Appendix H Questionnaire

In order for your proposal to be considered and accepted, your organization must provide answers to the questions presented in this section. Proposers should refer to the earlier sections of this RFP before responding to any of the questions to ensure that you have a complete understanding of the requirements with respect to your organization's proposal.

Each question must be answered completely, specifically and in detail. Include both the question and the answer in your proposal response. Reference should not be made to a prior response unless the question involved specifically provides such an option. After answering the question, vendors may include additional information you consider relevant or useful to the County as an appendix. An electronic copy of Appendix H Questionnaire has been provided to facilitate your response.

If this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated, any controversy arising over such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal.

The questionnaire is broken down into the following 11 categories

A. Organizational background, strength, and experience

B. Account Management

C. Implementation and Communication Materials

D. Plan Administration

E. Customer Service and Member Tools

F. Claims Administration

G. Medical Networks

H. Pharmacy Management

I. Clinical Management

J. HRA/HSA/FSA Experience and Administration

K. Stop Loss

A- Organizational background, strength, and experience

1. Provide a brief summary of your organization, including:
    - Company history
    - Organizational structure
    - Services provided
    - Length of time you have been in business
    - Ownership

- Significant organizational and operational developments within the past two years
- Future merger/acquisition plans

2. Please describe any qualifications or clarifications you would like to make regarding your company's ability to meet the requirements stated in the RFP.

3. Clearly identify any restrictions and/or limitations on coverage or eligibility for current and future participants.

4. Include a specimen copy of the contract that you propose to use (for medical, pharmacy, and stop loss).

5. Please describe the scope and type of strategic alliances your organization currently has in place. Include information on any subcontracted relationships and how will you be responsible for their performance.

6. Provide your organization's most recent ratings by the following organizations:

Agency	Rating	Last Rating Date
AM Best		
Moody's		
Standard & Poor's		
NCQA (by product)		

7. Please provide the average number of group members (or volume, as applicable) your organization serviced in 2023 on a national basis.

	# of Members Covered in 2023		
	Self-Insured	Fully-Insured	Total
Medical			
Pharmacy		N/A	
HSA Administration			

8. What were your member retention rate percentages in 2023?

Medical	
Pharmacy	
HSA Administration	

9. List in a table format all services that are currently outsources or subcontracted, the name of the vendor/partner, and length of the relationship. Describe how you ensure quality customer service and timely and effective issue resolution for these services.

B- Account Management

10. Provide the name, title, address, telephone and fax numbers and email address of the person(s) who will be responsible for managing the County's account. Where is that person located? Provide a brief biography, including a description of related

qualifications and experience, length of service with your organization, certifications or accreditations, and current account responsibilities.

11. Please provide the following information on the specific areas listed below that will be servicing Dakota County.

	Geographical Location(s)	**Hours of Operation (CST)**	**Is this service Outsourced? Yes or No?** *If Yes, provide name of company to which the function is outsourced*
Member Service Center			❑ Yes *Specify Company Name:* _____ ❑ No
Claims Administration Office			❑ Yes *Specify Company Name:* _____ ❑ No
Account Management Office			❑ Yes *Specify Company Name:* _____ ❑ No
Utilization Management			❑ Yes *Specify Company Name:* _____ ❑ No
Pharmacy Benefit Management			❑ Yes *Specify Company Name:* _____ ❑ No
Wellness Program			❑ Yes *Specify Company Name:* _____ ❑ No
HRA/HSA/FSA Administration			❑ Yes *Specify Company Name:* _____ ❑ No
Other (Specify functional area)			❑ Yes *Specify Company Name:* _____ ❑ No

12. Current Clients – Include a list of three (3) accounts with enrollment of at least 1,000 employees for whom your organization and the selected account service team provides

similar services. Public sector references are preferred and at least one reference must be from a public sector client. Include the following information:

- Organization name
- Number of members or lives
- Plan(s)/services offered through your organization
- Name, title, telephone number, and e-mail of individual who can be contacted
- Years as a client

13. The County will expect the following reporting formats. Please provide a listing of your standard report templates including timing and frequency.
    a. Summary of claims experience (by plan, employee group, medical, pharmacy, etc.)
    b. Claims by provider type (hospital, clinic/physician)
    c. Claims by coverage (for example, inpatient room and board, prescription drugs, outpatient surgery, chemical dependency, etc.)
    d. Results of disease management and case management efforts including frequency of various diseases and comparison to normative/book of business data.

14. Please indicate which features are available on your website.

Member Can:	**Yes**	**No**
Personal account information		
Personal claim (medical and Rx) information and status		
EOB		
Check for a provider (Name, address, location, tiering and provider clinic and provider)		
View individual/family deductible and out of pocket maximum (including list of Rx applied)		
Verify eligibility		
Email a question		
Live chat		
Review covered items under the plan on-line (i.e., On-line SPD or certificate)		
Print ID card		
Cost/quality estimates for medical services		
Cost/quality estimates for Rx		
Cost comparisons for services and care		
Cost analysis between the 3 County medical plans depending upon specific services and costs the employee may incur		
General medical or condition information/database (prior authorization needed)		
Health risk assessments		

Online drug formulary		
FSA claims status and online claim from/upload documentation		
FSA Statement and account history		
HRA/HSA claims status and online claim form/upload documentation		
HRA/HSA statements and account history		
Other?		
Employer Can:	**Yes**	**No**
Print Reports- claims, enrollment, stop loss		
Marketing materials - download PDF documents/applications		
Order supplies		
Add/Delete plan participants		
View eligibility information		
Check payment of fees		
Other?		
Provider Can:	**Yes**	**No**
Check eligibility of member		
Submit a claim electronically		
Search for a specialist		
Check status of claim payment		
Check to see if an item is covered		
Review plan requirements (for Pre-Cert)		
Other?		

15. How will you keep the County informed of legislative and regulatory changes that impact their plans?

C - Implementation and Communication Materials

16. Please provide two references for like-populations that you implemented effective 1/1/2023 or 1/1/2024.

17. Confirm you will provide an implementation manager to lead the implementation process.

18. Describe responsibilities the implementation manager will have related to the County's account.

19. Please confirm that your fee proposal includes all costs associated with implementation services. You must provide a detailed description of any implementation service and/or fee charge not specifically included in your fee proposal.

20. What data would you require from the current carrier(s)/administrator(s)/service provider(s) in order to assure a smooth transition?

21. Describe the implementation process and provide a detailed timeline and the specific tasks involved to convert the County's current arrangements to your proposed plan,

given selection in September 2024 and an effective date of January 1, 2025. Be specific with regard to the following:

- Timing of significant tasks
- County responsibilities
- Transition with incumbent health plan
- Availability of staff to attend open enrollment/educational sessions a County Open enrollment services, including deadline for submitting enrollment data

22. What kind of employee communication materials do you provide to support clients in educating their employees about their benefits? Can these be customized for particular clients? Please provide samples of these materials, including:
    - Educational/promotional materials
    - Sample new member packet

23. What is your deadline for receiving eligibility information in order to guarantee member ID cards are received by January 1, 2025? How much time will you require to issue?
    - Member ID cards
    - Administrative materials
    - Booklets/certificates/SPD's
    - Master policy/contract

D - Plan Administration

24. Confirm that you are willing to serve as the named Fiduciary with response to claims determinations and will determine all first and second level appeals.

25. How will you handle transition of care for members with ongoing treatment at the time of transition? Be specific with conditions or type of care that is typically transitioned, individuals who are in a course of treatment, transition process of current medical treatment and communication of transition issues to all plan members.

26. Confirm that you will communicate legislative changes related to the operations of the plan in a timely manner, and describe the support staff and process.

E -Customer Service and Member Tools

27. Describe the range of services provided by your customer service representatives and the qualifications of your staff. Are care advisors and/or care coordinators or services included in your customer service model?

28. Please describe your IVR system.

29. What languages are available to members through the call center? What services are available for members with a speech or hearing disability (e.g., IP CTS)?

30. What is the procedure when members call after business hours? Can members leave a message and if so, what is the standard for responding to this message?

31. Can a member escalate to a supervisor or manager if they feel that they are not getting questions answered?

32. What training will be provided to the customer service team that will serve the County to ensure that members receive accurate information?

33. Describe the performance of the customer service resources that would be available for County members, including your organization's goals and performance (over the last 18 months) for the following statistics:

Total number of daily incoming calls	
Number of representatives available to take calls	
Average customer wait time	
Number of calls unanswered	
Number of calls abandoned	
Percentage of member services inquiries resolved on the first call	

34. Describe your system for tracking inquiries, complaints and appeals. What are your standards for follow-up and resolution?

35. Are 100% of member calls recorded?

36. Are member call recordings, or transcripts, available to authorized members of the County's team for review and issue resolution?

37. Discuss the member website and mobile application, including tools and resources available to members.

38. Provide a link to your website and a demo ID and password to test the user experience

39. Can you customize the website and mobile application for the County?

40. Can you accommodate single-sign on (SSO) to and from your site and other County vendors?

41. Do you offer online chat function with a customer service representative through the website or mobile application?

42. Are your website and mobile application compliant with WCAG 2.1 AA accessibility standards? If not, which guidelines do not meet the standards and when do you expect to become compliant?

43. Describe how and when you communicate to members about available programs and services. Do you have an annual communication plan?

44. Do you mail any communications other than paper EOBs without approval of the County? If yes, describe the content and circumstances under which your firm would distribute these mailings.

45. Will both physical and digital ID cards be provided to members?

46. Will you provide a physical ID card for each member in the family (preferred) or only the subscriber?

47. Do employees have the option of using a preferred name for things like Member ID Card and member app/website?

48. Does your mobile app and website include the following capabilities:
    a. Copy of the member ID?
    b. Pharmacy locator?
    c. Ability for members to see their prescription drug claim history?
    d. Formulary lookup feature?
    e. Ability for members to track shipment of mail order medications?
    f. Support and tools to help members determine and find the best behavioral health services for them?

F- Claims Administration

49. Are there any benefits in the County's plan designs that would require manual intervention? If yes, please describe.

50. How long has your claims system been operational? Do you expect to make any major system changes (i.e., move locations, upgrades, etc.) in the next 24 months? If yes, what are they and how will this impact the County? Have you made any major system changes (i.e., move locations, upgrades, etc.) in the last 12 months? If yes, describe any negative impacts to your employer-sponsored group health plans.

51. Describe the claims payment process for participant claims. Describe your claims turnaround times and processes for plan administration.

52. What percentage of claims is submitted electronically? What percentage of claims are auto adjudicated?

	% of claims submitted electronically	% of claims auto-adjudicated
Hospitals		
Physicians		
Ancillary Providers		
Total		

53. Please briefly describe the scope of cost management programs:
    a. Coordination of Benefits (COB)

- How often do you require updating of other coverage?
- Is there a dollar threshold below which you would not pend/deny a claim?
- When COB information is updated, is prior COB status overwritten or maintained?

b. Fraud Detection

c. Over-Payment Recovery

d. Subrogation

- Identify if you perform this in-house or use an outside vendor, including any recovery fees that would apply.
- What dollar thresholds apply (e.g., claims under $1,000 are not investigated)?

54. Describe how you calculate reasonable and customary for out-of-network facilities. How does this differ for hospitals versus physicians versus other provide

55. Please describe your internal and external appeals process for self-insured plans. Confirm that your appeals process is compliant with state and federal rules/regulations. List the independent review organizations (IRO's) that will be utilized for the County.

G - Medical Networks

56. Identify and describe your national preferred provider organization.

    Please provide a listing of your proposed tiered network. The list should include the names of specific clinics and facilities in each network tier.
57. Does your website's Provider Search function clearly distinguish which network tier the clinic/facility/provider is in.

58. Describe your history, experience, and results with establishing and maintaining a tiered provider network. What data and information or methodology is used to place provider groups into cost and quality tiers?

59. Please identify any major provider groups or care systems which are not included in your proposed networks. Describe your proposed approach to contracting with providers that are not currently in the network to ensure they will be available to members effective January 1, 2025.

60. Provide a network match (Geo Access reports) using the enclosed employee census for all proposed provider networks. Your Geo Access report must show the access standard for each tier separately. Include reports showing the total number and percent of employees by city and zip code who meet and do not meet the access standards.

    The access standards should be defined as follows:

PROVIDER TYPE	ACCESS STANDARD
Primary care providers *(1)*	2 providers within 10 miles
Specialists	2 providers within 10 miles
Behavioral Health providers	2 providers within 10 miles
Hospitals	1 hospital within 10 miles
Pharmacies	1 pharmacy within 10 miles
Top Providers	Indicate which current Dakota County top providers (see reports provided) participate in your proposed networks (by provider and network proposed)

(1) Primary care providers should include the following areas of specialty: family/general practice, pediatrics, internal medicine and OB/GYNs.

61. Do you anticipate making significant changes to your network during the next 3 years? If so, explain.

62. Is any part of your network leased or will you rely on partnerships with other carriers in order to fill in gaps in your national network? If so, identify the primary owner of the leased/filler networks and the geographic service area

63. How do you select participating providers? What are your minimum requirements? Briefly describe your credentialing and re-contracting process.

64. What is the current percentage of primary care physicians that are accepting new patients for POS/PPO plans?

65. What is your standard process and advance notification timeframe to notify the County and its members of network changes?

66. How do you qualify your providers by tier? How often is the tiering assignments updated?

67. How often is your online provider directories updated?

68. Describe fully any specialized networks available (e.g., incentive-based, Centers of Excellence, narrow, etc.)?

69. Discuss your urgent care network. How do you communicate to members which stand-alone urgent care providers truly bill as urgent care facilities versus billing as an emergency room?

70. Discuss your behavioral health network. Do you subcontract with a third-party? How do you ensure access and availability of in-network providers?

71. What is your policy for continuation of care if a physician leaves the plan? If the answer differs due to either diagnosis or confinement status, explain.

72. Describe how your plan provides coverage for and handles the following coverage issues in your various product types.
    a. Chiropractic care (both inside and outside the network)
    b. Optometrists/ophthalmologists
    c. Urgent care centers
    d. Mental health/substance abuse
    e. Behavioral health
    f. Prescription drugs
    g. Convenience clinics (e.g., "Minute Clinic",)
    h. Other specialty networks

73. Describe the programs and methodologies currently in place to gather and measure meaningful provider quality and efficiency data that can be shared with members.

74. Describe in detail the performance standards you currently have in place with your contracted physicians, provider groups, hospitals, and other providers. Outline the types of measures utilized, how you monitor and track these measures, how providers are held accountable, and how frequently the data is compiled and shared with the physicians and provider groups.

75. What have you done to align your pay for performance programs with other pay for performance programs and initiatives in Minnesota?

76. Do you offer a 24/7 telehealth service to allow members to visit with board-certified doctors, mental health professionals, and dermatologists? If yes, please describe how the service works.

H -Pharmacy Management

77. Confirm that you can replicate the current plan design and your proposal assumes no changes to the current plan design.

78. Confirm that claims will be processed according to eligibility, plan design, and coverage requirements according to the City's plan documents.

79. What is the name of the adjudication platform used for processing pharmacy claims?

80. Do you own the adjudication platform or use a third-party platform?

81. Please confirm that there will be no platform transitions during the term of this contract.

82. Please confirm you will provide participating pharmacies with information identified during clinical and utilization management at the point-of-service.

83. Please confirm you will accept and process paper claims submitted by members.

84. Can you administer coordination of benefits at the point of sale? If client supplied indicators are required, please describe the requirements.

85. How do you manage lost, stolen, or not delivered prescriptions? Is the County responsible for payment?

86. Please confirm the County will be allowed to conduct a claims review ("audit") of benefit plan provisions, claims accuracy, financial guarantees (including rebates), and performance guarantees.

87. Please confirm that the County may initiate a claim review with no more than 30 days written notice.

88. Please confirm that the County may conduct a review of benefit plan provisions, claims accuracy, financial guarantees (including rebates), or performance guarantees or may combine all reviews into one.

89. Please confirm that the County will be allowed to select the claim reviewer ("auditor") at their sole discretion.

90. Please confirm that all data elements required to complete the claim review will be made available and not withheld.

91. Please provide a copy of your proposed audit protocol that governs the County's audit rights and responsibilities.

92. What is the name of your proposed formulary?

93. Does your proposed formulary exclude certain FDA approved drug products from coverage?

94. Please confirm your proposed formulary can accommodate the current design which has three-tiers including 1) Generic 2) Brand 3) Specialty 4) Non-formulary

95. If your proposed formulary does not have the same tier structure as the County uses today, please describe how your formulary will map to the City's copays.

96. Please describe why your proposed formulary is the right solution for the County?

97. What percentage of your book-of-business uses the formulary proposed for the County?

98. If your formulary is exclusionary, how many products are excluded?

99. How often are updates made to the formulary (and at what time(s) during the year)?

100. Are members notified when their drug moves tiers?

101. Does the proposed formulary have utilization management controls included (prior authorization and/or step therapy and/or quantity limits) or do clinical utilization management programs need to be added for a separate fee?

102. Describe your capabilities in managing prescription drug coverage and the various components of your managed pharmacy program, including retail, mail order, and other specialty pharmacy services. Describe your specialty drug program.

103. Indicate if you have a pharmacy and therapeutics committee (P&T) and include details about individuals involved in formulary development and review, whether a P&T committee exists or not. Include the background and associations of all individuals and do any of them accept grant money from drug manufacturers? How is this monitored?

104. Describe how your organization will manage and administer generic utilization and substitution for the County program. Do you have a mandatory generic substitution policy? What is the process for someone that requests the brand formula for a drug that has a generic substitution?

105. Explain if your organization can administer each provision listed below for members of the County group health insurance program. Describe your strategies and your incentive programs related to formulary drug products and indicate the effect on overall costs.
    a. Therapeutic Interchange
    b. Dispense As Written (DAW)
    c. Prior Authorization
        - What guidelines do you use to establish prior authorization criteria?
        - What is the typical turnaround time for prior authorization review and determination?
        - What is the difference between administrative and clinical prior authorizations?
        - How are prior authorizations resolved if the physician cannot be reached?
        - What is your overall approval rate?
        - Please describe how members are notified of denials and expiration of prior authorizations.
        - Will you provide reporting on prior authorizations and the number of approvals and denials by drug and therapeutic category?
        - What is your overall specialty drug prior authorization approval rate?
    d. Quantity Limit

e. Extended Supply
f. Step Therapy
g. Pill Splitting
h. 90-Day-At-Retail

106. Please provide a list of your clinical programs, with a short description of each, and associated cost for each program. This may be provided as a separate exhibit or included in this questionnaire. At minimum, please include prior authorization, step therapy, quantity limits, drug utilization review, opioid management, diabetes management, compound management, and any distinct specialty drug management programs. See example for desired format:

	Clinical Program	Short Description	Cost
EXAMPLE	*Diabetes Management*	*Members identified as diabetics receive one free meter per year as well as outreach from a care manager. Members can upload readings via mobile app to their pharmacist if desired. Claims are monitored for gaps in care and adherence.*	*$1.00 PMPM*

107. Please describe how you monitor for safety and appropriate utilization.

108. Please describe your fraud, waste, and abuse programs.

109. Do you track physician prescribing patterns, and do you educate physicians about their prescribing patterns? If yes, explain. If no, why not?

110. Do you have pharmacists that are dedicated to serving members with certain disease states?

111. Please describe how you identify and address gaps in care.

112. Please describe your approach to opioid management.

113. Do you have a vaccine administration program? If so, please describe the specifics of the program including if there are fixed prices for vaccine administration.

114. Please discuss how you measure adherence; do you track medication possession ratio (MPR) and/or proportion of days covered (PDC)? Are there other factors you evaluate for certain therapeutic classes?

115. Please describe your approach to specialty pharmacy. Focus on the aspects that differentiate your services in the market.

116. Are members contacted before each specialty fill? If so, is the outbound call made by a representative or an automated call?

117. Can you limit specialty drug distribution to a maximum of 30-day supply?

118. If specialty drug fills are limited to a 30-day supply, can exceptions be made for specific drug classes (HIV, Transplant, etc.)?

119. Do you agree to allow HIV and transplant drugs, regardless of specialty drug classification, to be dispensed up to 90-day supply?

120. Please discuss your strategy around biosimilars.
    a. Do you include biosimilars on your formulary?
    b. If biosimilars are excluded, please explain the clinical and/or financial rationale
    c. How do you expect biosimilars to impact cost and utilization over the next 3 years?

121. Please describe any specialty patient assistance programs that are offered. Describe how you can maximize the value of these programs for the member and the plan.

122. Please describe your specialty copay maximizer and/or accumulator program(s). Describe how these programs can benefit the member and the plan. If a savings analysis can be performed based on the data provided, please provide as an attachment.

123. Please describe your formulary strategy, and how you engage your self-insured clients on coverage decisions related to extremely high-cost therapies (e.g., Gene & Cell Therapy drugs like Luxturna, Zolgensma, Kymriah).

124. Do you have a system in place to determine quickly and accurately the medical necessity of requests for non-formulary drugs? How do you evaluate these requests?

125. Please provide a description of your national (broadest) network and your network proposed for the County. Identify any major chains that are being excluded from your networks.

126. Please confirm that your prescription drug proposal includes retail pharmacies that will dispense extended day supply prescription (90-day supply).

127. Please confirm if your proposal assumes you will be the "Exclusive" provider of specialty drugs (all specialty prescriptions must be dispensed through your specialty mail location(s)) or if your proposal assumes an "Open" specialty drug distribution network in which members may receive a specialty drug from any specialty pharmacy.

128. How many retail pharmacies participate in the proposed network?

129. How many pharmacies in your proposed network are authorized to dispense an extended day supply (90-day supply)?

130. Are there specific retail pharmacies (or pharmacy chains) that members will be required to get their extended day supply prescriptions from?

131. Would you agree to add a pharmacy to the network if the County requests inclusion?

132. Describe the process by which you credential, monitor and periodically re-credential pharmacies. How often are retail pharmacy contracts updated?

133. Describe your process for auditing network pharmacies.

134. Please confirm that if, at any time during this contract, there are retail pharmacy closures that impact more than 25 County members (e.g., must use an alternative pharmacy), you will provide reporting that details the members impacted.

135. How many mail pharmacies are in the proposed network?

136. Are mail pharmacies owned or subcontracted?

137. Where are the mail pharmacies located?

138. Which mail service pharmacy would primarily service the County account?

139. Do you have a program at the mail facility to align and bundle shipment for members with more than one prescription?

140. How many mail specialty pharmacies are in the proposed network?

141. Are specialty pharmacies owned or subcontracted?

142. Where are the specialty pharmacies located?

143. Which specialty pharmacy would primarily service the County account?

144. Please describe how you will assist members in procuring limited distribution drugs?

145. Confirm that your organization has no knowledge or intention of dropping any major pharmacy chains from the network that is in place at the time this contract will be negotiated. Explain your process of delivering continuity of care to members affected by network disruption.

146. How often are pharmacy contracts renegotiated?

147. Do you anticipate renegotiating pharmacy contracts in the next 12 to 24 months? Have you renegotiated any pharmacy contracts in the last 12 to 24 months? If you have, what was the financial impact to your organization and your customers?

148. Do you have a system for maintaining credentialing information? How often is each pharmacy re-credentialed? What information is verified during pharmacy re-credentialing?

149. If a copayment is greater than the cost of the drug as determined by the reimbursement formula, what will the member be charged?

150. If a copayment is greater than the actual cost of the drug based on the pharmacy's everyday cash price, what will the member be charged?

151. Describe expedited delivery services of mail order prescriptions that you offer. What is your policy or how do you handle expedited shipping to members due to service issues or errors?

152. Provide a statement that indicates the commitment of your organization to maintaining transparent pricing arrangements.

153. Do you offer both transparent retail pharmacy discounts as well as pass-through rebates?

154. How many of your clients currently operate under a transparent pricing model?

155. How does your organization demonstrate transparency to its clients?

156. Describe your pharmacy rebate reconciliation process and timing.

157. Please confirm you will load open prior authorizations files, specialty pharmacy claims histories, open mail order refills, and any lifetime limit accumulator files.

I - Clinical Management

159. Indicate which of the following methods you use to determine candidates for your programs.

Method	Yes or No
Medical claims	
Pharmacy claims	
Health risk assessment	
Other member surveys	
Physician referral	
Member self-referral	
Health plan referral	
PBM referral	
“Warm transfer” from member service representative	
Hospitalization	
ER Visit	
Nurse line	
Health coaching	
Utilization Management	

160. How do you use health coaching to actively engage member participation in care management / disease management programs?

161. Are members “assigned” to a specific coach based on their condition/ needs?

162. Do you provide custom health alerts to members and/or treating physicians when a potential gap in care has been identified?

163. Precertification Approval Protocols - what is the source of the criteria used in:
    a. Determining surgical necessity and whether a second opinion is required.
    b. Determining approved length of stay.

164. Concurrent Reviews/Discharge Planning:
    a. How are concurrent reviews conducted?
    b. Are all cases reviewed, or just those with specific diagnoses?

165. What is the average percentage of members who are actively engaged in health-risk management programs after receiving an invitation through an outbound call or email?

166. How do you handle reticence/privacy issues on the part of the member with regard to unsolicited outreach?

167. Does your organization offer the opportunity for members to generally speak to the same nurse? Are members assigned to a specific nurse?

168. Describe your organization's quality initiatives. How do you define and measure quality of care? Do members have access to provider quality information? Please also describe the source of any provider quality information published.

169. How do you measure patient/customer satisfaction? If you use questionnaires, explain how and when they are administered. How do you respond to negative comments/criticisms from members?

170. Do nurses/health coaches make outbound calls to engage members in care improvement programs? What percentage of members is contacted via outbound calls? What is the average percentage of members who actively engage in a care improvement program after being contacted by an outbound call?

171. Describe your utilization management and large case management programs. What types of UM are included in your administrative fees?
    a. Preadmission review
    b. Concurrent review
    c. Ambulatory review
    d. Large case management
    e. Referral management
    f. Chronic care management
    g. Demand management
    h. Nurse hotline
    i. Out-of-state case management

172. What is the process for identifying patients for UM?
    a. What are the automatic and manual triggers to identify cases for UM?
    b. How do you ensure that cases are appropriately managed?
    c. How do you calculate UM savings?
    d. How do you interface with medical group and hospital staff in the UM function?

173. What is the process for identifying members for large case management and how are claims transferred to case managers?
    a. What are the automatic and manual triggers to identify cases for large case management?
    b. How do you ensure that large cases are appropriately managed?
    c. How do you calculate case management savings?
    d. How do you interface with medical group and hospital staff in the case management function?

J - HRA/HSA/FSA Experience and Administration

174. Describe your experience with HSAs, HRAs and FSAs including the length of time you have provided administration of each.

175. Provide the details of your program, including descriptions of bundled or buy-up services options.

176. Do you require a minimum employer bank contribution? If so, please provide the detailed requirements.

177. For HSAs, describe your ability to monitor accounts for exces contributions as they relate to IRS guidelines.

178. Describe the payment/reimbursement process from member accounts. Do you reimburse the member or provider directly? Can the member choose?

179. Are you able to automatically submit or "streamline" claims from the medical plan to the HRA/HSA account and FSA account? Can you provide automatic FSA reimbursement for both the traditional plans and the account-based HSA/HRA plans? Do you require point-of-service payment at the pharmacy?

180. For FSA – Dakota County desires to have a 90% auto-substantiation rate. Provide detailed response on your ability to meet this level of auto-substantiation. How can members avoid being required to provide receipts when using their debit card? For transactions that require documentation from members in order to substantiate them, does your organization automatically send a request for substantiation letter that fail to auto-substantiate? How many requests for substantiation does your organization send before turning off the debit card? Will you allow the County to customize the letters if desired?

181. For HSA - please provide a list of the investment options available for members, including but not limited to, minimum account balances, available funds, interest rates and update schedules for money market or other interest-bearing options, transaction fees, etc.

182. For HSA - describe your online and program capabilities, such as employer and member reporting, enrollment updates, requesting an account withdrawal, paying a provider directly, etc.

K - Stop Loss

183. Confirm you will provide stop loss coverage effective as of 1/1/2025.

184. Confirm you will administer the stop loss coverage such that the claims covered by the medical and prescription drug plan are also covered under the stop loss policy.

185. Confirm you will reimburse the County when the total amount of Paid Claims exceeds the Specific Stop Loss Limit defined in the plan design ($450,000).

186. Confirm reimbursement shall begin no later than the month following the date on which the Specific Stop Loss Limit is exceeded.

187. Confirm you will provide a reporting package to the County with cost and utilization information necessary to validate payment accuracy.