Attachment A
Bidder Questionnaire
RFP 6102 Z1

Bidder Name: _____

Bidder should complete all questions in Attachment A.

CORPORATE OVERVIEW	
1.1	**BIDDER IDENTIFICATION AND INFORMATION** Provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business, whether the name and form of organization has changed since first organized, and Federal Employer Identification Number.
Response:	
1.2	**FINANCIAL STATEMENTS AND INFORMATION** Provide financial statements applicable to the firm. Provide a copy of the bidder's most recent annual report. If publicly held, provide a copy of the corporation's most recent two (2) years of audited financial reports and statements, and the name, address and telephone number of the fiscally responsible representative of the bidder's financial or banking organization. If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference. The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist. The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation. Indicate the most recent Financial Rating, Financial Rating Modifiers and the Financial Rating Effective Date that have been received by the following organizations. Indicate all changes that have occurred in the last twelve (12) months for each of these ratings. a. A.M.Best b. Standard and Poors c. Moody's d. Fitch
Response:	

1.3	**CHANGE OF OWNERSHIP** If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor will require notification to the State. Describe any parent/subsidiary relationship.
Response:	
1.4	**OFFICE LOCATION** The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.
Response:	
1.5	**RELATIONSHIPS WITH THE STATE** The bidder describe any dealings with the State over the previous twelve (12) months. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.
Response:	
1.6	**BIDDER'S EMPLOYEE RELATIONS TO STATE** If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare. If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.
Response:	

1.7

CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default. Bidder must provide information on administrative and/or litigation within the past three (3) years, include current/pending cases, expected litigation, judgments, awards, and settlements (both in and out of court) or other real or potential financial reversals, including any bankruptcy proceedings whether voluntary or involuntary, which might materially affect the viability or stability of the bidder.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

Response:

1.8

SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

Provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

1. Provide three narrative descriptions to highlight the similarities between previous experience and this Request for Proposal. These descriptions must include:

a. The time period of the projects;
b. The scheduled and actual completion dates;
c. The Contractor's responsibilities;
d. The number of contracts and the number of covered members for each project;
e. for reference purposes, three customer names (including the names of a contact person, current telephone numbers, facsimile numbers and e-mail addresses); and
f. Each project description shall identify whether the work was performed as the prime Contractor or as a subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion dates and budget, as well as the actual (or currently planned) completion dates and actual (or currently planned) budget.

2. Contractor and subcontractor(s) experience must be listed separately. Narrative descriptions submitted for subcontractors must be specifically identified as subcontractor projects.

3. If the work was performed as a subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

a. Is this an exclusive relationship?
b. Effective date of Subcontract?

4. Indicate years of service providing and administering the coverage(s) related to this RFP. Briefly describe abilities to administer such plans including:

a. Health Savings Accounts

5. For the entire book of business, provide the total year-end national group membership (number of contracts) that receives medical administration services and indicate how many of these are in Nebraska. Provide statistics for Public Sector clients

	National Group Membership (Number of Contracts)	**Nebraska Group Membership Number of Contracts)**	**Number of Public Sector Groups**	**Number of Public Sector Groups with 15,000+ lives**
2016				
2017				
2018				
2019				

6. What percentage of the 2018 total group membership renewed for the 2019 plan year?

Response:

1.9

SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if the company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified. The team shall include, but not be limited, to the following roles:

a. Implementation Manager
b. Account Executive
c. Clinical Pharmacist
d. Operations Director
e. Network Manager
f. Member Services Manager

Designated alternate Account Executive would be expected to be familiar with all aspects of the State's business as it relates to the State's Health Plan. The designated alternate Account Executive is not subject to the location requirements, but must be available via a conference call.

Provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address,

	and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.
Response:	
1.10	**SUBCONTRACTORS** If the bidder intends to subcontract any part of its performance hereunder, the bidder must provide: a. name, address and telephone number of the subcontractor(s); b. specific tasks for each subcontractor(s); c. advise if exclusive relationship for each subcontractor; d. Indicate effective date and expiration date of each Subcontract agreement; and e. Describe the management of suppliers/subcontractors to ensure delivery is effectively provided to the State of Nebraska and its employees.
Response:	
TECHNICAL APPROACH	
Proposals must include a current comparison to other state and large employers based on the claims data provided and current prescription programs in place at the State. Use the normative data and provide feedback comparing the State of Nebraska with other comparable state and municipality employers based on the claims data provided. This comparison should include, but not be limited to, suggestions for modifications to existing programs, the addition of new programs and/or recommendations for changes in the State's policies on how to improve the State's performance and specific methods to reduce costs.	
1.11	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the Regular Plan.
Response:	
1.12	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the Consumer Focused Health Plan.
Response:	
1.13	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the WellNebraska Plan.
Response:	
DIRECT PRIMARY CARE MEMBERSHIP	
1.14	Describe experiences in working with Direct Primary Care (DPC) models, as described in State of Nebraska's Direct Primary Pilot Program Act.

Response:	
1.15	Describe the DPC model and how it addresses primary care, prevention and coordination of services that are provided to State employees who choose the DPC model. If any services are provided by an affiliation or contract, describe how the standards and outcomes will be consistently met.
Response:	
1.16	Describe the DPC organizational chart, infrastructure, quality control measures and outcomes.
Response:	
1.17	Describe the plan for working with other DPC organizations to address the needs of State employees.
Response:	
1.18	Define the relationship of the DPC model to traditional insurance options. Describe how services between entities will be coordinated.
Response:	
1.19	Describe the processes to exchange data with the DPC provider? Describe how confidentiality will be assured, and how patient data will be secured and protected.
Response:	
1.20	Describe integration data from the DPC provider to gain a holistic picture of each member's health profile? Include a plan for documentation of patient visits, telehealth and securing medical records as well as how complete comprehensive healthcare records will be obtained.
Response:	
1.21	Describe how to administer the wrap plan for the DPC model.
Response:	
1.22	Describe the mechanisms in place to work with the DPC provider to ensure the member is referred to the medical plan for benefits, if treatment outside the DPC model is needed. Describe the process for specialist referral to ensure the maximum use of the primary care model.

Response:	
HIPAA	
1.23	Describe the capabilities in offering the State an annual HIPAA training seminar to comply with the annual education and training requirements as defined by HIPAA at no cost to the State.
Response:	
GENERAL PLAN INFORMATION AND REQUIREMENTS	
1.24	Provide a copy of a Suggested Employer Contract with a statement that the sample include all exclusions and limitations that will apply to a policy issued to the State.
Response:	
1.25	Describe any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.
Response:	
1.26	Provide a sample of your annual scorecard.
Response:	
MEMBER SERVICES	
1.27	Describe how members reach a live representative or an interactive voice response (IVR) unit when calling Member Services.
Response:	
1.28	Describe the system by which the Customer Service unit tracks and documents calls. Describe the process to review the findings of the call tracking and documentation process with the State.
Response:	
1.29	Describe how members can electronically access claims information and the Member Services group. Describe the internet, i.e. web chat, or email services offered.

Response:	
1.30	Describe the escalation process for Member Services satisfaction and complaints.
Response:	
1.31	Provide detailed information on how often provider directories are updated. Both hard copy and on-line provider directories must be made available by the Contractor to the State of Nebraska.
Response:	
1.32	Contractor will not render or administer services (including wellness) offshore, and all work performed will be in the contiguous United States. Describe where the Customer Service unit will be located.
Response:	
1.33	Describe the process for handling calls "after hours" of operation? Is there a voicemail system or capability for caller to leave messages after normal business hours?
Response:	
1.34	Describe ability to meet a 24-hour nurse line program. Staff must be available 24-hours a day, 365 days a year.
Response:	
1.35	What is the average wait time to speak with a registered nurse?
Response:	
1.36	Is the nurse line accredited by any external organizations?
Response:	
1.37	Describe if the nurse line connects members to a contact history allowing a current inquiry to be addressed with the context of previous calls?
Response:	

1.38	Describe the process for the nurse line to directly enroll callers into plan provided clinical programs such as case or condition management?
Response:	
1.39	Does the nurse line conduct quality surveys with users to determine member satisfaction with the service? Describe the process used for these surveys.
Response:	
1.40	Describe the drug cost look-up tool available to members via website that provides both the plan copay and full drug cost.
Response:	
MEDICAL PLAN DESIGN	
1.41	If a new member is receiving treatment from a non-participating provider, describe how the medical plan covers transitional conditions, such as pregnancy, chemotherapy, etc.
Response:	
DATA ANALYTICS TOOL	

1.42	Provide information on how the data analytics tool provides and calculates data from a client's view and from the account manager's view. **1.** Provide proof of these variables; a. Health Plan type/Option b. Member Status (Active, Early Retiree, Retiree) c. Relationship (Employee, Spouse, Dependent) d. Network Indicator e. Place of Service (Inpatient, Outpatient, Emergency Room, Physician's office, etc.) f. Major Diagnostic Category g. Diagnosis Related Group h. Member ID i. Provider ID j. Date of Service k. Date of Payment **2.** Provide proof of these calculations; a. Admissions b. Readmissions (7,15,30 days) c. Urgent Care Visits d. Other Facilities e. Avoidable Admissions f. Inpatient Days g. Emergency Room Visits h. Office Visits i. Preventive Screens j. Total number of claims k. Net Payment l. Healthcare Reimbursement Amount m. Copayment Amount n. Coinsurance Amount o. Deductible Amount
Response:	
1.43	Describe how State staff will be provided access to the data warehouse. Describe the training that will be provided to the State staff to allow them to navigate and utilize the data warehouse.
Response:	
CLAIMS PROCESSING	
1.44	The State requires the minimum hours for claims administration operation to be Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time. Describe if any additional hours are available beyond the core hours.

Response:

1.45	Describe performance standards with respect to: a. Adherence to implementation/annual enrollment timeline b. Readiness of claims and customer service systems c. Readiness of eligibility system d. Completion of plan documents

Response

1.46

Provide actual (achieved) performance measurements for an account size comparable to the State of Nebraska for 2017 and 2018 as well as the 2017 and 2018 performance standards targets for the claims office that will handle the State account.

Performance Measure	2017 Performance Targets	2017 Performance Actuals	2018 Performance Targets	2018 Performance Actuals	PG Measurement Utilized
Member Satisfaction Survey (% satisfied)					
Claim Administration					
Claim Accuracy (percentage)					
Financial Accuracy (percentage)					
Claims Turnaround Time (days)					
Overpayment recoveries (number of days to send check for overpayment)					
Customer Service					
Telephone call response time (seconds)					
First call resolution rate (percentage)					
Closure time for open inquiries (number of days)					
Timeliness of responding to web inquiries (number of days)					
Timeliness of resolution for grievances, complaints and appeals					

Response:

1.47	What percentage of claims were received electronically in 2018 for: a. Hospital/Facility services

	b. Physician services c. Laboratory, Radiology, etc. d. Overall total
Response:	
1.48	Provide auto-adjudication rate for clean claims received electronically in 2018 for: a. Hospital/Facility services b. Physician services c. Laboratory, Radiology, etc. d. Overall total
Response:	
1.49	Describe the internal audit procedures including if audits are performed on a pre- or post-disbursement basis, what percentage of all claims are audited by an internal audit group, how claims are selected for internal audit and what triggers are utilized.
Response:	
1.50	Provide in detail the procedure for processing claims based on benefit exceptions of denied claims as determined by the State.
Response:	
1.51	The State requires claims history be maintained on-line for a minimum of ten (10) years. Provide detail on how this will be met and/or exceeded.
Response:	
1.52	Provide detail on how to determine usual, customary and reasonable charges for out-of-network medical, surgical and anesthesia.
Response:	
1.53	Describe how claims are reviewed for billing irregularities by a provider (such as regular overcharging, unbundling of procedures, up coding or billing for inappropriate care for stated diagnosis, etc.).
Response:	
1.54	Provide a sample of claim and Explanation of Benefits (EOB) forms.

Response:	
1.55	What procedures are used to administer customer specific COB provisions?
Response:	
1.56	Provide a list of the location(s) of all service centers that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location.
Response:	
1.57	Provide a description of premium or administrative fee billing procedures, including information on the timing of billing and billing-payment reconciliations.
Response:	
1.58	Indicate for any current plan, under what circumstances members are required to submit claim forms and bills: a. In-Network b. Out-of-Network c. Out-of-Area d. Out-of-Country
Response:	
BEHAVIORAL HEALTH	
1.59	Provide a brief overview of programming and address how the behavioral health management interventions are integrated with the medical management interventions.
Response:	
1.60	Describe the behavioral health program, including the subcontractor, and background concerning the organization's relationship.
Response:	
1.61	Describe how plan participants access the behavioral health service.
Response:	

1.62	What credentials are required for specialty case managers that are used to manage Mental Health/Substance Abuse (MH/SA) cases?
Response:	
1.63	Does the same case manager handle the member's care through all levels of care? For example, inpatient, intermediate, and outpatient?
Response:	
1.64	How long is a patient monitored after discharge?
Response:	
1.65	How frequently are outpatient cases evaluated for case management?
Response:	
1.66	Are out-of-network cases considered for case management?
Response:	
1.67	Describe methods that are available and used within the organization to ensure appropriateness of treatment (utilization and duration).
Response:	
1.68	Do MH/SA case managers routinely co-manage cases with medical and/or disease management case managers?
Response:	
1.69	Explain how reporting on State-specific outcomes data will be provided. Describe the type of reporting available.
Response:	
1.70	Is a virtual network part of the programming? Describe the virtual network.

Response:	
1.71	Describe which specialty providers are included in the network, i.e. Medication assisted treatment, ABA, eating disorder, etc.
Response:	
1.72	Describe the pay-for-performance strategy for the Behavioral Health providers.
Response:	
1.73	Describe the strategies that are used to drive in-network and/or high-quality care.
Response:	
1.74	Describe how the organization is helping customers deal with the opioid epidemic.
Response:	
ELIGIBILITY AND MEMBERSHIP	
1.75	Describe if eligibility is processed in real time with the claims system.
Response:	
WEB ACCESS	
1.76	Describe member's capabilities to request additional or replacement ID cards.
Response:	
1.77	Describe member's capabilities to print ID cards directly from site.
Response:	
1.78	Describe member's capabilities to access historical health data.

Response:	
1.79	Describe member's access to provider directories.
Response:	
1.80	Describe member's access to provider selection where users enter search criteria.
Response:	
1.81	Describe member's access to review claim status.
Response:	
1.82	Describe member's access to plan design.
Response:	
1.83	Describe member's ability to email member services.
Response:	
1.84	Describe member's capabilities to customizable health content tools.
Response:	
1.85	Describe tools available to members for evaluation of cost and/or quality of healthcare providers.
Response:	
1.86	Describe member's online access to member appeals.
Response:	
1.87	Describe member's access to applications for mobile devices.

Response:	
1.88	Describe the ability to customize web site for the State.
Response:	
1.89	Describe the ability to hyperlink to the State's site.
Response:	
1.90	Describe employer/actuarial consultant inquiry capabilities.
Response:	
1.91	Describe security/privacy issues.
Response:	
1.92	Describe future plans/timeframes for enhancements.
Response:	
MEDICAL PROVIDER NETWORK	
1.93	Provide an accessibility report using Optum, GeoAccess, GeoNetwork or comparable software. Note geo-mapping method used. Urban/Suburban must be 1 within 20 miles and Rural must be 1 within 35 miles for the following provider types: a. Facilities: **i.** Hospitals **ii.** Ambulatory Surgical Center **iii.** Urgent Care facilities **iv.** Imaging Centers **v.** Inpatient Behavioral Health Faculties b. Primary Care: **i.** General/Family Practitioner **ii.** Internal Medicine **iii.** Family Medicine **iv.** General Medicine OB/GYN **v.** Pediatrician c. Specialists: **i.** Endocrinologist

	ii. Urologist **iii.** Cardiologist **iv.** Dermatologist **v.** Allergist **vi.** Psychologist/Psychiatrist **vii.** General Surgeon **viii.** Hematologist/Oncologist **ix.** Chiropractor
Response:	

NETWORK/PROVIDER ARRANGEMENTS	
1.94	Indicate whether the network proposed for the State is leased or owned or a combination. If a combination, indicate what percent is leased and what percent is owned. If any portion of the network is leased, provide the name of network lessee. As the result of this arrangement, the State will require no impact on preauthorization, quality assurance and hold harmless arrangements. Indicate how this requirement will be met. Also, indicate how negotiated discounts for leased networks are on-line and fully integrated with the claims system.
Response:	
1.95	Indicate which accreditation was selected, provide the date of accreditation, and give analysis on why said accreditation was selected.
Response:	
1.96	Describe in detail any restrictions or exclusive requirements for any provider Network.
Response:	
1.97	Indicate if separate provider contracts for PPO and POS networks are maintained and describe in detail the reasoning and methodology behind such provider contracts.
Response:	
1.98	Indicate how Centers of Excellence are utilized for high intensity procedures: a. List of Centers of Excellence by procedure b. Method of referral to Centers of Excellence c. Credentialing process for Center Excellence
Response:	
1.99	Indicate ongoing provider quality monitoring activities, such as physician profiling.

Response:	
1.100	Provide detailed information on how Contractor hold-harmless provisions and network agreements are enforced with providers/pharmacists.
Response:	
1.101	Provide the average trend rates for public sector customers with similar demographics and plan designs for the last five (5) years for PPO plans and POS plans.
Response:	
1.102	Describe the average in-network participation by provider and by claims paid for 2017 and 2018 for clients located in Nebraska.
Response:	
1.103	Describe the capability to develop and administer a network specifically for the State based upon State-defined criteria.
Response:	
NETWORK / PHYSICIAN	
1.104	Provide the ratio of physicians to members maintained in the State of Nebraska's provider network.
Response:	
1.105	Provide the ratio of participating specialists to physicians in the State of Nebraska's provider network (i.e., all providers not including family/general practitioners, OB/GYN, Pediatricians and Mid-Level Clinicians such as nurse practitioners and physicians assistants).
Response:	
1.106	In the service areas where there are plan members, indicate if there are any medical services or specialties that are not available in the physician networks. Indicate what services are not available and what provisions are made for patients requiring these services.
Response:	
1.107	Describe how the State would be informed of the termination of a provider.

Response:	
1.108	Describe the contract period for physicians.
Response:	
1.109	Describe how often physicians are credentialed.
Response:	
1.110	Describe physician credentialing process, specifically if the selection and credentialing process allows the declining of an individual physician or provider group or organization. What is the average time to credential and add an individual physician? What is the average time to credential and add a medical group?
Response:	
1.111	Describe if physicians in the network may limit the number of patients/cases that are accepted. Indicate how the limit is determined and what the limit is.
Response:	
1.112	Indicate what percentages of physicians in the provider network for the State's health plan are at full capacity.
Response:	
1.113	If a network gap or deficiency is identified by the Contractor or the State, how will the need for additional providers be addressed?
Response:	
NETWORK / HOSPITAL	
1.114	Describe what criteria is used to select hospitals and other health care facilities to participate in the network.
Response:	
1.115	Indicate which of the hospitals participating in any network are accredited by JCAHO and which are not.

Response:	
1.116	Indicate what liability coverage limits the participating hospitals are required to carry.
Response:	
1.117	Indicate if any hospitals or other medical facilities have been terminated or dropped from the network. Identify the hospital/medical facility and for what reason(s).
Response:	
1.118	Indicate what percentage of hospitals/facilities in Nebraska are in the provider network.
Response:	
1.119	Indicate what provisions are made for enrolled patients when hospitals/facilities leave the provider network.
Response:	
1.120	In the event that any of the Contractor's medical facilities are unable to provide service due to complete or partial destruction, labor disputes, epidemic or other causes, the Contractor shall make a good faith effort to arrange to have the services (to which a member is entitled) provided by other facilities and providers of services. Explain how to comply with this provision.
Response:	
1.121	In addition to the hospitals in the provider network, list all other types of facilities and ancillary providers available through the hospital provider network and indicate how each is paid.
Response:	
1.122	Indicate if there are any forms of treatment that cannot be provided by hospital provider network; indicate which ones. Describe what arrangements are made for the provision of these necessary services.
Response:	
1.123	Indicate if there are designated facilities for specific specialty care for services such as transplants, etc. and describe such arrangements in detail.

Response:	
QUALITY ASSURANCE	
1.124	Provide a quality assurance program in terms of any qualitative and quantitative measures used in the program. a. Describe how these programs are communicated to providers within the network(s). b. Describe how these programs are communicated to health plan members.
Response:	
UTILIZATION MANAGEMENT /CASE MANAGEMENT	
1.125	Provide descriptions for each UM/CM program, including the process to include individuals in the UM/CM program once paid claims exceeds $50,000. List and describe the case management services provided to members: Address complex, chronic, and short-term conditions.
Response:	
1.126	Describe the process for population risk analysis and population stratification. Identify the guidelines that are used to support UM/CM decisions. a. Who is responsible for follow up after discharge? b. Does this protocol apply to all discharges or is it limited to those with identified medical needs at discharge? c. How is follow up after discharge tracked? d. What processes are in place to assist individuals in obtaining qualified medical services at a low cost? e. Does a single/same case manager follow the case throughout its course in case Management? f. Does the case manager serve as the primary reviewer if the patient is readmitted to an acute care setting?
Response:	
1.127	Describe the UM/CM program in detail, including information on the following: a. Management of complex cases. b. Identification of complex cases. c. Ability for nurses to access member notes from other internal programs, including nurse line, condition management, wellness coaches. d. Management of special needs cases (traumatic brain injury, co-morbid conditions, neonatal cases, etc.). e. Ratio of case managers per 1,000 members. f. Methodology for determining savings related to the case management program.
Response:	

1.128	Describe predictive modeling and how predictive modeling capabilities identify at-risk members and potential interventions the State should consider. Include the ability to benchmark the wellness program and its financial impact.
Response:	
1.129	Describe the preauthorization and utilization review services in detail, including information on the following: a. Location of the office providing preauthorization and utilization review services, relationship with any subcontractors and current procedures with them to integrate data, criteria and program results. b. Nurse line and how these services integrate with medical/behavioral/wellness programs, including medication adherence education.
Response:	
1.130	Describe the qualifications of the case management staff and the level of staff providing interventions. Address how Utilization Management, Clinical Program Management, Behavioral Management and Pharmacy integrate to assist members in maximizing benefits while containing Plan costs.
Response:	
1.131	Describe the degree to which the medical management programs are integrated (i.e., electronic systems integration, etc.).
Response:	
DISEASE MANAGEMENT	
1.132	Provide an engagement model DM program that includes, at a minimum, asthma, diabetes for adult, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and co-morbid conditions. DM program must include a proven methodology for calculating and reporting a return on investment (ROI). Describe all DM programs currently available and if the member has the option to opt-out of DM programs.
Response:	
1.133	Indicate the percentage of members identified as candidates for DM and enrolled in the programs are actively participating, with a minimum of quarterly engagements, i.e., phone calls, face-to-face, and virtually.
Response:	
1.134	Indicate the percentage of members identified and enrolled for DM who receive only written communication, e.g. general health newsletters, disease specific educational materials?
Response:	

1.135	Indicate the total number of members of a similar account size to the State of Nebraska that are managed within the DM programs by diagnosis for calendar year 2018.
Response:	
1.136	Describe how member compliance and participation are monitored and reported on a quantified basis.
Response:	
1.137	With the data collected on members (e.g. health risk assessment, biometrics, claims), how is it made actionable for the member?
Response:	
1.138	Confirm availability and describe each of the following programs and/or services, and how long each has been in effect, including modalities for participation in: a. Health Risk Assessment (both web-based and telephonic) b. Individual action steps c. Online biometric tracking tools d. Blood pressure, blood sugar, BMI/weight and other online trackers e. Self-management education and goal-setting f. Nutrition g. Physical activity and related online trackers h. Prenatal care i. Tobacco cessation j. Stress management k. Weight management l. Injury prevention m. Preventive service reminders, sent by mail, phone or electronically n. Gaps in care reminders, sent by mail, phone or electronically o. Type of smart innovative health programming (i.e., smart phone tracking, Fit Bit, etc.)
Response:	
1.139	For the above programs and/or services (a. - o.), describe the performance results and anticipated ROI for each program and the total number of employees eligible for each program in 2018.
Response:	
1.140	Describe the standards related to frequency and content of interactions between the member and attending physician.
Response:	
1.141	Describe the qualifications of the staff that manage the DM cases.

Response:	
1.142	For the diagnoses that are managed in DM, indicate if there has been a resulting decrease in the admissions / ER visits for these diagnoses from the year prior to the program being implemented. Provide the percentage decrease.
Response:	
1.143	If no decrease has occurred in the hospitalizations for the diagnoses managed through DM, provide an assessment as to why this occurred, including what corrective actions were taken.
Response:	
1.144	If a participant has more than one DM diagnosis, describe how the programs manage the member's care. Describe the program that manages gaps in clinical care, beginning with the identification process and concluding with outcome.
Response:	
1.145	Describe the ability to administer copay waivers or customized member cost sharing based on individual member eligibility within the same plan options. For example, diabetics participating in a diabetic DM program may receive copay waivers for routine office visits.
Response:	
1.146	Provide a case study that highlights success in providing customized programs and solutions to a customer with similar characteristics as the State. Describe the goals, initiatives developed to achieve the goals, and successes and challenges in implementing the initiatives. Include specific metrics and outcomes measured to determine success.
Response:	
1.147	Describe how current DM program history from the State's existing services can be utilized to transition DM services.
Response:	
STANDARD MEDICAL REPORTING	

1.148	Attach sample of standard medical and utilization report(s) that would be prepared for the State. Items 1 through 11 are minimum reporting requirements for the State: 1. Daily Reporting The State requires a daily reporting of claims paid in a format acceptable to meet State requirements for Contractor reimbursement; such format shall be determined during contract finalization with the specified Contractor. The following are required data fields for daily reporting and should not include Personal Health Information (PHI): a. Policy/Group/Plan Number b. Claim Number c. Payee d. Provider Name e. Claim Expense Incurred Date f. Claim Payment Date g. Claim Process Date h. Claim Billed Amount i. Claim Allowed Amount j. Claim Paid Amount 2. Monthly reporting containing the following information: a. Paid claims b. Administrative/Network Fees (if applicable) c. Monthly enrollment counts d. Reconciliation of claim drafts to paid claims e. ASO reconciliation of monthly PEPM Administrative Fees f. Membership (Census) report g. Large Loss Report h. EPR and Rx Executive Summary 3. Quarterly Reports a. Appeals Reports b. Workers Comp Report c. Performance Guarantees (Service Report) d. Health Plan Review Report e. Medical/Rx Rebate report 4. Annual Reports a. General claim utilization reports by major line of coverage identifying: i. Claims submitted ii. Claims eligible iii. Deductible and coinsurance application iv. Payment reductions due to network negotiated rates v. Reasonable and Customary cutbacks and savings vi. COB savings vii. Ineligible expenses viii. Net benefits paid by major line of coverage 5. Consultative Reports a. Reports that analyze utilization of healthcare services of plan members: i. Identifies opportunities for plan design or care management interventions

	6. Claim utilization report will show separate experience for: a. Members b. Dependents c. COBRA Participants d. Retirees 7. Member contested claims separated by denial reason 8. Claim lag report 9. Network savings reports for each network offered 10. Most utilized hospitals and physicians reports 11. A year-end financial accounting for the program within 90 calendar days after fiscal year end
Response:	
1.149	Describe Ad Hoc Reporting Capability both online and paper formats.
Response:	
1.150	Describe how reporting capabilities (other than the ones required in 1.148 above) would provide value to the State.
Response:	
PHARMACY BENEFITS REPORTING	
1.151	Provide a brief sample of the reports listed below and the frequency of each report. a. Eligibility Report which shows accuracy of updates and changes b. Paid Claims Summary (Ingredient cost, days' supply, dispensing fees, taxes, copay totals by month) c. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the Drug name and dosage, submitted charge, allowable charge, paid) d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB) e. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average days' supply) f. Top Drug Report (detail of cost and utilization by top drug products) g. High Amount Claimant report h. Therapeutic Interchange Report detailing success rates and cost impacts of Contractor initiated interchanges i. Drug Utilization Review activity and Savings Report by type of edit j. Member compliance and adherence to therapy k. Formulary Savings and Rebate report l. Paid Claims Summary (see b.) showing total number of claims, eligible charges and claim payments for each category m. Prior Authorization and other clinical program reporting

	n. Specialty Rx reporting o. Pharmacy cost and utilization reporting
Response:	
REBATE AND FORMULARY MANAGEMENT	
1.152	Provide an analysis report indicating which prescription drugs would not be included and which prescription drugs would be added to the State's current formulary. Refer to http://das.nebraska.gov/Benefits/Active/2019/2019July-DecPrescriptionDrugList.pdf for the State's current formulary.
Response:	
1.153	Describe the current formulary appeal process to address member concerns regarding formulary alternatives or provider indications of medical necessity.
Response:	
1.154	Are any generic drugs considered "non-preferred" in the proposed formulary (i.e., subject to the "non-preferred" copay)? If yes, describe in detail and provide examples.
Response:	
1.155	Does the formulary currently exclude any prescription drugs from coverage? If yes: a. provide a list of those excluded from coverage b. indicate the notification process for any future changes to the exclusion list, including the amount of advanced notification that will be provide to the State and its members and the form the notification will take If no: a. Confirm that no such future exclusions will be required during the term of this contract?
Response:	
1.156	Do the manufacturer agreements contain provisions that limit the amount the manufacturer can raise the AWP price of prescription drugs each year? If yes, describe.
Response:	
1.157	What reporting will be provided to the State to demonstrate such manufacturer price limit agreements provide meaningful benefits to the State?

Response:

PHARMACY NETWORK ACCESS AND MANAGEMENT

1.158 What is the current number of retail pharmacies in the network?

Response:

1.159 List any pharmacy chains excluded from the retail pharmacy network.

Response:

1.160 Perform and provide a GeoAccess (driving distance) analysis based on the contracted pharmacy network. Utilize the access standards in the table below for the analysis.

Provider Type	Urban and Suburban Enrollees	Rural Enrollees
Pharmacies	2 in 20 miles	2 in 35 miles

Response:

1.161 Provide the number of participating retail pharmacies that were terminated from the network in the past 24 months:

Termination Rates	# of Pharmacies	% of Pharmacies	Reasons for Terminations
By Organization+			
By Pharmacy++			

+when the termination is initiated by the Contractor
++when the termination is initiated by a pharmacy

Response:

1.162 Using the pharmacy identifier on the provided PBM Claims Data File, identify and list all pharmacies that are not in your proposed retail pharmacy network.

Response:

1.163	The State has designed its pharmacy plan benefits to minimize the use of manufacturers' coupons or savings cards. Does the retail network agreements allow pharmacies to utilize manufacturer coupon and other programs to circumvent plan design incentives and disincentives? What action is taken to deter or minimize the use of manufacturer's coupons?
Response:	
1.164	What options are available to members regarding Prescription Drug Discount card programs for entities that do not accept the branded card used by the Contractor?
Response:	
1.165	What programs are available that can increase rebates to card programs.
Response:	
MAIL ORDER	
1.166	Describe the Mail Order process.
Response:	
1.167	Provide the locations of all Mail Order facilities nationwide.
Response:	
1.168	Describe the standard floor limit for accepting prescription orders from members without the correct payment?
Response:	
SPECIALTY PHARMACY	
1.169	Provide location information on specialty pharmacy if different from Mail Order Facility.
Response:	
1.170	Describe the relationship with the specialty pharmacy, including if it is part of a specialty pharmacy network.
Response:	

1.171	Provide the definition and qualification criteria of a specialty drug.
Response:	
1.172	Describe how the State is notified of the pricing terms for new specialty drugs including how far in advance such notice is provided.
Response:	
1.173	Describe any separate plan design that can be implemented for specialty drugs that would include generic, preferred brand, and non-preferred brand tiers.
Response:	
1.174	Describe the courier services utilized for specialty product delivery and how courier service vehicles maintain temperature control.
Response:	
1.175	Describe any limits on certain specialty drugs to less than 30 days' supply for a patient's initial prescription. Indicate which drugs and the days' supply limit.
Response:	
1.176	Describe any quantity limit rules for specialty drugs and include a list of the quantity limits by drug.
Response:	
1.177	Provide the customer and member service operation hours of the specialty pharmacy program.
Response:	
1.178	Provide a concise description of member service pharmacist support for specialty drugs, including how many pharmacists provide member support, the hours of availability and any specialized expertise.
Response:	

1.179	Provide a concise description of the member support services provided to members who utilize oncology specialty drugs.
Response:	
1.180	Provide a brief recommendation of how the Specialty Pharmacy will collaborate with the State's selected medical carriers to optimize patient care and utilization of specialty drugs.
Response:	
1.181	Describe any specialty drug categories that are recommended to clients which limit coverage to the pharmacy benefit only.
Response:	
1.182	Describe what procedures or management tools the organization has in-place to manage the use of manufacturer coupons for high cost drugs.
Response:	
1.183	Describe any specialty drug copay assistance programs (e.g. variable copay design, concierge service) available to reduce the State's Plan costs and describe any member impact and Plan requirements to implement.
Response:	

CLINICAL MANAGEMENT PROGRAMS AND CAPABILITIES	
1.184	How will the State be kept informed of changes to clinical management rules?
Response:	
1.185	Provide a sample client management report that details clinical rule activity and savings a. Provide a sample of client clinical management performance report. b. Describe PA, step therapy and quantity level limit program capabilities. c. Attach a list of drug categories for which such programs can be applied. d. Briefly describe drug utilization review (DUR) process and indicate which point-of-sale edits can be overwritten and which are "hard" rejects. Include a list of point-of-sale edits. e. Provide the detailed utilization management program list, including specific drugs names in each program. f. Provide a sample DUR report that is produced and made available to clients.
Response:	

1.186	What was the overall average DUR savings as a percentage of plan cost in 2018 in reference to Public Sector cases similar in size to the State of Nebraska?
Response:	
1.187	Summarize the DUR edits that detect fraud and/or abuse.
Response:	
1.188	Describe the “look-back” period utilized for the refill-too-soon edit and indicate whether it includes only the previous claim or cumulative historical claims.
Response:	
1.189	In addition to point-of-sale edits, describe any other tools or programs that are available to detect, prevent, and resolve fraud and/or abuse. Also provide a complete description and samples of any documents used.
Response:	
1.190	Indicate whether or not a DEA or other provider identifier is required to fill a prescription for controlled substances and also describe how such prescriptions are monitored and managed to identify and deter fraud or abuse.
Response:	
1.191	Does the prior authorization rule for drugs used to treat Hepatitis-C (Harvoni or Viekira Pack) take into account severity of illness? If yes, provide a copy of the complete criteria for approval.
Response:	
1.192	Describe medication compliance and adherence therapy programs.
Response:	
1.193	Describe how outcomes for specialty drug management programs (ROI, Clinical Results, etc.) are reported.
Response:	
1.194	Describe policies for lost medication, vacation supplies, and overseas supplies for prescription early refills.

Response:	
1.195	Describe policy for synchronization of prescriptions (refer to Legislative Bill 442).
Response:	
1.196	Provide a detailed description of how drugs that are preferred versus non-preferred are determined.
Response:	
1.197	Describe how individual physician prescribing patterns are monitored. Describe what actions are taken with physicians who have a high degree of non-compliance.
Response:	
1.198	Briefly describe methods currently in place to influence prescribing behavior. Include the process for State to opt-in/out of these programs.
Response:	
1.199	Provide a copy of any physician score card or other reporting that is provided to clients.
Response:	
1.200	Describe the process for the State to have managed injectable programs administered.
Response:	
TRANSPARENCY TOOLS	
1.201	Describe the capabilities regarding member access to: a. Physician and hospital quality and/or outcomes data b. Physician and hospital ranking or premium designation c. Physician and hospital pricing data by procedure by provider
Response:	
1.202	Describe capabilities toward educating members on price transparency and quality, include any decision matrices to help guide members in making a decision.

Response:	
1.203	Can members be messaged on more cost effective treatment options? For example, if a member has a non-emergent emergency room visit that does not result in a hospital admission, will a message be sent to the member suggesting alternatives?
Response:	
1.204	Is member messaging available electronically, telephonically, and/or through the mail? What types of messages are sent to members?
Response:	
1.205	What steps have been taken toward improving Health Information Technology (HIT)? Describe the progress, state of development, and future commitment in terms of education, communication, awareness, and integration with utilization management.
Response:	
IMPLEMENTATION AND COMMUNICATIONS	
1.206	Provide an implementation plan detailing the implementation timeline with a July 1, 2020 effective date. At a minimum, the Implementation Project Plan must provide specific details on the following: a. Identification and timing of significant responsibilities and tasks b. Names, titles, and implementation experience of key implementation staff and time dedicated to the State during implementation c. Identification and timing of the State's responsibilities d. Transition requirements with the incumbent Contractors e. Staff assigned to attend and present (if required) at Open Enrollment f. Data and timing requirements from current Contractors to ensure transition of care and prior-authorization data is appropriately transferred
Response:	
1.207	Provide detailed information on communication to the members. Provide sample communication materials such as certificate of coverage booklets, up-to-date provider network directories, request letters for clinical programs and sample EOBs.
Response:	
1.208	Provide detailed information on how long it will take to print and distribute benefits literature and indicate how long it will take to print and mail identification (ID) cards after receipt of correct eligibility data. During the year, ID cards must be distributed by the Contractor within three (3) business days of being notified of the new or changed enrollment by the State.

Response:	
1.209	Provide detailed information on its procedures and time frame to prepare for annual Open Enrollment. The State will offer an annual Open Enrollment period during which time covered members may switch plan coverage. The Contractor shall provide staff to assist State Human Resource Personnel and Administrative Services – State Employee Benefits with annual Open Enrollment meetings in various locations throughout the State. The Contractor shall have certificate books ready for distribution prior to the State's annual Open Enrollment; State will provide plan designs electronically to Contractor sixty (60) days prior to annual Open Enrollment. Describe timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual workarounds, dates for last pre-OE updates, OE file updates, etc.).
Response:	
1.210	Describe what a one-time implementation credit could be used for as approved by the State. (I.e. implementation support, pre-implementation audits, readiness assessments, communication plans, etc.).
Response:	
1.211	Describe the level of support that will be provided in assisting members in learning about benefit options.
Response:	
WELLNESS PROGRAMS	
1.212	Provide a description, capabilities, benefits and execution process of all Wellness Programs that could be made available to the State. Describe experiences administering various wellness program structures. I.e., requirement-based/point-based/etc.
Response:	
1.213	Describe overall wellness solution for State of Nebraska and how it is integrated for a seamless member experience.
Response:	
1.214	Describe the availability of and the process to ensure members have: a. Lifestyle coaching. b. 24-hour nurse line. c. Other Wellness services, including medication adherence education.
Response:	

1.215	Describe the process for population risk analysis, population stratification, including predictive modeling with respect to Member outreach.
Response:	
1.216	Describe the predictive modeling capabilities and the ability to benchmark the wellness program and its financial impact.
Response:	
1.217	Describe the process to share recommendations for improvement based on risk factors.
Response:	
1.218	Describe monitoring activities to identify gaps in care and opportunities for improvement.
Response:	
1.219	Describe affirmative steps that are employed to promote compliance among members.
Response:	
1.220	Provide the following outcomes results, for each of the last two (2) years, for each Wellness service: a. 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 each program offered including: i. 24 hour nurse line ii. Lifestyle coaching iii. Other Wellness services b. Member participation and ROI for incentive programs. c. Provider satisfaction survey results. d. Member satisfaction survey results. e. Clinical measures for each Wellness services provided. f. Gaps in care closures. g. Monitor changes in Member-reported physical and mental health status through a tool.
Response:	

1.221	Describe the ability to provide designated health coaches, lifestyle coaches, exercise physiologists, nutritionists, behavioral health specialists, maternity specialists or other clinical staff to carry out Wellness activities such as health risk assessment, telephonic coaching interventions including lifestyle coaching, a 24-hour nurse line and education about treatment options and health education to empower Members to manage their health.
Response:	
1.222	Describe outreach strategies including those for reaching Members with incomplete contact information. If outreach strategies vary by risk level or program, describe each of the different strategies and when each is used.
Response:	
1.223	Describe the health risk assessment completion rate.
Response:	
1.224	Describe how data collection will be administered and evaluation for the health risk assessment.
Response:	
1.225	Describe availability and describe each of the following programs and/or services: a. Health Risk Assessment (both web-based and telephonic) with Individual action steps b. Online biometric tracking tools c. Blood pressure, blood sugar, BMI/weight and other online trackers d. Self-management education and goal-setting e. Nutrition f. Physical activity and related online trackers g. Prenatal care h. Tobacco cessation i. Stress management j. Weight management k. Injury prevention l. Preventive service reminders, sent by mail, phone or electronically m. Gaps in care reminders, sent by mail, phone or electronically n. Type of smart innovative health programming, i.e., smart phone tracking, Fit Bit, etc.
Response:	
1.226	Describe wellness-coaching success.
Response:	
1.227	Describe the concept of success relate to improvement in employee population health risks.

Response:	
1.228	Describe how risk stratification is conducted for wellness programs.
Response:	
1.229	Provide the ROI calculation methodology for the overall Wellness program.
Response:	
1.230	Define and measure wellness outcomes related to the programming structure.
Response:	
1.231	Describe the program that manages gaps in clinical care, beginning with the identification process and concluding with outcome.
Response:	
1.232	Describe successful outcomes of the current wellness programs offered as pertaining to the following: a. Eligibility b. Centralized electronic medical records c. Medical Community integration processes and program details d. Education materials e. Identification, participation, engagement f. Risk stratification methodology g. Predictive modeling capabilities h. Including individuals in the disease management program once a member's paid claims exceed $50,000
Response:	
1.233	Describe the following tools and services available to Members via the Member portal: a. Health Risk Assessment. b. Wellness tools and trackers. c. Health promotion and health education tools. d. Any other web tools to support Wellness activities. e. Health services related to member cost
Response:	

1.234	What sets this organization apart from other competitors?
Response:	
1.235	Describe engagement strategies that are innovative and unique.
Response:	
1.236	The State has employees throughout the state. Describe the strategy for engaging individuals in remote locations?
Response:	
1.237	How will this program help the State be successful in evolving its culture of health in the workplace and engaging members into programs?
Response:	
WELLNESS PLATFORM	
1.238	Describe the web-based digital platform capabilities with respect to wellness programs and data aggregation. Include the ability for programs from other vendors to be "plugged into" the platform and describe the tools included in the digital platform.
Response:	
1.239	Describe how members are provided with personalized guidance and a longitudinal view of the member's health, healthcare and benefit needs.
Response:	
1.240	Describe all-in-one experience for members to access medical benefits and programs available, as well as to find the best and most cost-efficient care.
Response:	
1.241	Can individuals be tracked and rewarded for showing progression and build that activity into the incentive design? Explain.
Response:	

CURRENT AND FUTURE INNOVATIVE INITIATIVES	
1.242	Describe any such initiatives currently offered to self-funded groups such as the State, which are available within the State of Nebraska. Describe how these Nebraska initiatives can be implemented in the State's health plans and the incremental costs of the ASO fees. If any of these innovative Nebraska-based initiatives are in development or in the planning stages for the future, provide any information available to allow the State to understand concepts for developing each initiative. Include information on the expected implementation of such initiatives in Nebraska, when available to the State plans and the expected impact on program costs. Such initiatives may include, but are not limited, to the following: a. High Performance Networks or narrow networks, b. Patient-Centered Medical Home models, c. Accountable Care Organizations, d. Telemedicine/Virtual Visits (which also includes Behavioral Health); e. Other value-added services.
Response:	