**RFP No. 23-500**

**Lake County Board of County Commissioners**

**Attachment 2 – Proposal Worksheet**

**Health plan services**

**Section 1 - General Administration and Information. Medical and/or Pharmacy Administrative Services**

|  |  |
| --- | --- |
| **Company Information** |  |
| Proposer/Company Name |  |
| Primary RFP Contact Person Name: |  |
| Phone No: |  |
| E-mail Address: |  |

|  |
| --- |
| **Minimum Requirements:** |

Minimum Qualifications must be present in each proposal before further consideration will be given. Below is a checklist to ensure that the Proposer understands and confirms that all Mandatory Minimum Qualifications are included in the RFP response. If the stated feature is included in your proposal as requested, check “Yes”. If the stated feature is not included in your proposal, check “No”.

Important Note: Your proposal will be removed from consideration if any feature indicates a “No” check OR IF ANY ‘YES’ ANSWER INCLUDES EXCLUSIONS

| **Feature** | **Yes** | **No** |
| --- | --- | --- |
| 1. Proposal shall include Administrative Services Only (ASO) for the effective date of October 1, 2024. All benefit tracking and plan accumulators must track to a 10/1 plan year. |  |  |
| 1. Proposers shall have experience providing ASO health plan services as applicable to four or more employers each having 1,000 or more subscribers within the past five (5) years. |  |  |
| 1. Proposer shall have health plan accreditation by the National Committee for Quality Assurance (NCQA) as applicable as of the proposal due date. |  |  |
| 1. Proposal shall including Behavioral Health and Pharmacy Services for active employees, Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) Participants, retirees, and eligible dependents. |  |  |
| 1. Proposal includes two plan options: one plan that matches the current PPO health plan and one plan that matches the HMO health plan with the understanding that the County may alter, increase or decrease the plans in the future |  |  |
| 1. Proposers network for the plans shall include both Orlando Health and AdventHealth. |  |  |
| 1. Proposals shall include ASO fee guarantees for the initial term of five (5) years and are requested for the additional renewal for up to five (5) additional years (10 years total). |  |  |
| 1. Proposals shall be submitted net of commissions |  |  |

|  |
| --- |
| **Health Plan Service Background:** |

|  |  |
| --- | --- |
| # Years Providing Health Plan Services in Lake County |  |
| Number of Employer Groups (Self-Funded) in Lake County Area (Lake, Polk, Marion Orange, Osceola, Seminole, Sumter and Volusia Counties) over 1,000 Lives |  |
| Total # Covered Lives in Lake County Area (Lake, Polk, Marion Orange, Osceola, Seminole, Sumter and Volusia Counties) |  |
| Number of Employer Groups in Florida over 1,000 Lives |  |
| Total # Covered Lives in State of Florida |  |

|  |
| --- |
| **Company Representatives** |

**List the name of each employee that your company will assign to help administer the County’s Plan.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Role** | **Name** | **Location** | **Years with Company** | **Current Number of Clients** |
| Account Manager |  |  |  |  |
| Account Service Contact |  |  |  |  |
| Medical Director |  |  |  |  |
| Pharmacy Director |  |  |  |  |
| Implementation Manager |  |  |  |  |

|  |
| --- |
| **Medical and Pharmacy Administrative Services:** Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components succinctly**. |

| **Issue** | **Response** |
| --- | --- |
| 1. Confirm your Company will provide a copy of their System and Organization Controls 1 (SOC1) or System and Organization Controls 2 (SOC 2) report annually to the County and/or County auditor. If these two reports are not available then a copy of their Statement on Standards for Attestation Engagements (SSAE) No. 18, Service Organizations must be provided. Preference is provided for SOC 1 and SOC 2 reports. |  |
| 1. Confirm that your proposal includes a completed References Form, Attachment 3. |  |
| 1. Confirm your Company will have accessible hours of customer service, a designated customer service team familiar with the County’s plan design and claims administration, and demonstrated service results to administer the comprehensive health plan, including all medical and/or prescription drug benefits for active employees, COBRA participants, retirees, and eligible dependents. |  |
| 1. Confirm all customer service support involving interaction with members shall be handled within the territorial limits of the United States of America. Please State your member call in customer service location and hours of operation. |  |
| 1. For 2021, indicate your service performance results for your Company’s average speed of telephone answer (number of seconds) |  |
| 1. For 2021, indicate your service performance results for your Company’s average telephone call abandonment rate (percentage) |  |
| 1. Confirm your Company will have an experienced, dedicated account management team assigned to the County to assist with claims, eligibility and day-to-day service issues. |  |
| 1. Confirm your Company agrees to attend at least semi-annual meetings to review plan performance; meet monthly to review ongoing administrative, service, and plan management issues; and make available a Medical and/or Pharmacy Director for ongoing involvement in plan performance initiatives. |  |
| 1. Confirm ADA compliant, web-based eligibility administration will be made available to the County’s benefits department on an ongoing basis. |  |
| 1. Confirm your Company will provide ADA compliant, web-based tools, including online and via mobile app, to Plan participants providing information on issues such as claims status, explanation of benefits (EOBs), network providers by specialty, health and wellness topics, and provider / treatment cost calculators based on specific plan designs of the County. Please list the tools available. |  |
| 1. Confirm your Company will prepare and maintain the Summary Plan Description (SPD) and annually required Summary of Benefits and Coverage (SBC) on behalf of the County and provide these documents electronically for posting on the County’s website. |  |
| 1. Confirm your Company will assist the County with: annual enrollment by training the benefits and enrollment staff on plans; creating County specific enrollment and educational materials; attending on-site enrollment meetings (typically 4 onsite sessions are held); providing web portal assistance for annual enrollment; providing a representative for new hire orientation meetings; and providing representatives for on-site building meetings as requested. Meetings can be held virtually at the County’s discretion. |  |
| 1. Confirm your Company agrees to accept the County’s benefits enrollment files electronically on an ongoing basis from the County’s enrollment vendor, currently BenefitFocus. |  |
| 1. Confirm your Company shall be the claims fiduciary and accept fiduciary responsibility for claims payment decisions and for defense of actions taken for claims adjudicated and related appeals, including the legal defense of claims determinations and medical and /or pharmacy clinical decisions processed. The County will be responsible for the legal defense of claims for which the County made the choice as to the determination of coverage. The Contractor shall be responsible for the legal defense of claims that involve the claim determination based on the Contractor’s medical and/or pharmacy, and authorization standards. The County shall be informed of appeals and Contractor decisions on appeals, but is not to be responsible for any claims determination matters or appeals. |  |
| 1. Confirm your Company will have contractual arrangements in place with external claims review companies that will be made available to the County’s members and that your Company will be responsible for facilitating all aspects of the external review process. |  |
| 1. Confirm your Company agrees to process and adjudicate all medical and prescription drug claims in accordance with the health plan document and that your Company will be held liable for claims adjudicated outside of the terms and conditions of the health plan document. |  |
| 1. Confirm your Company will allow retroactive eligibility and claims adjudication at no additional cost the County. |  |
| 1. Confirm your Company will identify claims that could potentially be subject to third party liability such as workers’ compensation, auto accident, and coordination of benefits, and take action on the claims using the same standards in place for the Contractor’s fully insured health plan clients. |  |
| 1. Confirm your Company will comply with all applicable laws and regulations including any applicable regulations subsequently promulgated during the term of the contract by State or Federal authorities |  |
| 1. Confirm your Company will adhere to standards of care by agreeing to use the care, skill, prudence and diligence under the circumstances then prevailing that a prudent claims administrator/fiduciary acting in a like capacity, and familiar with such matters, would use under similar circumstances as the standard of care for medical and/or pharmacy services. |  |
| 1. Indicate whether your claims processing system or patient record captures and can report on compliance with periodic physicals and preventive diagnostic services specific to the member. |  |
| 1. Indicate whether your claims processing system or patient record captures and can report on Plan sponsored biometric screening values specific to the member performed by a third-party vendor selected by the County. |  |
| 1. Confirm your Company will work in collaboration with the County and its employee health clinic provider, currently Everside Health, to assimilate data, report outcomes, and plan strategies to improve health and manage costs. |  |
| 1. Confirm your Company can exchange claims data with the County’s employee health clinic provider, currently Everside Health, in a mutually agreeable format. |  |
| 1. Confirm your Company can accept encounter data from the County’s employee health clinic provider, currently Everside Health, in a mutually agreeable format. |  |

**Section 2 – Plan Design**

Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components** only as succinctly as possible.

| **Issue** | **Medical Response** |
| --- | --- |
| 1. Confirm your proposal for the medical plans is an open-access (non- Gatekeeper) model option. A referral should not be required for access to an In-Network; however certain services may require prior authorization. |  |
| 1. Confirm your proposal closely matches the current health plans as outlined in Exhibit K. Please disclose any deviations and propose alternatives if available. |  |
| 1. Confirm your Company will assist with plan design options, underwriting/cost impact analyses, recommendations for plan savings and will provide marketing/educational support on an ongoing basis. |  |
| 1. Confirm your Company has the ability to accumulate medical and pharmacy member costs toward the deductible and out of pocket maximums and that any overpayments by members will be reconciled by your Company and reimbursed to the member. |  |
| 1. Confirm your Company will provide discount arrangements to members for complementary and alternative medicine services not covered under the County’s Plan. |  |
| 1. Confirm your Company shall track End Stage Renal Disease eligibility toward Medicare enrollment, timely notify impacted members, and assist them in applying for Medicare benefits. |  |
| 1. Confirm your Company shall process claims for End Stage Renal Disease as secondary to Medicare at the end of the member’s applicable Medicare Coordination period. |  |
| 1. Confirm your Company will communicate any formulary changes to the County and any impacted members. |  |
| 1. Confirm your Company will perform required testing and make recommendations to ensure the County’s benefits for mental health and substance abuse coverage meet all requirements under the Mental Health Parity and Addiction Equity Act. |  |
| 1. Briefly describe currently available cost containment strategies to impact the plan such as condition specific programs, reference-based pricing, bundled payments or ACO options, including any plan design requirements. |  |

**Section 3– Medical Network Services**

Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components** only as succinctly as possible.

| **Issue** | **Response** |
| --- | --- |
| 1. Confirm that your proposal includes a completed Medical Network Participation Worksheet, Attachment 4. In addition, network physicians designated as a high performing provider, meeting your provider established cost and quality of care guidelines, and included in a high performance limited network as listed in appropriate column. |  |
| 1. Confirm that your proposal includes a comprehensive network of hospitals, outpatient facilities, physicians, convenience care clinics, and other covered healthcare providers, specifically in Lake, Polk, Marion Orange, Osceola, Seminole, Sumter and Volusia Counties. |  |
| 1. Confirm Company shall monitor regional network performance based on nationally recognized quality standards and take action with network providers when standards are not being met. |  |
| 1. Confirm that your proposal includes a comprehensive statewide and national network of hospitals, outpatient facilities, physicians, convenience care clinics, and other covered healthcare providers. |  |
| 1. Confirm your network shall include state and national access for services provided at Centers of Excellence. |  |
| 1. Confirm your network shall include coverage for international emergency and non-emergency care. |  |
| 1. Confirm network availability on a national basis for members residing and traveling outside of Lake County’s service locations. |  |
| 1. List the contracted services where a capitation fee will apply. Confirm that you will provide encounter data for services covered under your capitation arrangement. |  |
| 1. Confirm that your Company shall hold members harmless from balance billing when using in-network providers, when being referred for specialty services by an in-network provider, and for services provided by an in-network provider that are not covered under the Plan, in accordance with the applicable state and federal law(s) |  |
| 1. Confirm your Company will assist members with transition of care in accordance with the applicable state and federal law(s). |  |
| 1. Confirm your Company will allow the County’s onsite clinic providers to be designated as a primary care provider within your network. |  |
| 1. Confirm your Company has the ability to provide telemedicine services for members including urgent and convenience care type of medical care and behavioral health. |  |
| 1. Confirm your Company will provide telemedicine services for members who are established patients of primary care network providers for services such as follow up care, known condition specific care, and maintenance medication refills. |  |

**Section 4 – Health Management**

Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components** only as succinctly as possible.

| **Issue** | **Response** |
| --- | --- |
| 1. Confirm your Company will include an online health risk assessment (HRA) tool, accessible to members, capable of having biometric screening results loaded into an individual’s HRA, and will provide an aggregate report on the responses, including the changes in risk factors. |  |
| 1. Confirm your Company will include onsite biometric screenings and health coaching for members at convenient times and at a minimum of 7 locations each year. |  |
| 1. Confirm your Company shall be able to process onsite immunizations, such as flu shots, as a medical claim from the County’s selected vendor. |  |
| 1. Confirm that your Company shall assist the County as a resource with wellness initiatives, and health improvement strategies. Indicate that your Company will implement programs to increase preventive care utilization. |  |
| 1. Does your Company have the ability to track and manage health and wellness activities, administer member incentives, report performance, and provide improvement recommendations to the County? |  |
| 1. Confirm that your Company shall have the capability to administer co-payment incentives specifically for members participating in and adhering to the qualifications of health and wellness activities and County targeted initiative programs. |  |
| 1. Confirm that your Company shall assist the County with customized, targeted initiatives to improve the health of the population with comprehensive initiatives for    1. Musculoskeletal conditions    2. weight management for healthy weight, overweight, obese or morbidly obese members    3. diabetes control and prevention    4. tobacco cessation    5. a cardiology program, including hypertension control and prevention    6. an oncology management program    7. a healthy pregnancy program    8. other | a. |
| b. |
| c. |
| d. |
| e. |
| f. |
| g. |
| h. |
| 1. Confirm your proposal includes a Wellness Fund of an annual minimum of $25,000 for the County to help support the health management initiatives. |  |
| 1. Confirm that your Company shall identify large case and high risk plan members and assist them in managing their health. List proactive steps will your Company will take. |  |
| 1. Confirm your Company will provide an experienced case management team assigned to the County to address the specific needs of seriously ill plan members. |  |
| 1. Confirm your Company has implemented a Fraud, Waste and Abuse program. |  |
| 1. What is your process and average turnaround times for prior authorizations? |  |

**Section 5 – Financial Services, Reporting, and Data Interface**

Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components** only as succinctly as possible.

| **Issue** | **Medical Response** |
| --- | --- |
| 1. Confirm that the finance and banking arrangements for the self-funded health plan includes documentation for claims reimbursement and will meet the accounting and payment needs of the County, as determined by the County policy. The County shall pay for fees and medical pharmacy claims via monthly ACH wire transfer. |  |
| 1. Confirm your Company can provide the County’s Flexible Spending Account vendor, currently WEX, a debit card substantiation file, in a mutually agreeable format. |  |
| 1. Confirm your Company will accept self- billing by the County for administrative fees which is based on eligibility provided. |  |
| 1. Confirm that you agree to claims payment via monthly ACH wire transfer under a self-funded health plan. |  |
| 1. List the standard reports your Company will make available to the County. Include sample Reports in your proposal to the County. |  |
| 1. Confirm that your Company will make available eligibility, claims and utilization data on a monthly basis; and eligibility discrepancy reporting on a weekly basis via secure web-based portal. |  |
| 1. Confirm that your Company will provide medical and/or pharmacy claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format to the County benefits consultant on a monthly basis and will include, at minimum, all fields listed in the Claims File Layout (Exhibit G). |  |
| 1. Confirm that your Company agrees to provide to the County’s stop loss insurance carrier monthly reports on large claimants, to include the data fields needed by the insurance carrier to administer the County’s stop loss insurance policy. |  |
| 1. Confirm your Company can provide the County’s Flexible Spending Account vendor, currently WEX, a debit card substantiation file, in a mutually agreeable format. |  |
| 1. Confirm that your Company’s books and records, together with the supporting or underlying documents and materials shall be made available, upon request, to the County, through its employees, agents, representatives, contractors or other designees, during normal business hours at Contractor’s office or place of business in Orlando, Florida. In the event that no such location is available, then the books and records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location in Orlando, Florida, which is convenient for the County. This paragraph shall not be construed to limit, revoke, or abridge any other rights, powers, or obligations relating to audit which the County may have by state, city, or federal statute, ordinance, regulation, or agreement, whether those rights, powers, or obligations are express or implied. |  |
| 1. Confirm your Company will allow an annual risk-based or focused audit. The scope of such focused audit may include payment documents related to a focused, targeted or risk-based review of a sample of claims of not more than 400 claims paid during the two prior plan years and not previously audited. The focused audit may include claims prone to overpayments or other errors without regard to claims prone to underpayments. |  |

**Section 6 – Pharmacy Services**

Complete the following questions. When a response can be confirmed, indicate **“Confirmed”** only. If a brief description is requested, please **state key components** only as succinctly as possible.

| **Issue** | **Response** |
| --- | --- |
| 1. Confirm that your proposal includes a completed Pharmacy Network, Formulary, and Cost Guarantees Worksheet, Attachment 5. |  |
| 1. Confirm that your proposal of pharmacy services includes $0 administrative fees. |  |
| 1. Confirm that your company will utilize a broad network of pharmacies for pricing guarantees that will include the major chain pharmacies as In Network |  |
| 1. Confirm that your company will use their broadest formulary for pricing guarantees with no Brand and Specialty exclusions. |  |
| 1. Confirm that Single-Source Generic prescriptions, Multiple-Source generic prescriptions, MAC and Non-MAC prescriptions will be included in the generic medication category for discount and fill rate guarantee calculations. |  |
| 1. Confirm that the term brand drug shall mean the following: The multisource code field in Medi-Span that contains an “M” (co-branded product), “O” (originator brand), or an “N” (single source brand); however, if the Multisource Code is “O” and there is a DAW Code of 3, 4, 5, 6, or 9, the drug shall be considered a generic drug. |  |
| 1. Confirm that the term generic drug shall mean the following: The multisource code field in Medi-Span that contains a “Y” (generic). An item shall also be considered a generic drug if the Multisource Code is “O” and there is a DAW code of 3, 4, 5, 6, or 9. The parties agree that when a drug is identified as a generic drug, it shall be considered a generic drug for all purposes under this agreement. A Single Source generic drug shall also be considered a Generic drug. |  |
| 1. Confirm that Single-Source Generics will be identified as having one manufacturer during for discount and fill rate guarantee calculations |  |
| 1. Confirm that Usual and Customary (U & C) Claims, Zero Balance Claims, Compounds and Over-the-Counter claims will be excluded for discount and fill rate guarantee calculations. |  |
| 1. Confirm that “Ingredient Cost” will mean the lesser of MAC price, discounted AWP or the dispensing pharmacy’s U & C. |  |
| 1. Confirm that your company will utilize the timeliest, expansive, and cost effective MAC list of behalf of the County. |  |
| 1. Confirm that Plan members will always be charged the lesser of their plan copayment, the PBM’s contracted price, the pharmacy U&C, or the cash price. |  |
| 1. Confirm that your company will base AWP (Average Wholesale Price) on date sensitive, 11-digit National Drug Code (NDC) of the actual product dispensed as supplied by Medi-Span for retail, mail order, and specialty adjudicated claims with no repackage fee applied. |  |
| 1. Confirm that your proposed discount guarantees and other guarantees will be the minimum guarantees (not fixed) regardless of whether the County implements any additional specific clinical management programs such as step therapies or prior authorizations |  |
| 1. Confirm that your rebate guarantees shall be based on each brand medication dispensed |  |
| 1. Confirm that rebate revenue that is earned by the County during the term of the agreement will be paid to the County at least quarterly and will be paid following termination of the agreement, as long as claims reimbursements remain current |  |
| 1. Confirm that auditing of all pharmacy claims will be permitted versus a claims sample |  |
| 1. Confirm that each distinct pricing guarantee being measured and reconciled will be based on each of 4 components (1. retail and mail order generic and brand; 2. specialty; 3. rebates; and 4. generic fill rate) with no surpluses in one component offsetting deficits in another component |  |
| 1. Confirm that guarantee shortfalls will be guaranteed on a dollar-for-dollar basis with 100% of any shortfall in any component recouped by the County |  |
| 1. Confirm that specialty drugs are to be defined as FDA approved prescriptions that require special handling, storage, training, distribution, and management of therapy. The list of Specialty Drugs meeting this definition will be made available to the County upon implementation of the Contract and will be updated as drugs are included and excluded. |  |
| 1. Confirm that guaranteed specialty medication discounts shall be based on an aggregate specialty discount and shall include all specialty medications dispensed that have been approved by the Company’s Pharmacy Drug Review Committee |  |
| 1. Confirm that specialty drugs will be identified separately from generic and brand drugs in claims data and reports. |  |
| 1. Confirm your proposal commits to minimum guarantees on retail and mail order generic, brand, and specialty pharmacy discounts and costs on an annual aggregate basis for a minimum of three (3) years |  |
| 1. Confirm that your Company shall commit to retail 90 day generic and brand fill program. |  |
| 1. Provide your Company’s mail order facility name and location. |  |
| 1. Describe how pharmacy service allowances for international and non-emergency prescription services will be handled. |  |
| 1. Confirm that your Company will communicate to regional pharmacies plan design and formulary changes. |  |
| 1. Provide your Company’s specialty pharmacy facility name and location. |  |
| 1. List your Company’s mail order and specialty medication normal delivery service times. |  |
| 1. Confirm your proposal commits to minimum rebate guarantees on all brand and specialty drugs dispensed for a minimum of three (3) years. |  |
| 1. Confirm your proposal commits to minimum generic dispensing fill rate guarantees for a minimum of three (3) years. |  |
| 1. Confirm that your Company will notify impacted members of negative formulary changes that may occur throughout the plan year. |  |
| 1. Confirm your proposal includes any programs available to impact pharmacy utilization such as step therapy and clinical prior authorizations for consideration by the County. |  |
| 1. Confirm your Company has implemented cost containment strategies for dispensing of specialty medications such as short-fills on initial prescription, prior authorization, interceptor programs, etc. Briefly describe these cost containment strategies. |  |
| 1. Briefly describe any innovative programs that address the rising cost of Specialty Medications such as member coupons and Patient Assistance Programs. |  |
| 1. Confirm your Company monitors medication adherence on an ongoing basis and will take steps to outreach to providers and members to improve compliance. |  |
| 1. Confirm your Company will take proactive steps to identify high risk pharmacy use and actively manage polypharmacy issues. |  |
| 1. List the step therapy programs your Company will include for the County in the fees proposed. |  |
| 1. List the prior authorization programs your Company will include for the County in the fees proposed. |  |
| 1. Confirm that your Company shall include monthly pharmacy claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format, shall be provided to the County’s benefits consultant on a monthly basis. Monthly claims detail should include, at minimum, all fields listed in Claims File Layout (Exhibit G). |  |

**Section 7 – Cost of Services and Performance Guarantees**

The following provides a summary of the current enrollment by plan and paid claims experience.

**Plan Membership Based on RFP Census – see Exhibit D Census for enrollment detail.** The census is the actual census for the October 2022 enrollment eligibility.

|  |  |  |
| --- | --- | --- |
| **HMO** | **Subscribers** | **Members** |
| Subscriber Only | 327 | 327 |
| Subscriber and Family | 455 | 1545 |
| Total | 782 | 1872 |

|  |  |  |
| --- | --- | --- |
| **PPO** | **Subscribers** | **Members** |
| Subscriber Only | 216 | 216 |
| Subscriber and Family | 180 | 551 |
| Total | 396 | 767 |

|  |  |  |
| --- | --- | --- |
| **County Health Plan** | **Subscribers** | **Members** |
| Total for both Plans | 1178 | 2639 |

**Paid Claims Summary – see Exhibit E – Claims Experience for claims and enrollment by month and claims lag report.**

1. **Guaranteed Premiums and ASO Fees:** List your Company’s proposed Health Plan fully insured premiums and/or Administrative Services Only (ASO) Fees below. Companies are not required to include a proposal for fully insured premiums. Your premiums and ASO fees are to be inclusive of all administrative and network management services. Any service not included in the premiums and ASO fee must be disclosed in your response below.
2. **Self-Funded Administrative Services Only (ASO) Fees**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| The Plan Administrative Services Only (ASO) fees shall be stated and guaranteed for 2024-2025, 2025-2026, and 2026-2027 and quoted on an **incurred claim basis**. Additional rate guarantees for years four (4) and five (5) (2027-2028 and 2028-2029) are requested and desired, but not mandatory. **Claims administration for run-out claims following termination of the Contract shall be included in the Per Subscriber Per Month (PSPM) fees as proposed**. Use the “Subscriber” counts provided to calculate the PSPM total costs. | | | | | | |
|  |  | **Administrative Services Only (ASO) Fees** | | | | |
|  |  | **REQUIRED** | | | **OPTIONAL** | |
| **Fee Per Subscriber Per Month** | **Subscribers** | **2024-2025** | **2025-2026** | **2026-2027** | **2027-2028** | **2028-2029** |
| HMO Plan | 782 | $ | $ | $ | $ | $ |
| PPO Plan | 396 | $ | $ | $ | $ | $ |
| Total ASO Monthly Cost |  | **$** | **$** | **$** | **$** | **$** |
| Total ASO Annual Cost |  | **$** | **$** | **$** | **$** | **$** |

1. **Medical Discounts and Trend** - Complete the following sections using the claims data found in the **Medical Claims Pricing File (Exhibit I)** and complete **Medical Discount Pricing File (Exhibit H)** included in the RFP. Only provide Contractor’s aggregate amounts in the tables below. All amounts, summaries, reports, and discounts listed shall be subject to verification. The verification process will be conducted at Contractor’s facility, by reviewing network source documents such as actual network provider contracts and/or an actual pricing of the claim within the Contractor’s claims system. Contractor’s specific data shall be kept proprietary to the extent allowed under Florida law; only the aggregate amounts as verified shall be disclosed.
   1. **Provider Discount Pricing**. Using the utilization and cost information provided in **Medical Claims Pricing File (Exhibit I)** and the completion of **Medical Discount Pricing File (Exhibit H)**, indicate Contractor’s current average percent medical network discounts for the service categories listed below. You must complete the **Exhibit H** worksheets provided; however, do not submit this detailed information with your proposal. The responses provided below are subject to validation by reviewing the completed worksheets and provider contracts onsite at Contractor’s facility as a part of the evaluation process.

|  |  |  |
| --- | --- | --- |
| **Network Provider Category** | **Total Billed Charges** | **Current % Discount from Billed Charges** |
| Facility | $21,718,705 |  |
| Ancillary | $1,871,180 |  |
| Professional | $4,502,054 |  |
| **Total Medical Provider Charge** | **$28,091,939** |  |

* 1. **Provider Discount Guarantee**. Indicate the minimum discounts Contractor shall guarantee for 2024-2025, 2025-2026, 2026-2027 **with no corridor included in the guarantee**. Performance Guarantees shall be based on the aggregate medical provider discount guarantee.

|  |  |  |  |
| --- | --- | --- | --- |
| **Network Provider Category** | **Guaranteed % Discount for 2024-2025** | **Guaranteed % Discount for 2025-2026** | **Guaranteed % Discount for 2026-2027** |
| Facility |  |  |  |
| Ancillary |  |  |  |
| Professional |  |  |  |
| **Aggregate Medical Provider Discount** |  |  |  |

|  |  |
| --- | --- |
| **Aggregate Medical Provider Discount Guarantee Limitations and Conditions:** List any limitations and conditions that will apply to your Contractor’s Performance Guarantee. |  |

* 1. **Medical and Prescription Drug Trend**. List Contractor’s medical and prescription drug trends for the Lake County area in the following calendar year.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Trend** | **Medical Cost Increase (Medical Trend)** | **Prescription Drug Cost Increase**  **(Rx Trend)** | **Overall Cost Increase**  **(Overall Trend)** |
| 2022 Anticipated |  |  |  |

1. **Pharmacy Guarantees**. **Pharmacy guarantees are required for all ASO self-funded proposals**. **Pharmacy Guarantees are required for all proposals**. Complete the following sections using the claims data found in **Pharmacy Claims Pricing File (Exhibit J)** to the RFP. All amounts, summaries, reports, and discounts listed will be subject to verification. Your Company’s pharmacy discounts, rebates and dispensing fees are to be guaranteed for at least 2024-2025, 2025-2026, and 2026-2027. Additional guarantees for years 4 and 5 (2027-2028 and 2028-2029) are requested and desired but not mandatory. No administrative fees are to be charged. Single Source Generics are generic drugs in the first 6-month exclusivity period following a Brand drug losing its patent. Single Source Generic discount guarantees are to be included in the Generic Discount/Rx from AWP. Discounts are to be applied to zero balance claims, where the member copayment equals to total cost of the drug, but are to be excluded from the guarantees. 100% of the rebates received should be shared with the County. The lesser of Usual and Customary fees, or the guaranteed discounts, are to apply. Guarantees will be separated into the following three (3) categories: 1. Generic and Brand, at Retail and Mail Order; 2. Specialty Pharmacy; and 3. Rebate Guarantees.
2. **Pharmacy Cost Guarantee Worksheet**

|  |  |
| --- | --- |
| Confirm that Contractor has completed **Attachment 5 Pharmacy Network, Formulary, and Cost Guarantees Worksheet**, and that they are included with the response. |  |

1. **Generic Fill Rate Guarantee.**  Indicate the generic fill rate Contractor shall guarantee for the following years. Guarantees shall be factored on a dollar for dollar basis for any shortfall.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Required** | | | **Optional** | |
|  | **2024-2025** | **2025-2026** | **2026-2027** | **2027-2028** | **2028-2029** |
| Generic Fill Rate | % | % | % | % | % |
| Amount of Guarantee |  |  |  |  |  |

1. **Services Included and Cost.** Indicate whether the following services are included in the proposed self- funded ASO fee:

| **Service** | **Included in Proposal (Yes/No)** | **Additional Cost and/or Limitations (must be disclosed)** |
| --- | --- | --- |
| Current plan design administration |  |  |
| Plan design options that outline deviations |  |  |
| Dedicated account management team |  |  |
| At minimum, attendance at semi-annual administrative and Plan management meetings |  |  |
| Medical and Pharmacy Clinical Director attendance at annual utilization review meetings |  |  |
| Annual enrollment training and on-site enrollment meeting participation as outlined in RFP |  |  |
| Pre-enrollment customer service line |  |  |
| Master accumulator for medical and pharmacy deductible and out of pocket maximums |  |  |
| Run-out claims administration following termination of Contract for a minimum of 12 months |  |  |
| Provide run out claims data following termination of contract |  |  |
| On-line capability for eligibility additions, changes and deletions (prospective and retroactive) |  |  |
| Weekly eligibility discrepancy reports |  |  |
| Eligibility data interface with the County and its contracted vendor for retiree and COBRA participants on an ongoing basis |  |  |
| Debit card substantiation file interface with the County’s Flexible Spending Account vendor |  |  |
| Monthly comprehensive eligibility, claims and utilization experience downloads |  |  |
| Retroactive eligibility and claims reprocessing |  |  |
| Printing and distribution of ID cards initially and when Plan deductibles, co-pays, and co-insurance changes are made and when replacement cards are issued |  |  |
| Customize ID card to include applicable plan copays including carve out pharmacy if applicable |  |  |
| On- line access to provider Network directory |  |  |
| Development and maintenance of Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC) |  |  |
| Posting of the Plan SPD and SBC on your Company website for Member access |  |  |
| Printed Summary Plan Description (SPD) for hard copy requests (approx. fifty (50) per year) |  |  |
| Web-based access to administrative tools for Network providers to access Member coverage details |  |  |
| Web-based administrative tools for Members to view specific Plan information and access claims history and educational tools on provider Network, cost comparisons and wellness issues |  |  |
| Provider Network administration and access to a local and national Network of providers, including Centers of Excellence |  |  |
| Claims adjudication, including review and defense of appealed claims, up to the external claims review |  |  |
| Physician and Pharmacy claims adjudication and benefit appeals |  |  |
| Employee health clinic providers can be designated as a primary care provider within your network. |  |  |
| Acceptance and incorporation of encounter data from County’s employee health clinic provider |  |  |
| Exchange of claims data with the County’s employee health clinic provider |  |  |
| Full claims fiduciary responsibility, including all coverage determinations |  |  |
| Mental Health Parity Plan Testing |  |  |
| External claims administration and selection of review agency for medical and pharmacy appeals |  |  |
| Cost of external claims review |  |  |
| Legal defense of claims appeals involving clinical decisions Contractor made |  |  |
| Fraud, waste and abuse program |  |  |
| Third party liability recovery (subrogation) services |  |  |
| Coordination of benefits recoveries |  |  |
| Overpayment recovery services |  |  |
| Facility Reasonable and Customary (R&C) charge determination services |  |  |
| Out-of-Network discount negotiation services |  |  |
| Full Access to records and staff necessary to conduct annual external audits conducted by the County, State Auditor or its designated auditing firm |  |  |
| Monthly full claims detail to County’s benefits consultant in accordance with the fields outlined in the Claims File Layout. |  |  |
| Monthly reporting of large dollar claims to independent stop loss insurance carrier and submission of all data necessary for claims recovery to the County |  |  |
| Predictive modeling and ongoing outreach and management of members at risk |  |  |
| Case management with a dedicated case management nurse working closely with the County |  |  |
| Disease management programs |  |  |
| Assistance with comprehensive health management program design and implementation |  |  |
| Annual health fair participation |  |  |
| Wellness educational materials – electronic and printed |  |  |
| Telemedicine service administration |  |  |
| Online health risk assessments |  |  |
| Ability to upload biometric screening results from a third-party vendor to the individual member health record and ability to auto-populate the member’s health risk assessment |  |  |
| Activity tracking for wellness and health management activities and administration/tracking of incentives |  |  |
| Administration of value based benefit design for participation in health management programs |  |  |
| Pharmacy clinical prior authorization program and review |  |  |
| Pharmacy step therapy program and review |  |  |
| Pharmacy retrospective utilization review |  |  |
| Pharmacy clinical review for medical necessity |  |  |
| Formulary disruption letters to impacted members when changes occur |  |  |
| Targeted letters to members on pharmacy-related issues (any additional costs should be quoted on a per letter basis) |  |  |
| Pharmacy patient safety audits at point of sale |  |  |
| Claims data requests for GASB and other state and federal reporting requirements |  |  |
| Online report access with query capabilities including detailed eligibility, claims and utilization data |  |  |
| Direct Member claims reimbursement (paper claims) |  |  |
| Open file transfers to new Contractor using industry standard formats at termination |  |  |
| Provide all required notifications and data necessary to comply with any out-of-state requirements, e.g. New York Surcharge. |  |  |
| Annual satisfaction survey specific to County Members |  |  |
| List any additional services your Company will perform that have not been previously disclosed that will result in additional administrative charges to the County or any additional fees for your Company |  |  |

1. List any Implementation and/or Additional Funds that you will allocate to Lake County to offset transition costs associated with your program. Please specify the total dollar amount proposed and specify any limitations in how Lake County can utilize these funds.

|  |
| --- |
|  |

1. **Performance Guarantees:** List your proposed performance guarantees, including a description of the guarantee and measurement and dollar amount at risk for each of the categories listed below. Guarantees shall be for a minimum of three (3) years.

| **Area of Guarantee** | **Metric Required to Meet Guarantee** | **Dollar Amount at Risk** |
| --- | --- | --- |
| **Implementation** |  |  |
| Plan Implementation (plans loaded, tested; staff trained; eligibility accurate and ID cards issued before 10/1/2024) |  |  |
| Summary of Benefits and Coverage (SBC) completed by June 1, 2024 |  |  |
| **Administration** |  |  |
| Summary of Benefits and Coverage (SBC) completed by June 1st of each year. |  |  |
| Plan documents received by November 1st of each year. |  |  |
| Network stability should include an annual turnover of 3% or less in Lake, Polk, Marion Orange, Osceola, Seminole, Sumter and Volusia Counties. |  |  |
| Claims Financial Accuracy by using total claims dollars processed, compared to the combined over and under payment errors, with a minimum of 99% accuracy |  |  |
| Claims Processing Accuracy of at least 99% of the total number of correct claims divided by the total claims processed |  |  |
| Clean Claims Turnaround Time minimum of 94% clean claims in 14 calendar days and 100% all clean claims in 30 days |  |  |
| Timely Reporting due by the 20th of the following month |  |  |
| **Account Management** |  |  |
| Standard that demonstrates the Proposer’s commitment to maintain experienced, dedicated account service contacts that provide ongoing and timely service to the County’s administrative staff, conduct service meetings with the County to review the status of the account and services deliverable, and issue resolution as needed. |  |  |
| **Customer Service Standards** |  |  |
| Average speed of answer |  |  |
| Percent of issues answered on initial call |  |  |
| Call abandonment Rate |  |  |
| **Medical and Pharmacy** |  |  |
| Minimum Aggregate Network provider percentage guarantee |  |  |
| Network shall include a minimum of eighty-five percent (85%) of providers being Board Certified or eligible |  |  |
| Provider turnover rate of less than three percent (3%) annually |  |  |
| Generic discounts, brand discounts, and dispensing fee guarantee for retail and mail order |  |  |
| Specialty discount guarantees |  |  |
| Rebates on all brand and specialty drugs |  |  |
| Generic fill rate guarantee |  |  |
| **Satisfaction** |  |  |
| Account management satisfaction survey scores |  |  |
| Employee satisfaction survey scores |  |  |
| **Other performance guarantees you will provide** |  |  |
|  |  |  |
| **Indicate the total annual maximum performance penalty at risk for each year of the contract** | **$** | |

As an officer of the Company, I certify that the information contained in the proposal worksheet is accurate, and Contractor shall be bound by the contents of the proposal.

**Please return this Word document in print and electronic format with your responses and a separate PDF file of this signed certificate page.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_