GREGG COUNTY
RFP 2017-712

THIRD PARTY MEDICAL & DENTAL CLAIMS ADMINISTRATION SERVICES
UTILIATION REVIEW/CASE MANAGEMENT
MEDICAL NETWORK
PRESCRIPTION DRUG NETWORK

Addendum Number: 2
Date: June 20, 2017

Proposers shall acknowledge receipt of this ADDENDUM as a signed attachment included with their sealed Proposal.

This ADDENDUM to the above mentioned RFP is to clarify or modify the RFP specifications as follows:

1. Attached are the RFP Submission Forms in Word format.

Vendor Acknowledgement:

Company Name: _____

Authorized Signature: _____

Typed Signatory's Name: _____

Address: _____

City / State / Zip Code: _____

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSALS NO. 2017-712
THIRD PARTY MEDICAL & DENTAL CLAIMS ADMINISTRATION SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services& enrollment described in the Exhibits section of the RFP.

2. Gregg County has used the services of HealthFirst TPA since October 1, 2008 for claim administration services. Additional services provided by HealthFirst TPA include COBRA / HIPAA administration, plus record keeping for employee enrollment in various Gregg County insurance plans that include stop loss insurance, basic life / AD&D insurance, supplemental life / AD&D insurance and LTD insurance.

3. Effective date is to be **October 01, 2017**. All participants enrolled in the Health & Dental Benefits Plan as of **September 30, 2017**, are to be covered on a "No Loss/No Gain" basis. All health & dental services incurred on or after **October 01, 2017,** for enrolled participants are to be eligible expenses. Gregg County's enrollment records are to be the basis for "take-over."

4. "No Loss/No Gain" for participants is to include credit for accumulated deductible, coinsurance, and lifetime maximum benefits that will be provided in electronic format by current administrator.

5. First year administration services are for claims incurred and paid/processed during the year. Second and third year administration services are for all claims paid/processed during the respective year. **Current administrator will pay run-off claims**.

6. Gregg County requires the selected service provider to maintain all records on behalf of the County and to transfer the records to the County or their designee at contract termination.

7. Gregg County desires direct contract with claim administration provider. Thus, proposal is not to contain any commission or fee for agent services.

CLAIMS ADMINISTRATION QUESTIONNAIRE:

1. Describe organization submitting proposal:

   a. Name of firm _____

   b. Address _____

   _____

   c. Contact person _____

   d. Telephone number _____ Fax Number _____

   e. Email Address _____

   f. Year founded _____

2. Attach the following information to determine financial stability:
   a. Most recent financial statement. ☐ Yes ☐ No

   b. Certificate of insurance coverage for Professional Liability, General Liability, Crime, and Fidelity Bond. ☐ Yes ☐ No

   c. Texas license for Third-Party Administration services. ☐ Yes ☐ No

   d. Most recent Report or third party claim audit. ☐ Yes ☐ No

3. Describe claims administration experience:

   a. Number of clients _____

   b. Average employer size _____

   c. Claims staffing levels for every 1,000 members _____

4. Provide three Texas client references, preferably government entities, which have been with your organization for over three (3) years:

Client Name	Contact Person	Telephone #	# Employees

5. Attach the background information for the claims manager, and claims examiner who will be in charge of processing and servicing Gregg County's self-funded health & dental plan.

6. Will services include enrollment and education meetings? ☐ Yes ☐ No

If yes, how many times per year? _____

Comments: _____

7. Describe administration contract:

a. Does your contract provide quality standards for claims turnaround, claims adjudication and accuracy rates (please provide actual percentages)? ☐ Yes ☐ No

If yes, attach specific quality standards to be used.

b. Does your contract provide for payment of run-off claims after contract termination?

☐ Yes ☐ No

Comment: _____

c. Please provide a specimen copy of your administration services contract.

8. Describe claim payment services:

a. Where will claims be paid?

_____

b. Describe the claims payment system(s) that your company would utilize for this group.

_____

c. Does your claims system have the capability of being accessed via a remote terminal for employee inquiry ?

☐ Yes ☐ No

Comment: _____

d. Does your claims payment system have the capability of receiving claims electronically?

☐ Yes ☐ No

e. Is your claim system compliant with HIPAA Privacy requirements? ☐ Yes ☐ No

Comment: _____

f. Is your claims system capable of handling a group with different plan designs?
Please note two levels of In-Network benefits.

☐ Yes ☐ No

Comment: _____

g. Is your medical network repricing seamless? ☐ Yes ☐ No

If no, please explain your medical network repricing procedures.

_____

h. Describe your clinical editing capabilities to detect unbundling, upcoding, duplicate claims payment and other erroneous claims filing practices, including fraud and other abuses.

_____

i. Describe source of reasonable and customary tables and how frequently they are updated.

_____

j. Describe the procedures used for subrogation investigation._____

k. Describe the procedures used for coordination of benefits._____

_____

l. Describe procedure used to screen for duplicate charges: _____

_____

m. Please provide a sample explanation of benefits (EOB).

9. Describe customer service and appeal process:

a. Is a toll-free number available for checking claim status? ☐ Yes ☐ No

Comment: _____

b. What are your customer service hours?

_____

c. Will you provide a local contact for Gregg County? ☐ Yes ☐ No

Comment:_____

d. Will a designated claim examiner process all of the Gregg County claims? ☐ Yes ☐ No

Comment: _____

e. Describe the process of appeal for a contested claim.

_____

10. Describe other services:

a. Will you provide COBRA / HIPAA administration services? ☐ Yes ☐ No

If yes, attach description of services to be provided.

b. Will you provide record keeping services for employee enrollment in various Gregg County insurance plans? ☐ Yes ☐ No

If yes, attach description of services to be provided.

c. Will you provide on-line enrollment services? ☐ Yes ☐ No

If yes, attach description of services to be provided.

d. Are claim reports available on-line? ☐Yes ☐No
Attach sample reports.

e. Will you provide Gregg County with a monthly claim data file in Excel format? ☐Yes ☐No

If yes, attach sample of data to be provided.

f. Will you provide Gregg County, upon request, subscriber eligibility file in Excel format? ☐ Yes ☐ No

If yes, attach sample of data to be provided.

g. Do you offer Health Risk Assessment services? ☐ Yes ☐ No

If so, attach description of services to be provided.

11. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? Yes☐ No☐

12. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers and 621 dental subscribers:

a. Medical Claim Administration

b. Dental Claim Administration

c. COBRA / HIPAA Administration

d. Insurance Enrollment Administration

13. Acknowledge Statement – Claims Administration

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this proposal has been arrived at independently and is submitted without collusion to obtain information or gain any favoritism that would in any way limit competition or give unfair advantage to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSAL NO. 2017-712
UTILIZATION REVIEW/CASE MANAGEMENT

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services& enrollment described in the Exhibits section of the RFP.

2. Gregg County has used the services of MM Solutions since October 1, 2008 for utilization review, large case management and disease management services.

3. The service provider will be expected to coordinate services with the stop loss insurance company and with Gregg County's administrator for their partially self-funded health benefit plan.

4. Effective date is to be October 01, 2017.

5. Gregg County requires the selected service provider to maintain all records on behalf of the County and to transfer the records to the County or their designee at contract termination.

UTILIZATION REVIEW / CASE MANAGEMENT QUESTIONNAIRE:

1. Describe organization submitting proposal.
   a. Company Name: _____
   b. Address: _____
      _____
   c. Contact Person: _____
   d. Telephone Number: _____ Fax Number: _____
   e. Email Address: _____
   f. Year Founded: _____
2. Attach the following information to determine financial stability:
   a. Most recent financial statement Yes☐ No☐
   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐
3. Provide three Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

4. Provide the date services first began for:
   a. Utilization Review
   b. Large Case management
   c. Disease Management
5. Provide complete description of services proposed to include the following:
   a. Professional staff
   b. Pre-Certification procedures & reports
   c. Large Case Management procedures & reports.
   d. Disease Management procedures & reports.

6. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? Yes☐ No☐

   Comment: _____

7. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers:

   a. Utilization Review

   b. Large Case Management

   c. Disease Management

   d. High Risk Pregnancy

8. Acknowledge Statement – Utilization Review/Case Management:

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

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Company Name	Authorized Signature
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GREGG COUNTY, TEXAS

REQUEST FOR PROPOSALS NO. 2017-712
MEDICAL NETWORK SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services & enrollment as described in the Exhibit section of the RFP.

2. Gregg County has used two medical networks, Access Direct Platinum (ADP) and Verity with client specific contracts with Good Shepard Medical Center, Longview Regional Medical Center & other Gregg County providers. The wrap network for medical providers outside of Gregg County & ADP Counties has been PHCS Health Directions.

3. Effective date is to be October 1, 2017.

MEDICAL NETWORK QUESTIONNAIRE:

1. Describe organization submitting proposal.

   a. Company Name: _____

   b. Address: _____

   _____

   c. Contact Person: _____

   e. Telephone Number: _____ Fax Number: _____

   d. Email Address: _____

   f. Year Founded: _____

2. Attach the following information to determine financial stability:

   a. Most recent financial statement Yes☐ No☐

   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐

   c. Copy of Texas license for Medical Network services. Yes☐ No☐

3. Provide three Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

4. How long has proposer been providing a Medical Network in Texas? _____

5. Assuming Gregg County makes their selection and notifies the selected Medical Network on August 4, 2017 can the proposer complete all steps necessary to provide both a hospital and physician Medical Network on October 1, 2017?

6. Attach a copy of the proposer's Medical Network Directory for the Gregg County area in Excel format.

7. Does the proposer have a Web Site that includes the Medical Network Directory? Yes☐ No☐

8. Which hospital, Longview Regional or Good Shepherd Medical Center, is included in your Network? _____

9. If both hospitals are not currently in your Network, how is discount for each hospital affected if both hospitals are included in Network? _____

10. If your Network is only regional, which Network are you proposing to use as a wrap-around?_____

    a. Is this cost included in your proposed fee? Yes☐ No☐

11. Will the proposer provide, at no additional cost, to Gregg County or their designee, a quarterly report in either Microsoft Excel or Microsoft Access that lists for all claims: the provider, provider TIN, date of service, procedure code, procedure description, charged amount and discount? Yes☐ No☐

12. Does the proposer allow the County's claims administrator to audit a bill from Network providers?

13. If the proposer's Network is determined to not have sufficient providers in the geographic area or in a specialty:

    a. Does the proposer provide the County with the assistance to negotiate and secure additional provider contracts on a single case basis, direct and/or comprehensive basis? Yes☐ No☐

    b. Does the proposer allow for multiple Networks? Yes☐ No☐

14. Will the proposer provide specific payment information for selected providers to determine specific payment arrangements/discounts for selected providers? Yes☐ No☐

    If yes, please attach confidentiality agreement with proposal.

15. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? Yes☐ No☐

    Comment: _____

16. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers:

    a. Medical Network - Primary

    b. Medical Network - Wrap

17. Acknowledge Statement – Medical Network

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

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The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSAL NO. 2017-712
PRESCRIPTION DRUG NETWORK SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services & enrollment as described in the Exhibit section of the RFP.

2. Gregg County has used the services of MEDTRAK since October 1, 2014 for PBM services.

3. Gregg County has used the services of TRIA Health since January 1, 2016 for Medication Therapy Management Services.

4. Effective date is to be October 1, 2017.

PRESCRIPTION DRUG QUESTIONNAIRE:

1. Describe organization submitting proposal:

   a. Name of Firm: _____

   b. Address: _____

   c. Contact Person: _____

   d. Telephone Number: _____ Fax Number: _____

   e. Email Address: _____

   f. Year Founded: _____

2. Attach the following information to determine financial stability:

   a. Most recent financial statement Yes☐ No☐

   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐

   c. Most recent _____ Report or third party operations audit. Yes☐ No☐

3. Describe Prescription Drug experience:

   a. Number of Texas Clients: _____

   b. Number of Texas Pharmacies: _____

   c. Other: _____

4. Provide three (3) Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

5. Describe Pharmacy network:

   a. Please provide list of pharmacists currently in pharmacy network in Gregg County in electronic spreadsheet format.

b. Describe relationship with pharmacists including degree of automation and reimbursement procedures:

_____

6. Will you be willing to provide a sample identification card upon request? ☐ Yes ☐ No

   a. Can identification card be mailed to employee's home? ☐ Yes ☐ No

   b. Can identification card be combined with medical card? ☐ Yes ☐ No

7. Prescription Drug Costs

   a. Please provide the following cost information for the proposed network:

Retail	Non Preferred Brand	Preferred Brand	Generic
• Filling Fee			
• AWP Discount			
• Other			
Mail Order			
• Filling Fee			
• AWP Discount			
• Other			

8. Other Services:

   a. Generic Drug Substitution: _____

   _____

   b. Maintenance Drugs: _____

   _____

   c. Mail Order Prescriptions: _____

   _____

   d. Medication Therapy Management Services: _____

   _____

9. Manufacturer Refunds:
   Please provide complete description for allocation of manufacturers' refunds; including allocation formula for sharing refund with Gregg County:_____

10. Reports:
    a. Are reports provided in electronic spreadsheet format? ☐ Yes ☐ No

    Comment: _____

    b. Please provide sample of reports that will be provided and the frequency of the reports.

11. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? ☐ Yes ☐ No

    Comment: _____

12. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 prescription drug subscribers:

    a. Retail Pharmacy Services

    b. Mail-Order Pharmacy Services

    c. Medication Therapy Management Services

13. Acknowledge Statement – Prescription Drug Network

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this proposal has been arrived at independently and is submitted without collusion to obtain information or gain any favoritism that would in any way limit competition or give unfair advantage to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSAL NO. 2017-712

MEDICATION THERAPY MANAGEMENT SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services & enrollment as described in the Exhibit section of the RFP.

2. Gregg County has used the services of TRIA Health since January 1, 2016 for Medication Therapy Management Services.

3. TRIA Health services are provided thru HealthFirst TPA. HealthFirst provides electronic reporting & billing for TRIA.

4. Description of services provided by TRIA Health to Gregg County is presented on pages 4 and 5.

5. Effective date is to be October 1, 2017.

MEDICATION THERAPY MANAGEMENT SERVICES QUESTIONNAIRE:

1. Describe organization submitting proposal:

   a. Name of Firm: _____

   b. Address: _____

   c. Contact Person: _____

   d. Telephone Number: _____ Fax Number: _____

   e. Email Address: _____

   f. Year Founded: _____

2. Attach the following information to determine financial stability:

   a. Most recent financial statement Yes ___ No ____

   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes ___ No ____

3. Describe MTMS experience:

   a. Number of Texas Clients:

   b. Number of Third Party Administrators:

   c. Number of Prescription Benefit Managers:

   d. Other:

4. Provide three (3) Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

5. Describe your chronic condition management services.

6. What is procedure to identify high-risk patients?

7. What are the disease states you focus on?

8. What are qualifications of health coaches that consult on appropriate medication use?

9. Will a member have a designated health coach?

10. How do you coordinate care with the patient's providers?

11. How do you coordinate care with medical case management?

12. Will you provide reports that allow Gregg County to track cost by individual for your recommendations?

13. Will you agree to hold Gregg County harmless for any legal action resulting from your services?

14. Attach cost information based on 562 employees and 768 members.

15. Acknowledge Statement – Medication Therapy Management Services:

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this proposal has been arrived at independently and is submitted without collusion to obtain information or gain any favoritism that would in any way limit competition or give unfair advantage to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address