**Questionnaire Instructions to OFFERORS:**

**\*\*\*DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING\*\*\***

* Please complete all appropriate sections of the questionnaire.
* **Provide answers to the questionnaires in Word format.**
* Provide an answer to each question even if the answer is “not applicable” or “unknown.”
* Answer the question as directly as possible.
  + If the question asks “How many…” provide a number
  + If the question asks, “Do you…” indicate Yes or No followed by any additional brief narrative explanation to clarify.
* **IMPORTANT: Be concise in your response.** Use bullet points as appropriate. Reconsider how to word any response that exceeds 200 words in length so that the response contains the **most important points** you want displayed. Referring the reader to an attachment for further information should be avoided or used on a limited basis. Any response that does not directly address the question, but only contains marketing information will be considered non-responsive.
* OFFEROR will be held accountable for accuracy/validity of all answers.
* Remember, RFP responses will become part of the contract between the winning OFFEROR and the EUTF and to the extent that the RFP and successful proposal conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.
* The submission of your proposal will be deemed a certification that you will comply with all requirements set forth in this RFP. If a multiple option plan is being requested, it will be assumed that all answers apply equally to all options. If this is not the case, separate answers should be provided for each option.

**NOTE: Answers to the questions must be provided in hard copy and WORD format on CD or USB flash drive**

**DO NOT PDF or otherwise protect the CD or USB flash drive**

**QUESTIONNAIRE**

**Medical Benefits Only**

| **GENERAL INFORMATION** | |
| --- | --- |
|  | **OFFEROR RESPONSE** |
| 1. Do you agree that if this proposal results in your company being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in the Proposal Response that any controversy arising over such discrepancy will be resolved in favor of the language contained in the RFP, unless specifically modified by the contract? |  |
| 2. Do you agree to perform all of the services contained in this RFP? If NO and there are exceptions to these requirements, please specify in Attachment 5, *Exceptions*, as a separate section to your proposal and provide a complete explanation of each exception. Failure to respond to the services required in this RFP may result in your proposal being deemed incomplete. |  |
| 3. Do you agree to all the terms and conditions in Section I of this RFP? If NO, list all exceptions to this RFP in Attachment 5, *Exceptions.* |  |
| 4. Verify that all deviations from the requested plan design and coverage are included in the tables in Section V. |  |
| 5. Is your organization currently or in the near future undertaking any mergers, acquisitions, sell-offs, change of ownership, etc.? If yes, explain. |  |
| 6. The EUTF requires written notification of renewal actions 240 days preceding the expiration of the contract. Confirm your agreement to this requirement. |  |
| 7. What are the most recent ratings for your company by the following: |  |
| Standard and Poor's - Rating |  |
| Standard and Poor’s - Date |  |
| Fitch - Rating |  |
| Fitch - Date |  |
| A.M. Best - Rating |  |
| A.M. Best - Date |  |
| Moody’s - Rating |  |
| Moody’s - Date |  |
| Has there been any downgrade in your ratings in the last 2 years? If your firm is not rated, submit documentation of a similar nature which attests to your firm’s financial stability. |  |
| 1. Confirm that you will provide the following minimum reporting requirements:    1. Monthly Enrollment Reports    2. Monthly Financial Claim Reports    3. Semi-Annual Utilization Reports    4. Annual Utilization Reports    5. All required Disease Management, Integrated Health Management and Wellness Program Reports |  |
| 9. Does your company, including any affiliates, subsidiaries, or principals of the company, have any pending or has had any legal actions against the State of Hawaii, the EUTF Board, or any EUTF Trustee within the last five years? If yes, describe in detail. |  |
| **A. ORGANIZATIONAL EXPERIENCE AND STABILITY** | |
| **Network Ownership and Background** | |
| 1. Name of Parent Company, if any: |  |
| 1. Identify service team:    1. Local Overall Account Manager    2. Senior Account Manager (supervisor of above)    3. Local Enrollment Manager    4. Local IT Manager    5. Location of your local telephone service office and number of staff    6. Location of your walk-in customer service office and number of staff |  |
| 3. Is your firm anticipating restructuring or reorganization in the next year? If yes, please explain. Include any major staff relocations or office closings. |  |
| 4. In the past 12 months, has your organization closed any network service areas? If yes, please list the centers. |  |
| 5. In the past 12 months, has your organization combined/consolidated member service or claims service centers? If yes, please list the centers. |  |
| 6. In the past 12 months, has your organization closed/consolidated or relocated any claims offices. If yes, please list the offices? |  |
| 7. In the past 24 months, has your organization acquired, been acquired by, or merged with another organization? If yes, please explain. |  |
| 8. Please provide annual Membership counts for three years. |  |
| National PPO   * 2019 * 2018 * 2017 |  |
| Hawaii PPO   * 2019 * 2018 * 2017 |  |
| National HMO   * 2019 * 2018 * 2017 |  |
| Hawaii HMO   * 2019 * 2018 * 2017 |  |
| 9. Please provide the percentage client retention rates requested below (Group Accounts Only): |  |
| **Client Retention Rates** |  |
| PPO Fully Insured Plans   * 1 year * 2 years * 3 years |  |
| HMO Fully Insured Plans   * 1 year * 2 years * 3 years |  |
| Self-Insured Plans   * 1 year * 2 years * 3 years |  |
| Fully-Insured Pharmacy   * 1 year * 2 years * 3 years |  |
| **Termination Rates** |  |
| PPO   * 1 year * 2 years * 3 years |  |
| HMO   * 1 year * 2 years * 3 years |  |
| Self-Insured Plans   * 1 year * 2 years * 3 years |  |
| Fully-Insured Pharmacy   * 1 year * 2 years * 3 years |  |
| **B. ADMINISTRATIVE SERVICES** | |
| **Account Service** | |
| 1. Do you agree to notify the EUTF immediately if the network loses any accreditation, licenses, or liability insurance coverage or if there is a change in hospital network contracts? (Answer Yes or No) |  |
| 2 Are there any Special Conditions outlined in Section I that you cannot meet? (Answer Yes or No) |  |
| 1. Payment Options: EUTF to Vendor (Choose only one)    1. Electronic Funds Transfer    2. Manual Invoicing    3. Both options available |  |
| 4. Do customer service representatives have online access to real-time claim status information? (Answer Yes or No) |  |
| 5. Will you transfer enrollment cards, claim information, prior authorizations, quantity limits, TROOP balances and other administrative records to any carrier/TPA that would replace you in the event of termination of this contract and at no charge? (Answer Yes or No) |  |
| 6. a) Do you offer any services with respect to reporting requirements under PPACA? (Answer Yes or No) |  |
| b) If yes, what services do you offer? |  |
| c) Indicate any additional charges required to provide the service. |  |
| 1. a) What online services/functions will be made available to the EUTF administrative staff via the Internet? (List all that apply)    * Claims Summary    * Billing History    * Premium Rates    * Provider Directory    * Eligibility Summary    * Enrollment Counts    * Plan Details/Benefit Summary    * Health Topics/Medical Information    * Address Changes    * Other |  |
| 1. What online services/functions will be made available to the EUTF members via the Internet? (List all that apply)    * Claims Summary    * Billing History    * Premium Rates    * Provider Directory    * Eligibility Summary    * Enrollment Counts    * Plan Details/Benefit Summary    * Health Topics/Medical Information    * Address Changes    * Other |  |
| 1. Provide name of website and sample password, if applicable. |  |
| 8. For each of the services listed below, please indicate if the service is available and if the cost is included in the basic fee. If not, please provide any additional fee that may apply. |  |
| 1. SPDs and SBC    * Available/not available    * Included in basic fee    * Indicate additional cost |  |
| 1. Claims Forms    * Available/not available    * Included in basic fee    * Indicate additional cost |  |
| 1. EOBs    * Available/not available    * Included in basic fee    * Indicate additional cost |  |
| 1. Network Directory    * Available/not available    * Included in basic fee    * Indicate additional cost |  |
| 1. Other, please describe    * Available/not available    * Included in basic fee    * Indicate additional cost |  |
| **Audit Requirements** |  |
| 9. a) Do you agree to allow the EUTF the right to audit the performance of the plan and services provided? |  |
| b) Indicate what services, records and access will be made available to the EUTF at no additional charge. |  |
| c) Indicate frequency and notice requirements that are part of the right to audit provision and all other limitations or restrictions on the conduct of an audit. |  |
| 10. Will you agree to an independent annual audit that measures performance through random sampling? Please include a copy of your audit policy. |  |
| 11. Will you agree to provide a comprehensive data file to the auditor that will facilitate electronic analysis with target samples validated through the auditor’s review of supporting documentation of sufficient sample size to meet the auditor’s requirements to achieve the level of confidence determined by the auditor? |  |
| 12. Confirm your understanding that results from an independent random claims sample will determine compliance with processing guarantees. |  |
| 13. Confirm your understanding that non-processing performance guarantees may be validated through an independent audit with such results determining the amount of any penalty due and if performance guarantees cannot be validated because of insufficient documentation, you will be considered non-compliant with the performance guarantee. |  |
| **Member Services** |  |
| 14. Confirm the cost of providing a toll-free number to be made available to participants to handle claims or other service issues is included in your quotation. (Answer Yes or No) |  |
| 1. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. (List all that apply)    1. No special accommodations    2. Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired    3. Contract with an independent translation company to accommodate non-English special enrollees    4. Maintain customer service staff with the ability to translate multiple languages. If so, which languages? |  |
| 1. Do you offer a 24-hour telephone Nurse Triage or Live Medical Services (physician or nurse advice/demand management) telephone and/or video program for enrollees? (Choose only one)    1. Yes, staffed by live health professionals, at no additional charge    2. Yes, staffed by live health professionals, at an additional charge of $ \_\_\_    3. No, not offered    4. Other |  |
| 17. Do you agree to receive and timely and accurately process as indicated in this RFP all of the enrollment and eligibility information in the format as provided by EUTF, without the EUTF making changes to its file format? See Exhibit G for sample 834 file. (Answer Yes or No) |  |
| 1. Which of the following Member Functions by Website do you provide? (List all that apply)    1. Provider Profiles    2. Health Information    3. Claim Status    4. Lab Results    5. Submission of Referrals    6. Request for Prior Authorization    7. Submission of Rx    8. Other (List) |  |
| 1. Do your provider directories include the following: (List all that apply)    1. Physician office address and phone number    2. Specialty designation (e.g., cardiology, pediatrics, urgent care)    3. Doctor accepting new patients    4. Office hours    5. Languages spoken in office    6. List of hospital with admitting privileges |  |
| 20. Do you agree to notify members at no additional cost if an HMO network physician terminates their contract during the plan year? *(*Answer Yes or No) |  |
| **C. UNDERWRITING ISSUES – FULLY INSURED PLANS** | |
| 1. a) Explain the methodology and data to be used for the renewal process. How will projected incurred claims be estimated for these plans? |  |
| b) What experience period(s) will be used for the first renewal? |  |
| c) What credibility will be given to each period of experience used? |  |
| 2. Explain your methodology for establishing Incurred But Not Reported (IBNR) reserve? |  |
| 1. Indicate the factors used to set the rates for the proposal.    1. Annual Trend Factor % of expected claims    2. Reserve Factor % of expected claims    3. Margin % of expected claims    4. Retention as a fixed cost PEPM or PRPM |  |
| 4. Explain any other required reserves other than for IBNR. Indicate amounts, reason for reserve, whether interest is credited, and whether reserves are refunded to the client upon policy termination. |  |
| 5. Detail any underwriting provisions/rules you will impose on the EUTF. |  |
| **D. DISEASE MANAGEMENT and INTEGRATED HEALTH MANAGEMENT (DM/IHM)** | |
| 1. Do you perform these services? If yes, describe the DM/IHM services in detail that are covered by your basic fee. For each program service include: program name, a description of the program, condition(s) managed, stratification levels, member identification process, program goals, interventions, and performance metrics. |  |
| 2. Do you have a minimum of three years of experience in performing these services? Provide years of experience for each program listed in No. 1 above. |  |
| 3. Are you currently providing DM/IHM services to a group of at least 100,000 covered members? |  |
| 4. Do you have the ability and are you willing to customize your DM/IHM services to meet the needs/desires of the EUTF? Describe limitations if any. |  |
| 5. Do you have the capability to identify specific members targeted for these DM/IHM services (e.g. retirees vs. actives)? |  |
| 6. Do you agree to provide EUTF specific data reports of DM/IHM activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within 3 months of the close of the prior year? |  |
| 7. Do you agree (that after the award of this contract and during the implementation phase of your services) you will mine the EUTF medical claims and prescription drug data and identify those individuals appropriate for your DM/IHM services AND provide the EUTF (prior to the start date of the contract) with a report that outlines what you found in their data, including but not limited to the following elements: |  |
| a) The total number of members identified with one or more chronic diseases you will manage in the initial data analysis by specific DM/IHM program service |  |
| b) The number of members you identified in each of your risk classes/level |  |
| c) The costs associated with the above groups |  |
| d) The percent of clinical goals/objectives the population is NOT adhering to in the baseline data search |  |
| e) A comparison of the EUTF’s performance to HEDIS 90th percentile benchmark and “book of business” outcomes for similar sized clients of the same or similar industry |  |
| 1. Which of your DM/IHM program(s) focus on helping members identify and lessen the following disease conditions and risk factors:    1. Obesity    2. Smoking    3. High cholesterol    4. Lack of activity/exercise    5. Stress Management    6. Diabetes    7. Asthma    8. Chronic obstructive pulmonary disease    9. High blood pressure    10. Ischemic heart disease    11. Congestive heart failure |  |
| 9. Are your DM/IHM services available to be used by participants who live in any of the 50 states? |  |
| 10. Describe in detail your methods and strategies to engage members, both retirees and actives, to participate in DM/IHM programs. |  |
| 11. How do you recommend that a client communicate and encourage the use of these services among retirees and active members. |  |
| 12. Describe your expected participation rates in DM/IHM programs. |  |
| 13. Based on data, what DM/IHM programs have been the most effective to improve the health condition of members with chronic conditions? |  |
| 14. Explain how your staff introduces themselves to members for the first time for DM/IHM programs (e.g. phone call, letter)? |  |
| 15. What DM/IHM programs are available at an additional cost? Explain in detail and include the additional cost. |  |
| **E. WELLNESS PROGRAMS and INTEGRATED HEALTH MANAGEMENT (IHM)** | |
| 1. Describe your wellness program. List all components of your wellness program (e.g. health risk survey, health coaching, health education classes). For each component describe:    1. The intervention    2. Risk factors the program addresses (e.g. obesity, poor nutrition, lack of physical activity, smoking, high blood pressure, high blood cholesterol, medication adherence)    3. Program goals    4. Format offered (face-to-face, telephonic, online, etc.)    5. Setting (e.g. worksite, other)    6. Target member population (retirees and/or actives)    7. How you measure the effectiveness of the program and its individual components. |  |
| 2. Do you have a minimum of three years of experience in delivering wellness program services? Provide years of experience for each program component listed in No. 1 above. |  |
| 3. Describe strategies and methods you plan to implement to engage participation in the wellness program components described above for the active and retiree population. |  |
| 4. For each service listed and/or requested, provide expected participation (based on a percent of total eligible members). |  |
| 5. Describe factors to improve participation for both active and retiree members. |  |
| 6. Describe factors that will reduce participation? |  |
| 1. Based on the demographics list the wellness program components you would expect to have the greatest impact on the following listed from highest to lowest impact:    1. Reducing medical plan costs    2. Increase productivity    3. Member satisfaction and acceptance |  |
| 8. Describe your capacity to report wellness program activity by member type (retiree and/or active) and by employer. |  |
| 9. Do you agree to provide EUTF specific data reports of wellness program/IHM utilization activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within three months of the close of the prior year? |  |
| 1. Based on your prior experience with wellness programs, for the program components listed above, provide the expected dollar savings per eligible member per year? Indicate expected savings by:    1. Reduction in medical plan costs    2. Reduction in lost workdays    3. Increases in productivity    4. Other factors you can identity |  |
| 11. What is the method used in the derivation of savings estimate provided in No. 10 above. |  |
| 12. For each program implemented what is the expected ratio of savings to program expenses in the first 12 months, 24 months and 36 months? |  |
| 13. What is done to assess plan participant satisfaction with the program? Are management reports available? If so, please include a sample(s). |  |
| 14. Explain in detail each wellness program component included in your quote. What wellness programs are available at an additional cost? Explain in detail and include additional cost. |  |
| 15. Provide a full explanation of how your company reimburses providers in order to control cost and manage utilization, other than fee for service arrangements. |  |
| 16. Explain what programs you have implemented that address progress toward achieving patient centered outcome measurement and reimbursement to providers that improve these outcomes. |  |
| 1. Performance Improvement Projects (PIPs)    1. Describe current PIP with providers. |  |
| 1. If no response is provided in A above, can your company undertake a Performance Improvement Project with providers that are to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction? The PIPs shall include the following:    * The use of objective, measurable, and clearly defined quality indicators to measure performance;    * Valid sampling techniques;    * Accurate and complete data collection;    * The implementation of appropriate planned system interventions to achieve improvement in quality;    * An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis;    * An achievement of real improvement that is sustained; and    * A plan and activities that shall increase or sustain improvement. |  |
| c) Are all of the services included in your base quote? If not, indicate the changes on a per capita basis. |  |
| 18. Describe methods to identify members with pre- diabetes and programs to address this member population. |  |
| **F. CLAIM COSTS** | |
| **Provider Reimbursement and Discount Worksheets** | |
| 1. Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement. |  |
| 2. Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other). |  |
| 3. When you are the secondary payor in a COB situation, do you use your UCR profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement? |  |
| **Hospital and Outpatient Facility Charges** |  |
| 4. Describe how network hospitals are reimbursed. Your answer should be consistent with the fees provided on the proposal sheets provided. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor. |  |
| 5. Network Hospital and Outpatient Facility Profile - Complete the following table(s) for the network within the geographic areas requested. |  |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Island**  **List Number by Island** | **Oahu** | **Maui** | **Hawaii** | **Kauai** | **Lanai** | **Molokai** | | Acute Hospitals |  |  |  |  |  |  | | Urgent Care Facilities |  |  |  |  |  |  | | Outpatient Surgical Centers |  |  |  |  |  |  | | Clinics |  |  |  |  |  |  | | General/Family Practice Physicians |  |  |  |  |  |  | | OBGYN Specialists |  |  |  |  |  |  | | Other Specialists |  |  |  |  |  |  | | |
| 6. a) How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, or pre-paid capitated arrangement)? |  |
| b) If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived. |  |
| 7. Do you have a contractual relationship with outpatient facilities? |  |
| 8. Describe any other contractual relationships with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers. |  |
| 9. Do you have any special arrangements with “Centers of Excellence” facilities? |  |
| a) Describe the illnesses/conditions and services associated with your Centers of Excellence programs. |  |
| * 1. Are services bundled with regard to reimbursement? |  |
| * 1. Is the facility at risk for cost incurred in excess of the negotiated charge? |  |
| * 1. Include the actual bundled charge for each condition, AND list the facilities by name and region. |  |
| **Claims Processing** | |
| 10. With regard to the claim offices that will be used, provide the following: |  |
| a) Location: |  |
| 1. Average Claims/Processor/Day: |  |
| 1. Annual Claim Volume: |  |
| 1. Provide number of:    * Processors    * Supervisors    * Managers |  |
| 1. Average years of claims administration experience for:    * Processors    * Supervisors    * Managers |  |
| 1. Annual turnover percent (%):    * Processors    * Supervisors    * Managers |  |
| 1. Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims, please discuss separately. For example, do you batch process checks to network providers? If so, explain. |  |
| 1. Based upon the latest 12-month period: (Please answer all parts of this question) |  |
| * 1. Average number of business days to process a claim from date received to date check/EOB issued: |  |
| * 1. What percent of all claims submitted, regardless of information provided on claim, are processed (from date received to date check/EOB issued) within 10 business days? |  |
| * 1. What percent of all claims submitted, regardless of information provided on claim, are processed (from date received to date check/EOB issued) within 30 business days? |  |
| 1. Have you been penalized by any state for failing to meet state average claim turnaround requirements?    1. Yes. List state(s) where you were sanctioned in the last 12 months.    2. No. |  |
| 1. For the claim office proposed, please provide the following data for the latest 12-month period: |  |
| a) Financial accuracy as a percent of total claims dollars paid (include over/underpayments) |  |
| b) Coding accuracy (claims without error) as a percent of total claims submitted |  |
| 15. a) What are your procedures for recovery of the overpayments or duplicate payments? |  |
| 1. Do you agree to return all recovered monies from overpayments or duplicate payments to client? (Choose only one)    * Yes, 100% of recovery    * Yes, less recovery collection fee    * No, do not agree |  |
| 1. a) Explain your COB procedures. |  |
| 1. Do you pursue COB prospectively or retrospectively to payments? |  |
| 1. How often are records updated for new information on other coverage? |  |
| 1. What is the average COB savings as a percent of total plan cost for:    * Active/Early retiree    * Medicare Eligible |  |
| 1. Will you guarantee COB savings for: (Answer Yes or No)    * Active/Early retiree    * Medicare Eligible |  |
| 1. Please provide at a minimum a description of any fraud detection programs, whether there is a formal written program, and the total number of events per 1,000 covered lives for the following:    1. Ineligible Claimants    2. Errors in service billed vs. actually rendered    3. Over billings    4. If there is a formal written program, please include a full description of the program and the total number of cases of fraud per 1,000 covered lives. |  |
| 1. a) Do you retain medical consultants for the review of any unusual claims or charges? (Answer Yes or No) |  |
| b) If yes, explain the method in which such consultants are used and describe their qualifications and any affiliations. |  |
| 1. a) How do you reimburse multiple surgical procedures being performed during one operation? |  |
| b) Is a reduced scale used for the first and subsequent procedures? (Answer Yes or No) |  |
| 1. What programs do you offer to address potential drug abuse? |  |

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| **GENERAL NETWORK INFORMATION** | |
|  | **OFFEROR RESPONSE** |
| **G. NETWORK MANAGEMENT** | |
| **Provider Relations Education** | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1A. For the City & County of Honolulu (Oahu) service area provide the number of Network Providers that have terminated their contract: | | | | | |
| **Provider Type** | **Unknown** | **Total # of Terminations in the Past 12 Months** | **Terminations Equate to What % of Your Contracted Providers?** | **% of Terminations That Are Voluntary** | **Most Common Reasons for Termination (e.g. contract dispute, death, moved)** |
| **HMO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |
| **PPO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1B. For the County of Hawaii service area provide the number of Network Providers that have terminated their contract: | | | | | |
| **Provider Type** | **Unknown** | **Total # of Terminations in the Past 12 Months** | **Terminations Equate to What % of Your Contracted Providers?** | **% of Terminations That Are Voluntary** | **Most Common Reasons for Termination (e.g. contract dispute, death, moved)** |
| **HMO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |
| **PPO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1C. For the County of Maui (including Kalaupapa) service area, provide the number of Network Providers that have terminated their contract: | | | | | |
| **Provider Type** | **Unknown** | **Total # of Terminations in the Past 12 Months** | **Terminations Equate to What % of Your Contracted Providers?** | **% of Terminations That Are Voluntary** | **Most Common Reasons for Termination (e.g. contract dispute, death, moved)** |
| **HMO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |
| **PPO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1D. For the County of Kauai service area provide the number of Network Providers that have terminated their contract: | | | | | |
| **Provider Type** | **Unknown** | **Total # of Terminations in the Past 12 Months** | **Terminations Equate to What % of Your Contracted Providers?** | **% of Terminations That Are Voluntary** | **Most Common Reasons for Termination (e.g. contract dispute, death, moved)** |
| **HMO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |
| **PPO** |  |  |  |  |  |
| Hospital |  |  |  |  |  |
| Physicians |  |  |  |  |  |

| **GENERAL INFORMATION** | |
| --- | --- |
|  | **OFFEROR RESPONSE** |
| **G. NETWORK MANAGEMENT (continued)** | |
| **Provider Profiling** | |
| 2. Do you have a mechanism for routinely investigating if a contracted provider has any disciplinary actions imposed by their State licensure medical board? (Answer Yes or No) |  |
| 1. Do you compare individual network provider practice patterns against Best practices or averages on any of the following: (List all that apply)    1. Referral rates to specialists    2. Frequency and quality of prescription drug dispensing    3. Rates of diagnostic procedures ordered (lab/imaging)    4. Rates of surgical procedure relative to peers    5. Repeat procedures within given timeframes    6. Hospital readmission rates    7. Unknown/do not track |  |
| 1. Other than provider directories and access to providers via your website, what quality or practice pattern data about your contracted providers do you make available to plan participants? |  |
| **H. COVERAGE AND CONTRACT ISSUES** | |
| **General Contract Provisions** | |
| * 1. Will you agree to be bound by the terms of the RFP and your proposal until a final contract is executed? (Answer Yes or No) |  |
| **Termination Clauses** | |
| 2. Do you agree to cover all eligible expenses incurred by a covered participant who is hospitalized on the date of termination until that person is discharged from the hospital? (Answer Yes or No) |  |
| **I. HIPAA QUESTIONS** | |
| 1. a) Do you have a formal HIPAA compliance plan in place? (Answer Yes or No) |  |
| b) If yes, attach a copy to your proposal. |  |
| 2. a) Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions? |  |
| b) Where does the copy of your Companion Guide for HIPAA EDI transactions reside? |  |
| 3. Will your organization be issuing Notices of Privacy Practices as required by HIPAA to each new plan enrollee? At what cost if any? |  |