to enter text. |
| Osteoporosis | | | | | | Click here to enter text. |
| Prenatal care | | | | | | Click here to enter text. |
| Smoking cessation | | | | | | Click here to enter text. |
| Stress management | | | | | | Click here to enter text. |
| Weight management | | | | | | Click here to enter text. |
| Other (Please specify.) | | | | | | Click here to enter text. |
| Please describe any other wellness programs offered by your organization. | | | | | | Click here to enter text. |
|  | Provide your normal staffing levels (per 10,000 lives) for the following categories: | | | | | |  |
| Wellness coaches | | | | | | Click here to enter text. |
| Dieticians | | | | | | Click here to enter text. |
| Clinical staff who are managing telephonic health coaching | | | | | | Click here to enter text. |
| Onsite biometric screening health events | | | | | | Click here to enter text. |
|  | Describe your use of dedicated wellness coaches, exercise physiologists, nutritionists, or other clinical staff to carry out wellness activities such as risk assessment, telephonic coaching interventions including lifestyle coaching, and education about treatment options and health education to empower members to manage their health in support of the plan indicated in this RFP. | | | | | | Click here to enter text. |
|  | Describe your ability to utilize retrospective episode-based payment (REBP)? | | | | | | Click here to enter text. |
|  | What conditions are you currently tracking with REBP? | | | | | | Click here to enter text. |
|  | Describe the role community health workers play in your delivery system. | | | | | | Click here to enter text. |
|  | Please specifically address the following and cite examples of success with current customers and how success was achieved and measured | | | | | |  |
| Tobacco use | | | | | | Click here to enter text. |
| Obesity and BMI | | | | | | Click here to enter text. |
| Stress management | | | | | | Click here to enter text. |
| High blood pressure | | | | | | Click here to enter text. |
| High cholesterol | | | | | | Click here to enter text. |
| Lack of exercise | | | | | | Click here to enter text. |
| Nutrition | | | | | | Click here to enter text. |
| Diabetes | | | | | | Click here to enter text. |
|  | Describe your overall approach to increasing member engagement. Describe the activities and support that you will provide the State in order to increase and sustain member engagement. | | | | | | Click here to enter text. |
|  | Define member “engagement” and “participation”: | | | | | | Click here to enter text. |
| How does the Offeror differentiate between the two? | | | | | | Click here to enter text. |
| Discuss how these definitions can vary by program, specifically addressing tobacco use, weight management, and nutrition programs. | | | | | | Click here to enter text. |
| Describe specific metrics and supporting materials (e.g., log books, tracking member progress, tracking member participation in web-based education modules, etc.) | | | | | | Click here to enter text. |
|  | Provide the following outcomes results, for each of the last two (2) years, for each wellness service: | | | | | |  |
| Overall and program specific engagement rates (defined as the percentage of Members who are contacted, consent to participate in the program, complete an assessment and schedule a follow-up) and realized ROI for the Telephonic health coaching program offered: | | | | | | Click here to enter text. |
| Member participation | | | | | | Click here to enter text. |
| ROI for program. | | | | | | Click here to enter text. |
| Provider satisfaction survey results. | | | | | | Click here to enter text. |
| Member satisfaction survey results. | | | | | | Click here to enter text. |
| Clinical measures or other measurable data outlining positive impact of the program. | | | | | | Click here to enter text. |
|  | Describe your current telephonic coaching programs for the following: | | | | | |  |
| Tobacco cessation | | | | | | Click here to enter text. |
| Weight management | | | | | | Click here to enter text. |
| Nutrition | | | | | | Click here to enter text. |
|  | Describe the strategies to reach members with the following situations. If outreach strategies vary by risk level or program, describe each of the different strategies and when each is utilized. | | | | | |  |
| Difficult or unable to reach | | | | | | Click here to enter text. |
| Contact data is incomplete or inaccurate | | | | | | Click here to enter text. |
| Little or no access to computers | | | | | | Click here to enter text. |
| Without a traditional office or those who work “in the field” | | | | | | Click here to enter text. |
| Only available after hours or on weekends. | | | | | | Click here to enter text. |
|  | Describe your educational resources utilized by health coaches to promote member learning and personal health responsibility. | | | | | |  |
| What are the qualifications (e.g., education, licenses, certifications, etc.) of your wellness promotion coaches? | | | | | | Click here to enter text. |
| What is the overall level of experience for the wellness coaches that will staff the State account? | | | | | | Click here to enter text. |
| What has been the turnover rate for your wellness coaching staff for the last for 2012? | | | | | | Click here to enter text. |
| Describe the ongoing training and continuing education opportunities and requirements for the wellness coaching staff. | | | | | | Click here to enter text. |
|  | Describe Offeror’s wellness outreach staff, including licensure requirements and the clinical training of the staff doing the outreach | | | | | | Click here to enter text. |
|  | What services and programs are provided by your online coaching program? | | | | | | Click here to enter text. |
|  | Does your online wellness coaching include access to live chat? | | | | | | Choose an item. |
| If yes, how do members access wellness coaches for live chat? | | | | | | Click here to enter text. |
|  | Describe your capability to provide member portal tools to track the following: | | | | | |  |
| Nutrition | | | | | | Click here to enter text. |
| Workouts | | | | | | Click here to enter text. |
| Fitness | | | | | | Click here to enter text. |
| Weight | | | | | | Click here to enter text. |
| Biometric data | | | | | | Click here to enter text. |
| Screenings and preventive service utilization | | | | | | Click here to enter text. |
| Biometric Screenings | | | | | | Click here to enter text. |
|  | Can your health promotion materials be customized, including the State logo as requested by the State? | | | | | | Choose an item. |
| Provide a sample of your health promotion materials. | | | | | | Please provide a sample of your health promotion materials and label as **“Response Attachment: Health Promotion Materials.”** |
|  | **Wellness Activity Monitoring / Tracking** | | | | | |  |
|  | Describe your ability to administer, track and report member participation in the State’s wellness programs. | | | | | | Click here to enter text. |
|  | Detail how you will track each member’s completion of individual health activities (i.e. Health Assessment, biometric screening, health education modules, the completion of other Wellness Program requirements, etc.): | | | | | |  |
| How are members notified they have completed individual Health Activities? How are members able to track and review their progress? What are your safeguards to protect the privacy of any personal or PHI included in these communications? | | | | | | Click here to enter text. |
| Are members able to print a confirmation of completion or report and if so, does this report specifically include the member’s name and date of activity completion? | | | | | | Click here to enter text. |
| How is completion and progress communicated to the State? What is the frequency of the communication? | | | | | | Click here to enter text. |
| What is the expected time from activity completion to your reporting completion to the member and to the State? | | | | | | Click here to enter text. |
| What is your ability to communicate activity completion to the provider community? | | | | | | Click here to enter text. |
|  | Would the State have access to “real-time” Wellness data? | | | | | | Choose an item. |
| If so, please describe what information would be available? | | | | | | Click here to enter text. |
|  | Describe additional recommendations, capabilities, materials, and tools/accessories you have to support the State’s objectives around member health promotion and personal responsibility. | | | | | | Click here to enter text. |
|  | Describe the capabilities currently utilized to coordinate quality data measures, such as HEDIS data from insurers/DM vendors/Data managers and to integrate such measures as treatment compliance and medication adherence with your programs quality measures. | | | | | | Click here to enter text. |
|  | What measures does the Offeror use to measure the quality improvements in the health profile of participants in each of your wellness programs? | | | | | | Click here to enter text. |
| **QUALITY** | | | | | | |  |
|  | | | | Please describe the Offeror's plan for the following Quality Management Programs: | | |  |
|  | | | | a.) Monitoring adherence to treatment guidelines and protocols. | | | Click here to enter text. |
|  | | | | b.) Ongoing maintenance and evaluation of the quality and appropriateness of care. | | | Click here to enter text. |
|  | | | | c.) Utilization management. | | | Click here to enter text. |
|  | | | | d.) Reviewing and approving credentials of patient care professionals. | | | Click here to enter text. |
|  | | | | e.) Clinical aspects of risk management. | | | Click here to enter text. |
|  | | | | f.) Infection control. | | | Click here to enter text. |
|  | | | | g.) Facility quality (i.e., location, cleanliness, parking, etc.). | | | Click here to enter text. |
|  | | | | Describe quality improvement initiatives, including results, undertaken in the last twelve months. | | | Click here to enter text. |
|  | | | | Describe specific examples of how your quality assurance program has led to improved care. | | | Click here to enter text. |
|  | | | Describe your approach to identifying medical services with high value outcomes (e.g. medication adherence for a chronic condition) and the process in place to track outcomes. How frequently are these services reviewed and additional high-value services identified? What incentives are currently in place to encourage participants’ use of these medical services? | | | | Click here to enter text. |
|  | | | Describe your approach to assessing the effectiveness of your Quality Management programs for both clinical services within the network and administrative operations and the health plan. | | | | Click here to enter text. |
|  | | | Describe the role and content of training programs for QM or CQI initiatives with health plan staff, providers and their administrative staffs. | | | | Click here to enter text. |
|  | | | Describe your programs to evaluate physicians and facilities for your high quality/performance network, specifically addressing the following: | | | |  |
|  | | | Criteria (e.g. quality, cost, efficiency) | | | | Click here to enter text. |
|  | | | How is quality information conveyed to plan enrollees? | | | | Click here to enter text. |
|  | | | What are your sources of quality and performance information on physicians and facilities? | | | | Click here to enter text. |
|  | | | Describe your mechanisms to monitor hospital quality at the general level and based on specific procedures. | | | | Click here to enter text. |
| **NETWORK MANAGEMENT** | | | | | | |  |
|  | | | Do you monitor waiting times for patients seeking appointments? | | | | Choose an item. |
| If yes, please provide the average number of working days between the date an appointment is made and the date of the actual visit for the following: | | | |  |
| non-emergency care | | | | Click here to enter text. |
| urgent care | | | | Click here to enter text. |
|  | | | Do you require members to select a Primary Care Physician? | | | | Choose an item. |
|  | | | Describe the referral process. Do all participants have to choose the same medical group/individual physician? Is there a limit on the number of changes allowed? | | | | Click here to enter text. |
|  | | | Do primary care physicians assist in arranging for services such as: home healthcare, hospice, skilled nursing, convalescent facilities, durable medical equipment and mental health/chemical dependency? Please explain. | | | | Click here to enter text. |
|  | | | Confirm that OBGYNs, pediatricians, or others can be selected as primary care physicians (PCPs). | | | | Choose an item. |
|  | | | Are there any financial incentives or disincentives to network providers that are tied to utilization goals, specialty referrals, quality of care outcomes or other performance results? If so, please explain. Describe any/all Risk Sharing arrangements. | | | | Click here to enter text. |
|  | | | Describe the nature of your network structure and provide an organization chart of your organization. Are any key personnel, including officers, medical directors and board members affiliated with any hospital, physician medical association, or other provider interest? Please submit an organization chart in Microsoft Word format and label as **"Response Attachment: Network Organization Chart.”** | | | | Click here to enter text. |
|  | | | Who conducts the provider credentialing process? Please indicate the qualifications of the person(s) or organization(s) responsible for conducting this review. | | | | Click here to enter text. |
|  | | | Are onsite visits conducted during the credentialing process? | | | | Choose an item. |
|  | | | During the physician selection/credentialing process, indicate which of the following are verified or reviewed: | | | |  |
| **During credentialing** | | | |  |
| Current valid license to practice | | | | Choose an item. |
| Admitting privileges at a contracting hospital | | | | Choose an item. |
| Valid DEA license | | | | Choose an item. |
| Board certification | | | | Choose an item. |
| Malpractice insurance | | | | Choose an item. |
| Restrictions on license or admitting privileges | | | | Choose an item. |
| Disciplinary actions by state or federal agencies | | | | Choose an item. |
| Felony convictions | | | | Choose an item. |
| **During Re-credentialing** | | | |  |
| Current valid license to practice | | | | Choose an item. |
| Admitting privileges at a contracting hospital | | | | Choose an item. |
| Valid DEA license | | | | Choose an item. |
| Board certification | | | | Choose an item. |
| Malpractice insurance | | | | Choose an item. |
| Restrictions on license or admitting privileges | | | | Choose an item. |
| Disciplinary actions by state or federal agencies | | | | Choose an item. |
| Felony convictions | | | | Choose an item. |
|  | | | Do you conduct onsite visits during a hospital credentialing process? | | | | Choose an item. |
|  | | | How often are network hospitals re-credentialed? | | | | Choose an item. |
| If "Other,” please specify. | | | | Click here to enter text. |
|  | | | How often are provider directories updated and distributed to plan members? | | | | Click here to enter text. |
|  | | | What formats are the provider directories available in (e.g. Internet)? | | | | Click here to enter text. |
|  | | | What assistance do you provide plan members if a network physician terminates his or her contract during the plan year? | | | | Click here to enter text. |
|  | | | How and when are members notified? | | | | Click here to enter text. |
|  | | | What happens to patients that are receiving ongoing treatment from that network physician? | | | | Click here to enter text. |
|  | | | Please provide responses to the following items that apply when an individual provider or group practice notifies your plan of an intent to terminate participation in your network: | | | |  |
| Describe what actions are taken by your plan to retain the individual provider or group practice in the network. | | | | Click here to enter text. |
| Describe what actions are taken to recruit individual providers or another group practice for the network in place of the terminated providers. | | | | Click here to enter text. |
| Describe what notices are sent to members concerning termination of their PCPs. | | | | Click here to enter text. |
| Describe what happens to members if they fail to notify the plan of the selection of another PCP. (Is the member auto-assigned to another PCP?) | | | | Click here to enter text. |
| Describe what happens to the coverage of the members if they fail to notify the plan of another PCP selection. Does the plan auto-assign another PCP? Is the member unable to obtain services? | | | | Click here to enter text. |
|  | | | Do you conduct provider satisfaction surveys? | | | | Choose an item. |
| If yes, please provide a copy of the results of your latest survey. | | | | Please submit a response and label as **“Response Attachment: Provider Satisfaction Survey.”** |
|  | | | What percentage of providers are satisfied with your plan? | | | | Click here to enter text. |
|  | | | List the top five most common complaints by your network providers: | | | |  |
| #1 Complaint | | | | Click here to enter text. |
| #2 Complaint | | | | Click here to enter text. |
| #3 Complaint | | | | Click here to enter text. |
| #4 Complaint | | | | Click here to enter text. |
| #5 Complaint | | | | Click here to enter text. |
|  | | | What is your annual physician turnover (on a gross basis, not net of additions) for the following? | | | |  |
| Family practice, general medicine and internal medicine combined | | | | Click here to enter text. |
| Other specialists | | | | Click here to enter text. |
|  | | | If you utilize a fee schedule, is it based on Medicare RBRVS? | | | | Choose an item. |
| If yes, please indicate the percentage of RBRVS it represents for primary codes and for secondary codes. | | | | Click here to enter text. |
| If no, what is the basis for your fee schedule? | | | | Click here to enter text. |
|  | | | How are acute care hospital providers in the network compensated for the medical services they provide? Provide the percentage of each. | | | |  |
| Discount off charges | | | | Click here to enter text. |
| DRG | | | | Click here to enter text. |
| Per diem | | | | Click here to enter text. |
| Other | | | | Click here to enter text. |
|  | | | How are network outpatient facilities such as surgicenters and laboratories reimbursed? Provide the percentage of each. | | | |  |
| Discounted fee | | | | Click here to enter text. |
| Bulk billing arrangement | | | | Click here to enter text. |
| Capitated arrangement | | | | Click here to enter text. |
| Other | | | | Click here to enter text. |
| If the basis is on a scheduled fee arrangement, please describe how the scheduled fees are derived. | | | | Click here to enter text. |
|  | | | Describe any other contractual relationships with any other providers such as physical therapists, orthotics suppliers, prosthetic suppliers, eye care and home healthcare providers. | | | | Click here to enter text. |
|  | | | Explain any contractual relationships with outpatient facilities such as imaging centers, surgical centers and laboratories. Are referrals restricted to contractual facilities only? What utilization controls are in place with these facilities to reduce the number of unnecessary services being performed? | | | | Click here to enter text. |
|  | | | Do the participating hospital agreements include hospital-based physicians (including radiologists, pathologists, anesthesiologists, emergency room physicians, neonatal physicians, etc.)? How would you identify non-participating providers? What is your process for informing participants about non-participating physicians when a participant is hospitalized? Please explain. | | | | Click here to enter text. |
|  | | | Describe the procedure in place for covering emergency care services performed by non-network facilities. | | | | Click here to enter text. |
|  | | | Using HEDIS' technical specifications, identify the percentage of contracted physicians who were board certified in 2012. | | | |  |
| PCPs | | | | Click here to enter text. |
| Specialists | | | | Click here to enter text. |
|  | | | Does your organization perform provider profiling or other quality measures to identify providers with patterns of over/under treatment to members? | | | |  |
| If yes, please give examples. | | | | Click here to enter text. |
|  | | | Have you successfully negotiated discounts on the costs of drugs dispensed in an inpatient setting? | | | | Choose an item. |
| If yes, describe your approach to pursuing these cost reductions on behalf of the State. | | | | Click here to enter text. |
|  | | | Do you prohibit network physicians from being direct owners, or having any financial involvement of outpatient facilities such as labs, surgicenters or imaging centers? | | | | Choose an item. |
| If not, is there any monitoring of self-referrals to physician owned outpatient facilities? | | | | Click here to enter text. |
|  | | | Do you have any ownership interest in or are you involved in the operations of any network outpatient facilities? | | | | Choose an item. |
| CASE MANAGEMENT | | | | | | |  |
|  | | | Please provide (as attachments) biographies of the medical management staff assigned to the State's account. | | | | Please submit response and label as **“Response Attachment: Medical Management Staff Biographies.”** |
|  | | | What credentials are required when hiring case management review staff? (Indicate all that apply.) | | | |  |
| RN license | | | | Choose an item. |
| Managed care background | | | | Choose an item. |
| Years clinical experience (please explain) | | | | Click here to enter text. |
| Other (please explain) | | | | Click here to enter text. |
|  | | | Describe the training programs and monitoring for your Case Management staff. | | | | Click here to enter text. |
|  | | | What is the average number of years of clinical expertise of the current case management staff? | | | | Click here to enter text. |
|  | | | Please describe your organization's philosophy of case management and the model under which it currently operates. Describe how the case management program integrates with other care management programs such as utilization review and quality management. | | | | Click here to enter text. |
|  | | | Do members have access to a nurse-line for counseling/support? | | | | Choose an item. |
| If yes, what hours is it available? | | | | Click here to enter text. |
|  | | | Describe any accreditations your Case Management program currently holds, or is in the process of pursuing. | | | | Click here to enter text. |
| **DISEASE MANAGEMENT** | | | | | | |  |
|  | | | If you offer a DM program, indicate the number of patients enrolled and the date the program started for the following clinical conditions: | | | |  |
| Asthma | | | | Click here to enter text. |
| Cancer | | | | Click here to enter text. |
| Cardiovascular disease | | | | Click here to enter text. |
| Congestive heart failure | | | | Click here to enter text. |
| Chronic obstructive pulmonary disease | | | | Click here to enter text. |
| Depression | | | | Click here to enter text. |
| Diabetes | | | | Click here to enter text. |
| Eating disorders | | | | Click here to enter text. |
| Hypertension | | | | Click here to enter text. |
| HIV/AIDS | | | | Click here to enter text. |
| Lower Back problems | | | | Click here to enter text. |
| Osteoporosis | | | | Click here to enter text. |
| Other (Please specify.) | | | | Click here to enter text. |
|  | | | Indicate whether each of the following items is used as a source of identifying program candidates. Select all that apply. | | | |  |
| Medical claims data | | | | Choose an item. |
| Prescription drug claims | | | | Choose an item. |
| Physician referrals | | | | Choose an item. |
| Case Management | | | | Choose an item. |
| Health Risk Appraisals | | | | Choose an item. |
| Other | | | | Click here to enter text. |
|  | | | Which of the following types of disease management interventions are utilized? Select all that apply. | | | |  |
| Patient education (mailings) | | | | Choose an item. |
| Telephone based health coaching | | | | Choose an item. |
| Online coaching/counseling | | | | Choose an item. |
| Physician education | | | | Choose an item. |
|  | | | Confirm that DM patients have access to nurse-line support services on a 24/7 basis using a toll-free number. | | | | Choose an item. |
|  | | | Are automated reminders sent on a routine basis to patients and/or physicians to encourage appropriate health actions? | | | | Choose an item. |
| If yes, through what medium (e.g., mail, telephonic, text) | | | | Click here to enter text. |
|  | | | Which of the following reporting types can be provided to the State on a quarterly basis with respect to the DM program? Select all that apply. | | | |  |
| Utilization (admission rate, days/1000, average length of stay, etc.) | | | | Choose an item. |
| Cost per patient per month | | | | Choose an item. |
| Treatment Compliance by chronic condition | | | | Choose an item. |
| Provider treatment profile | | | | Choose an item. |
| Quality of life/functional status | | | | Choose an item. |
| Return on investment | | | | Choose an item. |
| Risk stratification and progression | | | | Choose an item. |
| Clinical outcome improvements | | | | Choose an item. |
| **CENTERS OF EXCELLENCE / TIERED NETWORKS** | | | | | | |  |
|  | | | Do you have a network of Centers of Excellence/Tiered Networks? (If no, skip the remainder of this subsection.) | | | | Choose an item. |
|  | | | Please indicate high-risk and high-technology services coordinated with the Centers of Excellence. | | | |  |
| Bone Marrow transplants | | | | Choose an item. |
| Heart transplants | | | | Choose an item. |
| Lung transplants | | | | Choose an item. |
| Kidney transplants | | | | Choose an item. |
| Other transplants (please specify) | | | | Click here to enter text. |
| Burns | | | | Choose an item. |
| Cancer | | | | Choose an item. |
| HIV | | | | Choose an item. |
| Joint Replacement | | | | Choose an item. |
| Cardiac Surgery and Interventional Cardiac procedures | | | | Choose an item. |
| Other non-transplant procedures (please specify) | | | | Click here to enter text. |
| Disease Management | | | | Choose an item. |
| Wellness | | | | Choose an item. |
|  | | | Please complete the following table for your top five (5) Centers of Excellence by volume. | | | |  |
| 1. Center Type | | | | Click here to enter text. |
| Location | | | | Click here to enter text. |
| Date of Participation | | | | Click here to enter text. |
| 2. Center Type | | | | Click here to enter text. |
| Location | | | | Click here to enter text. |
| Date of Participation | | | | Click here to enter text. |
| 3. Center Type | | | | Click here to enter text. |
| Location | | | | Click here to enter text. |
| Date of Participation | | | | Click here to enter text. |
| 4. Center Type | | | | Click here to enter text. |
| Location | | | | Click here to enter text. |
| Date of Participation | | | | Click here to enter text. |
| 5. Center Type | | | | Click here to enter text. |
| Location | | | | Click here to enter text. |
| Date of Participation | | | | Click here to enter text. |
|  | | | How are these members’ cases managed? (i.e. Are they handled in a unit separate from other catastrophic cases?) | | | | Click here to enter text. |
|  | | | What are the financial arrangements for the Centers of Excellence? | | | | Choose an item. |
| If "other,” please explain. | | | | Click here to enter text. |
|  | | | Will travel or companion costs be covered? | | | | Choose an item. |
| If yes, please specify any limits. | | | | Click here to enter text. |
|  | | | Will there be any changes in the coming year to your current Centers of Excellence arrangements? | | | | Choose an item. |
| If yes, please specify expected changes. | | | | Click here to enter text. |
|  | | | What capabilities does the Offeror provide to participants to measure improvements in their health risk profile in each of the programs that you are proposing? | | | | Click here to enter text. |
|  | | | What support are you providing patients to alert them to possible hospital safety issues while they are in the process of making medical decisions? | | | | Click here to enter text. |
|  | | | What efforts have you made to develop “tiered networks” by identifying high quality and high efficiency hospitals, educating referring physicians to quality variations, and using the information to guide patients to the high quality, better outcomes hospitals? | | | | Click here to enter text. |
|  | | | How would you collaborate with the State to develop an approach to identify and differentiate hospitals by quality, patient safety, and use that information to support a referral process that assured that plan participants were referred to the highest quality hospitals based on the procedure that each person needed? | | | | Click here to enter text. |
|  | | | What impact do you expect the tiered networks will have on trend in 2013? If the State chooses to offer tiered-networks are you willing to guarantee the percentage trend for the State’s population under a tiered network? | | | | Click here to enter text. |
|  | | | Describe the types of programs you have to incent desired provider practices. | | | |  |
| Describe any outreach programs directly to the provider community, relationships with TPAs/provider networks and medical management vendors. | | | | Click here to enter text. |
| Describe the Offeror’s experience in developing such programs and relationships to support specific customer strategic initiatives. | | | | Click here to enter text. |
|  | | | Explain in detail how you identify and reward high performing physicians. | | | | Click here to enter text. |
|  | | | Do you currently rank providers based on quality and/or cost? | | | | Choose an item. |
| If yes, please describe how you determine the specific quality ranking of each provider and facility, including all criteria and specifics regarding the formula you utilize. | | | | Click here to enter text. |
|  | | | How often is each provider’s quality ranking revisited? | | | | Click here to enter text. |
|  | | | Provide a brief overview of your high quality or high performance network capabilities. | | | |  |
| Provide a listing of the markets where the network is currently available, including plans for future expansion. | | | | Click here to enter text. |
| What types of medical providers/facilities are in your high performance network? | | | | Click here to enter text. |
| Provide a detailed list of physician subspecialties that are included in your high performance network. | | | | Click here to enter text. |
| How do you engage and drive consumers to use high quality, high performing physicians and facilities in your high performance network? | | | | Click here to enter text. |
| How is quality and performance information shared with physicians? | | | | Click here to enter text. |
| Please describe any additional programs (excluding a tiered network plan design) that you utilize to provide incentives to members to select the high performing providers (providers with the best combination of quality and cost). | | | | Click here to enter text. |
| **MEMBER SERVICES** | | | | | | |  |
|  | | | | | Describe the structure, number of representatives, qualifications and average years of experience of the member service unit that will be assigned to the State. | |  |
| Structure | | Click here to enter text. |
| Number of representatives | | Click here to enter text. |
| Qualifications | | Click here to enter text. |
| Average years of experience | | Click here to enter text. |
|  | | | | | What is the most recent annual turnover rate of the member services unit that will be assigned to the State? | | Click here to enter text. |
|  | | | | | Please describe the training of a member service representative. | | Click here to enter text. |
|  | | | | | Can your member services unit support non-English speaking members? | | Choose an item. |
| If yes, please specify languages. | | Click here to enter text. |
|  | | | | | What is the average speed to answer in seconds? | | Click here to enter text. |
|  | | | | | What is the percent call abandonment rate? | | Click here to enter text. |
|  | | | | | What percentage of employee calls is recorded? | | Click here to enter text. |
|  | | | | | Identify which of the following functions are automatically tracked and reported by the system. Select all that apply. | |  |
| Call abandonment rate | | Choose an item. |
| Length of call | | Choose an item. |
| Number of calls taken | | Choose an item. |
| Online call recording | | Choose an item. |
| Speed of call response | | Choose an item. |
| Type of call/complaint | | Choose an item. |
|  | | | | | Does your system utilize an Interactive Voice Response (IVR) system? | | Choose an item. |
|  | | | | | Does your system allow members to access information over the IVR? | | Choose an item. |
| If yes, please specify the type of information accessible over the IVR. | | Click here to enter text. |
|  | | | | | Do you have a correspondence tracking system to log in, assign and track correspondence? | | Choose an item. |
|  | | | | | What is the average ID card turnaround (number of days between employer reporting a new member and plan mailing ID card)? | | Click here to enter text. |
|  | | | | | What processes do you use to identify potential subrogation claims? | | Click here to enter text. |
|  | | | | | Do you subcontract for mental/health/substance abuse care? | | Choose an item. |
| If "Yes,” please identify the organization and provide a detailed description of their program and the organization's relationship to the subcontractor (e.g. subsidiary). | | Click here to enter text. |
|  | | | | | Provide a detailed description of the mental health/substance abuse access and triage process. | | Click here to enter text. |
|  | | | | | Describe your mental health/substance abuse utilization review and management functions. | | Click here to enter text. |
|  | | | | | Describe your mental health/substance abuse case management service from structural and functional perspectives and how these lend to long-term stability of an employee. | | Click here to enter text. |
| **PLAN ADMINISTRATION - ELIGIBILITY** | | | | | | |  |
|  | | | | | The State of Maryland would like direct access to the Offeror's eligibility systems for review and input purposes. Please describe your ability to provide the State with direct access to the eligibility system only. | | Click here to enter text. |
|  | | | | | Please describe your eligibility system that will be used to keep track of the State's eligibility files, including: | | Click here to enter text. |
| System "trade name" | | Click here to enter text. |
| System organization | | Click here to enter text. |
| Date eligibility system was put in place | | Click here to enter text. |
| Number of system upgrades since inception | | Click here to enter text. |
|  | | | | | Is eligibility processing real-time with the claim system? | | Choose an item. |
| If no, what is the delay time? | | Click here to enter text. |
|  | | | | | Briefly describe your process for correcting data in the event of a data tape which contains "bad data.” | | Click here to enter text. |
| **REPORTING** | | | | | | |  |
|  | | | | | What limitations do you have with customizing standard reports? Please explain. | | Click here to enter text. |
|  | | | | | The State requires online access to standard reports; describe how you will make your reports available online. | | Click here to enter text. |
|  | | | | | Describe your organization’s ability to provide the following items at a minimum in your reports, including your ability to report member detail to the State. | |  |
| Billed amount | | Click here to enter text. |
| Paid amount | | Click here to enter text. |
| Network savings | | Click here to enter text. |
| Non-Medicare COB savings | | Click here to enter text. |
| Medicare COB savings | | Click here to enter text. |
| Negotiated savings | | Click here to enter text. |
|  | | | | | What clinical or financial reports, would be provided to the State in order to help manage benefit costs? | | Click here to enter text. |
|  | | | | | Please include sample financial reports. | | Please include sample reports and label as **“ Response Attachment: Sample Financial Reports.”** |
|  | | | | | Describe how your organization will coordinate the requirements of worksite biometric screening, scheduling, and reporting. | | Click here to enter text. |
|  | | | | | What type of reporting will you provide to the State regarding your high quality, high performance medical provider? | | Click here to enter text. |
|  | | | | | Would the State have access to “real-time” data regarding employees' health and wellness activities being tracked by your organization? | | Choose an item. |
|  | | | | | Do you have the ability to notify members of completed Healthy Activities? | | Choose an item. |
| Please explain. | | Click here to enter text. |
|  | | | | | How are members able to track and review their progress? | | Click here to enter text. |
|  | | | | | What are your safeguards to protect the privacy of any personal or PHI included in these communications? Please explain. | | Click here to enter text. |
|  | | | | | Will members be able to print a confirmation or report of required and completed activities? | | Choose an item. |
| If so will the report specify the date of activity completion? | | Choose an item. |
|  | | | | | Which of the following reporting types can be provided to the State on a quarterly basis with respect to the DM program? Select all that apply. | |  |
| Utilization (admission rate, days/1000, average length of stay, etc.) | | Choose an item. |
| Risk stratification by condition | | Choose an item. |
| Engagement rates (including numbers & percentages) by condition | | Choose an item. |
| Telephonic reach rates by condition | | Choose an item. |
| Program completion rates by condition | | Choose an item. |
| Program dropout rates by condition | | Choose an item. |
| Cost per patient per month | | Choose an item. |
| Treatment compliance | | Choose an item. |
| Provider treatment profile | | Choose an item. |
| Return on Investment | | Choose an item. |
|  | | | | | Clinical outcome improvements | | Choose an item. |
| **CLAIMS ADMINISTRATION** | | | | | | |  |
|  | | | | | How many claims processors will be assigned to handle the State's account? | | Click here to enter text. |
|  | | | | | Do customer service representatives (CSRs) have authority to approve claims? | | Choose an item. |
|  | | | | | What access do CSRs have to the medical director? | | Click here to enter text. |
|  | | | | | What is the most recent annual turnover rate for your claims processing staff in your proposed location? | | Choose an item. |
|  | | | | | Describe the initial and ongoing training programs for the claim administration team (e.g. claim processors, supervisors and other management staff). | | Click here to enter text. |
|  | | | | | What is the average amount of time claims staff spend in annual ongoing training? | | Choose an item. |
|  | | | | | What is the procedure to handle emergencies or non-office hour admission requests? | | Click here to enter text. |
|  | | | | | Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. | | Click here to enter text. |
|  | | | | | How does your system automatically identify and edit claims for bundling and unbundling? | | Click here to enter text. |
|  | | | | | Confirm that you will provide advance notice to the State prior to implementing any changes in covered services. | | Choose an item. |
|  | | | | | What is your preferred process for handling exceptions and payment of claims outside the stated plan provisions? | | Click here to enter text. |
|  | | | | | When and under what circumstances are claims pended? | | Click here to enter text. |
| Does a pending notice go into the system? | | Choose an item. |
| Is there an automatic follow-up? | | Choose an item. |
| What is the frequency of the follow-up? | | Click here to enter text. |
| How many follow-ups are performed? | | Click here to enter text. |
|  | | | | | Describe your administrative requirements with respect to claims filed directly by members. | | Click here to enter text. |
|  | | | | | How do you adjust for overpayments or duplicate payments? | | Click here to enter text. |
|  | | | | | How often and in what manner is COB information verified? | | Click here to enter text. |
|  | | | | | What is your percentage of claims dollars recovered or avoided through effective coordination of benefits for last year? (Total COB savings/Total claim dollars paid) | | Click here to enter text. |
|  | | | | | If you receive information that confirms other coverage, would you review and adjust prior claims in which services incurred are within the period when other COB coverage was available? | | Choose an item. |
| If yes, please describe your process. | | Click here to enter text. |
|  | | | | | Provide your claims processing standards for claim adjudication financial accuracy versus actual for 2012. | | Click here to enter text. |
|  | | | | | Provide your claims timeliness standards for claim adjudication versus actual for 2012. | | Click here to enter text. |
|  | | | | | What percent of claims are automatically adjudicated? | | Click here to enter text. |
|  | | | | | What percent of hospital claims are currently received by electronic submission? | | Click here to enter text. |
|  | | | | | What percent of professional claims are currently received by electronic submission? | | Click here to enter text. |
|  | | | | | Describe the procedure for submitting and processing out-of-country medical claims. | | Click here to enter text. |
|  | | | | | Describe in detail your standard claims appeal process. | | Click here to enter text. |
|  | | | | | Describe your policy and procedures for auditing hospital bills/claims. | | Click here to enter text. |
|  | | | | | How frequently are internal audits performed? | | Choose an item. |
| If "Other,” please describe. | | Click here to enter text. |
|  | | | | | Overall, what percent of claims are subject to internal audit? | | Click here to enter text. |
|  | | | | | What is the typical audit size? | | Click here to enter text. |
|  | | | | | Describe your system protocols for detecting fraudulent claims both inside and outside of the U.S. | | Click here to enter text. |
| **IMPLEMENTATION PROGRAM / TRANSITION** | | | | | | |  |
|  | | | | | | Please discuss your procedures and processes for handling the following during the transition period: |  |
| Transition of care | Click here to enter text. |
| Employee communications regarding change in administrators | Click here to enter text. |
|  | | | | | | **Implementation Plan** |  |
| Name of the person with overall responsibility for planning, supervising and implementing the program for the State. | Click here to enter text. |
| Title | Click here to enter text. |
| What other duties, if any, will this person have during implementation? Please include the number and size of other accounts for which this person will be responsible during the same time period. | Click here to enter text. |
| What percentage of this person's time will be devoted to the State during the implementation process? | Click here to enter text. |
| Please provide an organizational chart identifying the names, area of expertise, functions, and reporting relationships of key people directly responsible for implementing the State of Maryland account. In addition, resumes of these individuals should be included. | Please include Organizational Chart and Resumes of Implementation Team and label as **“Response Attachment:**  **Implementation Team.”** |
|  | | | | | | Provide a detailed implementation plan that clearly demonstrates the Offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on January 1, 2015. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (January 1, 2015). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. | Please include Implementation Plan and label as “**Response Attachment:**  **Implementation Plan.”** |
|  | | | | | | Do you anticipate any major transition issues during implementation? | Choose an item. |
| If yes, please describe. | Click here to enter text. |
|  | | | | | | **Account Management Team** |  |
| Name of the person with overall responsibility for planning, supervising and performing account services for the State. | Click here to enter text. |
| Title | Click here to enter text. |
| What other duties, if any, does this person have? Please include the number and size of other accounts for which this person is responsible. | Click here to enter text. |
| What percentage of this person's time will be devoted to the State? | Click here to enter text. |
|  | | | | | | Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the State. It should also document how many account executives and group services representatives will work full-time on the State's account and how many will work part-time on the State's account. Please also provide resumes for key personnel. | Please include Organizational Chart and Resumes of Account Management Team and label as **“Response Attachment:**  **Account Management Team Organizational Chart and Resumes.”** |
|  | | | | | | Describe account management support, including the mechanisms and processes in place to allow Employee Benefits Division personnel to communicate with account service representatives, hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available online. The Employee Benefits Division requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract.  Please submit the Management Plan in Microsoft Word format and label as **"Response Attachment: Account Management Plan”** | Please include the Offeror's description of account management support in a Microsoft Word document and label as **“Response Attachment:**  **Account Management Plan.”** |
| **IT SYSTEMS** | | | | | | |  |
|  | | | Please describe the systems that will be used to process the State's billing, enrollment and claims data. | | | |  |
| **Claims Administration** | | | |  |
| System "trade name" | | | | Click here to enter text. |
| System organization | | | | Click here to enter text. |
| Date system put in place | | | | Click here to enter text. |
| Number of system upgrades since inception | | | | Click here to enter text. |
| **Billing System** | | | |  |
| System "trade name" | | | | Click here to enter text. |
| System organization | | | | Click here to enter text. |
| Date system put in place | | | | Click here to enter text. |
| Number of system upgrades since inception | | | | Click here to enter text. |
| **Member Services** | | | |  |
| System "trade name" | | | | Click here to enter text. |
| System organization | | | | Click here to enter text. |
| Date system put in place | | | | Click here to enter text. |
| Number of system upgrades since inception | | | | Click here to enter text. |
| **Eligibility/Enrollment System** | | | |  |
| System "trade name" | | | | Click here to enter text. |
| System organization | | | | Click here to enter text. |
| Date system put in place | | | | Click here to enter text. |
| Number of system upgrades since inception | | | | Click here to enter text. |
|  | | | Are there any electronic system changes planned for the contract term? | | | | Choose an item. |
| If so, please describe. | | | | Click here to enter text. |
|  | | | What are your online interface capabilities between your organization's membership services department and each of the following units? | | | |  |
| Care Management unit | | | | Click here to enter text. |
| Claims processing unit | | | | Click here to enter text. |
| Eligibility administration | | | | Click here to enter text. |
| Fraud unit | | | | Click here to enter text. |
| Provider relations | | | | Click here to enter text. |
| Quality improvement | | | | Click here to enter text. |
|  | | | Describe how your claim system interfaces with your utilization review program. | | | | Click here to enter text. |
|  | | | Indicate whether each of the following functions below is an automated process or manual process with respect to the claims system. | | | |  |
| Application of contract provider reimbursements | | | | Choose an item. |
| Application of plan provisions (e.g., deductible, out-of-pocket maximums, benefit maximums, etc.) | | | | Choose an item. |
| Effective dates of coverage | | | | Choose an item. |
| Dependent coverage | | | | Choose an item. |
| Third party liability calculations/monitoring, including automobile injuries and subrogation | | | | Choose an item. |
| Automatic diary/follow-up | | | | Choose an item. |
| COB recovery amounts | | | | Choose an item. |
| Identification of network providers | | | | Choose an item. |
| Identification of potential duplicate submissions | | | | Choose an item. |
| Identification of unbundling and up-coding/coding fragmentation | | | | Choose an item. |
| Identification of potential case management opportunities | | | | Choose an item. |
| Medicare coordination | | | | Choose an item. |
| Online eligibility maintenance and verification process | | | | Choose an item. |
| Payment authority limits | | | | Choose an item. |
| Pre-certification/concurrent review verification | | | | Choose an item. |
| Reasonable and customary allowances | | | | Choose an item. |
| Retroactive adjustments | | | | Choose an item. |
| System tracking of pending/suspended claims | | | | Choose an item. |
| Indicate which of the following internal audits, logic, and controls that currently exist within your organization. (Select all that apply.) | | | | Choose an item. |
| Patient's gender or age is inconsistent with the procedure code | | | | Choose an item. |
| Diagnosis code and procedure code are inconsistent | | | | Choose an item. |
| Patient's gender or age is inconsistent with the diagnosis code | | | | Choose an item. |
| Valid date of service | | | | Choose an item. |
| Valid procedure code | | | | Choose an item. |
| Valid diagnosis code | | | | Choose an item. |
| Pre-certification is necessary for claim payment | | | | Choose an item. |
| Appropriateness review is necessary for procedure | | | | Choose an item. |
| Service is not usually considered medically necessary | | | | Choose an item. |
| Claim is a possible candidate for audit | | | | Choose an item. |
| Claimant is a candidate for case management | | | | Choose an item. |
| Client-specific ICD10 and CPT "flags" | | | | Choose an item. |
|  | | | Does your claim system maintain the Social Security numbers, DOB, and names of covered dependents, as well as members? | | | | Choose an item. |
|  | | | Describe how your system handles eligibility changes for members and dependents (including COB information). | | | | Click here to enter text. |
|  | | | Is there a contingency plan(s), procedure, and system in place to provide backup service in the event of strike, natural disaster or backlog? | | | | Choose an item. |
| If yes, please describe. | | | | Click here to enter text. |
|  | | | How often are the systems backup and disaster recovery systems tested? | | | | Click here to enter text. |
|  | | | When were the systems last tested and what were the results? | | | | Click here to enter text. |
|  | | | What system down time have you experienced during the most recent 12 months? | | | | Click here to enter text. |
|  | | | How long are records maintained? | | | | Click here to enter text. |
|  | | | How quickly can the State's services be replaced in the event of permanent disaster to both the hardware and software? | | | | Click here to enter text. |
| **ELECTRONIC COMMERCE** | | | | | | |  |
|  | | | | | | Provide a list of all services that are available through your website at both the plan level and the member level. | Click here to enter text. |
|  | | | | | | Elaborate on the tools and ways members can communicate with the carrier, including use of technology and social media. | Click here to enter text. |
|  | | | | | | What percentage of your network providers utilize telemedicine? Describe. | Click here to enter text. |
|  | | | | | | How will you use health information technology to help people live healthier lives? | Click here to enter text. |
|  | | | | | | Have you implemented, or do you plan to implement within the next 12 months, an Internet or other electronic connection available to providers for the following? (Select all that apply.) |  |
| Medical records | Choose an item. |
| Remote consultation on cases | Choose an item. |
| A physician chat line | Choose an item. |
| Other applications | Choose an item. |
|  | | | | | | Do you have a mapping facility that allows members to identify providers close to their location? | Choose an item. |
|  | | | | | | Briefly describe your web based wellness capabilities and functionality. | Click here to enter text. |
|  | | | | | | Describe the following tools and services available to members via the web portal, including your ability to customize for the State. Mark “n/a” if not available. |  |
| Health Assessment (HA) – provide an example of a current HA | Click here to enter text. |
| Wellness tools and trackers - provide a list of tools and trackers available to the State | Click here to enter text. |
| Health promotion and health education tools - provide a list and sample materials | Click here to enter text. |
| Any other web tools to support Wellness activities. | Click here to enter text. |
| Is a paper-based alternative available for members without internet access? | Choose an item. |
|  | | | | | | Describe your plan for handling periods of expected high rates of utilization of the website such as open enrollments or media campaigns. | Click here to enter text. |
|  | | | | | | Describe how your organization will develop content for member learning as well as specialized newsletters for the State website. | Click here to enter text. |
|  | | | | | | Describe your organization’s experience in managing web based educational media for clients, including the number of clients over 200,000 members, technology used, and content developed. Describe your ability to support emerging technologies, in particular mobile applications. | Click here to enter text. |
| **SUBCONTRACTORS** | | | | | | |  |
|  | | | | | | Provide a complete listing of all services which are subcontracted and the subcontractor used. (Please complete **"FA2 EPO-SF Attachment S-13: Subcontractor Questionnaire"** for each of the subcontractors listed here.) | Click here to enter text. |

## FA2 Attachment S-11a: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
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|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |
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## FA2 Attachment S-11b: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
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|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

## FA2 Attachment S-11c: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
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|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

## FA2 Attachment S-11d: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
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|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

## FA2 Attachment S-11e: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

## FA2 Attachment S-11f: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"FA2 Attachment S-13: Subcontractors Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

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**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Question** | | **Offeror’s Response** |
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|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

## FA2 Attachment S-12: Performance Guarantees Amendment 4

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

Offeror will report results on all performance measurements quarterly per the requirements of the Report Card and separately for each plan type. Performance results will also be audited annually by the State's contract auditor.

**NOTE:** It is critical to the success of the State's programs that services be maintained in accordance with the schedules agreed upon by the State. It is also critical to the success of the State's programs that the Contractor operates in an extremely reliable manner. It would be impracticable and extremely difficult to fix the actual damage sustained by the State in the event of delays or failures in claims administration, service, reporting, and attendance of Contractor personnel on scheduled work and provision of services to the citizens of the State. The State and the Contractor, therefore, presume that in the event of certain delay(s) or failure(s), the amount of damage which will be sustained from the delay or failure will be the amount set forth below, and the Contractor agrees that in the event of any such failure of performance, the Contractor shall pay such amount as liquidated damages and not as a penalty. The State, at its option for amount due the State as liquidated damages, may deduct such from any money payable to the Contractor or may bill the Contractor as a separate item.

**NOTE:** Items in the response column with the words **"Willing to Comply”** contain a drop down list of options including Yes or No. Please select a response from those options as applicable. All "No" responses must be addressed in **"FA2 Attachment S-2: Explanations and Deviations.”**

|  | **Performance Indicator** | **Standard/Goal** | **Reporting Measurement**  (subject to audit by State and/or contract auditors) | **Liquidated Damages\*** | **Willing to Comply** |
| --- | --- | --- | --- | --- | --- |
|  | Telephone Call Availability:  Measurements must be State-specific or for only the service center handling the State account. | 98% of telephone calls are answered by a live service representative (with knowledge of State of Maryland account) within 20 seconds. The representative must have knowledge of the State of Maryland and be able to address the member's issue/question.  Time over which standard is measured: Quarter | Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Offeror).  Frequency of report: Quarterly | 0.10% of fees for each percentage point, or fraction thereof, below 98%. | Choose an item. |
|  | Telephone Call Abandonment Rate  Measurements must be State-specific or for only the service center handling the State account. | Abandonment rate of less than 3%.  Time over which standard is measured: Quarter. | Quarterly Plan Performance Measurement Report Care (Report Card to be submitted by the Offeror).  Frequency of report: Quarterly | 0.10% of fees for each percentage point, or fraction thereof, over 3%. | Choose an item. |
|  | Processing of Enrollment Eligibility Update Information | Plan will process electronic interchange of State enrollment information by 5:00 PM of the second business day after receipt. If tape is received after 12 noon, record as having been received as of the next business day.  Time over which standard is measured: Quarter | Report Card - Vendor to maintain log for review by the State's contract auditor.  Frequency of report: Quarterly | 0.20% of fees for each calendar day, or portion thereof, of delay | Choose an item. |
|  | Accuracy of Processing Enrollment Eligibility Information | Plan will process electronic interchange of State enrollment with at least 98% accuracy.  Time over which standard is measured: Quarter | Report Card - Vendor to maintain log and system generated reports for review by the State's contract auditor.  Frequency of report: Quarterly | 0.20% of fees for each percentage point, or fraction thereof, under 98%. | Choose an item. |
|  | Contractor attendance at State-sponsored Open Enrollment meetings. | Attendance by plan representatives trained on State of Maryland plan benefits at 100% of meetings scheduled by the State, for 100% of the meeting's duration.  Representative must arrive early enough to have their table set-up prior to meeting start time. Display must be organized and include appropriate covering of table. Representative must have detailed plan knowledge, interact with members, and exhibit professional appearance and behavior.  Time over which standard is measured: Annual | Sign-in sheets at meetings or minutes of State meetings.  Frequency of report: Annually | 0.05% of fees for each scheduled meeting date that vendor fails to attend. | Choose an item. |
|  | Delivery of Quarterly Utilization, Case Management, Wellness Activity and Disease Management Data Reports to State's Consultant. | Delivery to the State by 6:00 pm on the following dates\*\*: | Documentation of receipt by State's Benefit Consultant, i.e., date-stamp of mailing package for data information and verification of completeness. (All required fields must be filled in correctly.)  Frequency of report: Quarterly | 0.20% of fees for each week, or fraction thereof, the data report is not received or is incomplete. | Choose an item. |
| First Quarter  (Jan – Mar) **Due: May 1st** |
| Second Quarter  (Apr – Jun) **Due: August 1st** |
| Third Quarter  (Jul – Sep) **Due: November 1st** |
| Fourth Quarter  (Oct – Dec) **Due: February 1st** |
|  | Delivery of Rate Renewal Reports | Delivery to the State and to the State's actuarial consultant of reports required for annual rate renewal process by 6:00 pm March 1 of each contract year. At a minimum, the renewal reports must include (but not be limited to) the following: | Date-stamp of receipt by the State and verification of completeness of required documentation.  Frequency of report: Annually | 0.20% of fees for each week, or fraction thereof, that the rate renewal reports are not received or are incomplete. | Choose an item. |
| Projection of incurred claim costs for renewal year. | Choose an item. |
| Estimate of IBNR reserves at end of current year; including the most recent 36 months of incurred/paid triangular reports. | Choose an item. |
| Complete documentation of the methodology and assumptions utilized to develop the projected costs. | Choose an item. |
| Disclosure of supporting data used in the calculations, including monthly paid claims and enrollment, large claims analysis, trend analysis, demographic analysis, etc. | Choose an item. |
|  | Substantiation of any proposed increase in fixed costs via a thorough analysis of activities and costs covered by those fees. |  |  | Choose an item. |
|  | Explanations for any unusual trend results (high relative to the market, low relative to the market). |  |  | Choose an item. |
|  | Claims Standards: Financial Accuracy Measures the gross dollars paid incorrectly (overpayments) plus underpayments) subtracted from total paid claim dollars, divided by total paid claim dollars within the audit sample | 99% of claim dollars processed accurately. | Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. | 2.00% of fees if below 99% but at least 97%. 4.00% of fees if less than 97%. | Choose an item. |
|  | Claims Standards: Payment Accuracy Measures the number of incorrect drafts of payments made on behalf of the State, subtracted from the total draft or payments transactions, divided by the total draft or payment transactions. | 97% of claims w/ benefit payments are processed accurately. | Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. | 2.00% of fees if below 97% but at least 95%. 4.00% of fees if less than 95%. | Choose an item. |
|  | Claims Standards: Processing Time | 95% of all claims are adjudicated within 10 business days; and 98% of all claims are adjudicated within 20 business days. | Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. | 3.00% of fees if performance is less than standards. | Choose an item. |
|  | Provision of claims and eligibility data to third party vendors. | Delivery of agreed-upon claims and eligibility data to third party vendors in the format and frequency required by the applicable vendor(s). | Date-stamp of receipt by the third-party vendor and verification of completeness of required documentation. | One-half of a Unit Point for each calendar day the data is not received or is incomplete.[[1]](#footnote-1) | Choose an item. |
|  | Annual Hospital Records Claims Audit | Conduct hospital records (including clinical and billing issues) audits for every admission with paid claims in excess of $25,000, subject to a minimum of 2% of all hospital claims. Audits are to be conducted on-site to ensure accuracy of billed charges in relation to the clinical services delivered. | Provide quarterly reporting of the number of audits conducted, the amount of recoveries to the State. | 3.00% of fees if performance is less than standards. | Choose an item. |
|  | Employee Satisfaction – Satisfactory | Satisfactory or better results from an annual State-conducted Participant satisfaction survey.  Time over which standard is measured: Annual  90% of members indicate satisfied or very satisfied  Time over which standard is measured: Quarter | Survey results  Frequency of report: Annually | 1% of fees if performance is less than standards | Choose an item. |
|  | Pre-admission outreach call | 95% of members meeting criteria for receiving a preadmission outreach call will receive a call. | Documentation of outbound call. | 1.00% of fees if performance is less than standards. | Choose an item. |
|  | Disease Management Outreach Call | 95% of members meeting criteria for receiving an outreach call (and have a telephone number in the eligibility system) will have documentation of all outreach call attempts. | Documentation of attempted member contact. | 1.50% of fees if performance is less than standards. | Choose an item. |
|  | Complex Case Management Program | 95% of member meeting criteria for participation in the complex case management program will have document of attempted member and physician contact. | Documentation of attempted contacts. | 1.00% of fees if performance is less than standards. | Choose an item. |
|  | Provision of Draft Plan Documents  Certificate/ Evidence of Coverage for Self-Insured plans and Summary Plan Description for the fully-insured plans | Draft Plan Document  (Certificate/Evidence of Coverage or Summary Plan Description as appropriate by plan) including all required updates is provided to the State at least three months prior to the first day of the plan year. For example if the plan year effective date January 1st, the vendor must provide the State the draft by October 1st of the prior year. | Receipt date as documented by vendor and confirmed by State | $500 per day for the first three calendar days that the draft document is not received.  $1,000 per calendar day for each day the draft document is not received for the fourth calendar day and beyond. | Choose an item. |
|  | Provision of Final Plan Documents | Final Plan Document  (Certificate/Evidence of Coverage or Summary Plan Description as appropriate by plan) including all of the required edits and in the format ready for posting to State intranet is returned to the State within 30 calendar days of the carrier’s receipt of the State’s edits. | Receipt date as documented by vendor and confirmed by State | $500 per day for each calendar day the draft plan document is not received for the first 3 calendar days.  $1,000 per day for each day the draft plan document is not received for the fourth calendar day and beyond. | Choose an item. |
|  | DBM Claims Eligibility Audits | Plan will provide response files to Department’s Audit Unit within 14 business days of receipt of error report from Department. | Receipt date as documented by vendor and confirmed by State | $500 per day for each calendar day the draft plan document is not received for the first 3 calendar days.  $1,000 per day for each day the draft plan document is not received for the fourth calendar day and beyond. | Choose an item. |

\*Determination of results and any applicable damages will be conducted by the State's contract auditor.

\*\* If due date falls on a state / vendor holiday or a weekend, Report Card and reports are due next business day.

## FA2 Attachment S-13: Performance Metrics

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

Contractor will report results on all performance metrics annually for each plan type. Performance results may also be audited annually by the State's contract auditor.

1. Shared savings will be based on the 100 point performance metric scale. Each metric has a target goal based on NCQA guidelines. The goal of the shared savings program is to partner with the Contractor to improve the health risk profile of the covered population and close the gap from the baseline clinical metrics to the goal year over year. For example, using the first item under Diabetes the Contract Year (CY) 2 goal is to close the gap by 50% of the target or (45% = 50% of the target of the 90% five year target). Then in CY3 increase to 65% of the target or 59%; CY4 increase to 80% of the target or 72%, CY5 increase to 90% of the target or 81% and CY6 increase to 100% of target of 90% of the population diagnosed with the diabetes have reached the target level of treatment compliance/improvement. The term Participants means the number of State Health Plan participant/members enrolled in the Contractor’s plan identified in 2015 via biometric and claims data as having the specific chronic condition indicated. The vendor’s baseline for each metric will be determined by self-reported 2015 data. Carriers will achieve points based on increases in these metrics for CY2, CY3, CY4, CY5, and CY6. If at any time a vendor’s compliance level is higher than the target metric the vendor’s compliance level should be maintained, at a minimum. Each vendor will be required to reach the compliance level each year beginning CY2. The target levels and available points are as follows:

| **Clinical Compliance Metric** | **Available Points** | **Target Level** | **Contract Year (CY) Compliance\*** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CY2 | CY3 | CY4 | CY5 | CY6 |
| **Diabetes** |  |  |  |  |  |  |  |
| Participant(s) that had 2 Hb A1c tests in last 12 reported months | 3 | 90% | 45% | 59% | 72% | 81% | 90% |
| Increase participants with HbA1c tests of < 8.0% (target < 7.0%) | 6 | 70% | 38% | 49% | 60% | 68% | 70% |
| Participant(s) that had an annual screening test for diabetic nephropathy. | 3 | 80% | 40% | 52% | 64% | 72% | 80% |
| Increase percentage of participants with BP control of <140/90 | 5 | 75% | 38% | 49% | 60% | 68% | 75% |
| Increase the percentage of participants with HbA1c < 9% | 5 | 90% | 45% | 59% | 72% | 81% | 90% |
| **Hypertension** |  |  |  |  |  |  |  |
| Participant(s) on anti-hypertensives that had a serum potassium in last 12 reported months. | 6 | 80% | 40% | 52% | 64% | 72% | 80% |
| Participant(s) that had a serum creatinine in last 12 reported months. | 6 | 80% | 40% | 52% | 64% | 72% | 80% |
| Increase percentage of participants with BP control of <140/90 | 10 | 70% | 35% | 46% | 56% | 63% | 70% |
| **Hyperlipidemia** |  |  |  |  |  |  |  |
| Participant(s) with a LDL/HDL cholesterol test in last 12 reported months. | 6 | 85% | 43% | 55% | 68% | 77% | 85% |
| Participant(s) with a triglyceride test in the last 12 reported months. | 6 | 85% | 43% | 55% | 68% | 77% | 85% |
| Increase the percentage of participants with cholesterol levels below 220mg/dl | 10 | 70% | 35% | 46% | 56% | 63% | 70% |
| **Preventive Screening** |  |  |  |  |  |  |  |
| Increase percentage of women age 40-69 who have had at least 1 mammogram in last 24 months to screen for breast cancer. | 3 | 75% | 38% | 49% | 60% | 68% | 75% |
| Increase percentage of participants age 50-75 who have had appropriate colorectal cancer screening every two years. | 3 | 75% | 38% | 49% | 60% | 68% | 75% |
| % of population with attestation of Health Risk Assessment discussion with PCP | 6 | 85% | 40% | 50% | 60% | 70% | 85% |
| **Utilization Rates** |  |  |  |  |  |  |  |
| Increase percentage of participants with major cardiac events, COPD, asthma, or congestive heart failure that do not require readmission within 30 days of discharge. | 11 | 95% | 75% | 80% | 85% | 90% | 95% |
| Increase the percentage of participants with asthma/COPD and diabetes that do not have a disease related ER visit. | 11 | 90% | 45% | 59% | 72% | 81% | 90% |

Note: The Percentage Compliance equals the number of participants in compliance divided by the number of participants identified with the condition through medical claims, prescription drug claims, the biometrics provided in the health risk assessment in 2015 as At Risk, Multiple Chronic and Advanced Critical, and any other source available.

1. Points will be distributed based on a pass/fail methodology for each metric. Total points will then be calculated and incentives/disincentives will be based on number of points and number of Employees enrolled in each plan. Annual incentive/disincentive pay outs will be as follows:

|  |  |  |
| --- | --- | --- |
| **Points** | **Payment**  **Per Covered Employee** | **Incentive/Disincentive** |
| 90-100 | $120.00 | State of Maryland  pays Carrier |
| 80-90 | $100.00 |
| 70-80 | $80.00 |
| 60-70 | $60.00 |
| 50-60 | $40.00 |
| 40-50 | $20.00 |
| 20-40 | $0.00 |  |
| 10-20 | $15.00 | Carrier pays  State of Maryland |
| 0-10 | $30.00 |

1. Offerors must indicate their willingness to comply with the incentive/disincentive plan as laid out above by selecting “Will Comply” from the following drop down box: Choose an item.

1. One unit is 0.1%. One-half of a unit point is .05%. [↑](#footnote-ref-1)