

Attachment E: Questionnaire

The Attachment should be completed and submitted under Tab V.

The following questionnaire will assist NEW HORIZON in evaluating the quality of care and benefits being offered to employees/retirees and dependents as well as assist in the evaluation of the financial and contractual information requested of the offeror. An offeror's evaluation score will not be adversely impacted if a specific question does not apply.

Instructions

- o Each question and response must be provided in TAB V as instructed in Section 3.4.
- o Answer all questions fully, clearly and concisely unless a specific question is inapplicable to the service you are proposing to provide.
- o Each response must immediately follow the respective questions. The question as well as the answer shall be typed. All questions and responses shall be numbered/labeled exactly as in this questionnaire.
- o If the offeror is unable to answer a questions or the question does not apply, the offeror shall indicate why.
- o If the offeror is unwilling to disclose particular information asked in a questions, the offeror shall indicate why.
- o Samples of document requested in the Questionnaire should be labeled with the corresponding question number and submitted in Tabs as specified in Section 3.4 of the RFP.

A. GENERAL

1. Type in the following information:

Point of Contact: _____
Title: _____
Company: _____
Address: _____
Telephone/fax: _____
E-Mail _____

2. Identify all subcontractors (including consultants, advisors, network managers and suppliers) to be used and describe specific responsibilities, qualifications, and background experience of all key personnel. Including financial ratings for each major subcontractor, consultant, or advisor.
3. Are you SAS 70 certified?
4. Provide pertinent financial data that demonstrates your organization's ability to successfully perform this contract. Include a copy of the three (3) most recent annual reports and financial statements for each quarter since the last annual report to date. (Include in TAB VI.) Please provide your most recent ratings (include the date of the rating) by each of the following:

Company	Rating	Date of Rating	Legal Name of Company to Which Rating Applies
Weiss			
Fitch (Duff & Phelps)			

Standard & Poors			
Moody's			
A.m. Best			

5. Provide references (should be similar in size, industry, and location if possible): three active accounts and two recently terminated accounts (that did not terminate solely due to merger, acquisition, etc.). Include group name, contact person, and telephone number.
6. Can terminated employees convert to individual coverage? If so, please describe what is available, how pre-existing conditions and deductible are handled, what charges are assessed for conversion, how the terminated employee is notified, and the procedures to enroll.
7. Are you currently compliant with the HIPAA legislation as it pertains to Private Health Information, EDI Standards? If not, what is your timeline for compliance? Do you have a privacy statement? If yes, please provide. Who is your named Privacy Official?
8. Have administrative contracts been amended to incorporate the language required by HIPAA in order for **NEW HORIZON** to receive protected health information (as defined by HIPAA) from the plan?

B. ADMINISTRATION

8. What is the location of the claims office that will be processing claims and providing general administration for this account? If more than one location, please identify all locations where claims will be processed.
9. What is the location of any local service and office assistance that would be available for group administrators and/or employees?
10. What will be the days and hours of operation for the customer service unit(s)? Would you be willing to offer extended hours, if necessary? Is there a toll-free number? Do the customer service representatives have the authority to resolve problems immediately? What percentages of problems are resolved during the initial call?
11. Describe your enrollment procedures both for account set-up and ongoing services. Indicate the services you would be willing to provide, such as on-site assistance with employees, etc., if your company is selected. Please provide samples of the communication materials you have available. (Include in TAB VIII)
12. Discuss your willingness and ability to work with NEW HORIZON to create a group specific web site for members to access benefits-related information and services. Indicate your willingness to work with other vendors to create a comprehensive site.
13. Please explain your billing process.
14. Explain the process NEW HORIZON must follow to add and delete employees and retirees to and from the bill. How long does it normally take for your billing department to make requested changes to the bill (additions/deletions) and make the proper adjustments in premium? Would you agree to performance guarantees (including financial penalties) associated with accurate and timely bills and billing adjustments?

15. Explain your requirements for verification of student status? How frequently do you require an update? What documentation is required? Will you send a reminder to the employee? Do you pend claims if verification is not received? Will you agree to administer the verification of student status process for NEW HORIZON?
16. Give the average number of years experience for the proposed dedicated service team: a) account executive, b) customer service staff and c) clinical support staff. Please provide a resume for the account executive. Are you proposing a dedicated service team?
17. Do the customer service representatives have the authority to resolve problems immediately? What is the percentage of problems resolved during the initial call? During what hours is a customer service representative available to take calls?
18. How long has the current computerized claims system been in operation? Do you anticipate any significant changes to your claim payment system, which might impact NEW HORIZON?
19. What is the average turnaround time, from date of receipt for the following:

Claims	_____
ID Cards	_____
COB Claims	_____
Dental Review Claims	_____
Investigated Claims	_____

21. How long does a participant have to submit a claim from date of service?
22. Please furnish a copy of the payment explanation form and claim form that would be used by the claimant. Also furnish language used for denied claims.
23. Please furnish a copy of the booklets/certificate of coverage/evidence of coverage that would be provided to plan members (for each plan you are proposing). Include in TAB VIII.
24. How are claim disputes and denials handled? Please describe your appeal process. What is your turnaround time for response to claim disputes?
25. Do you have a secure Web site? If yes, do you have certification from the Verified Internet Pharmacy Practice Sites (VIPPS)?
26. Explain your on-line enrollment and eligibility capabilities, as well as any other on-line services, such as reporting, network directories, etc. Identify on-line services available to benefits administrators versus health plan members.
27. Do your systems have the following capabilities? If yes, indicate if there are additional charges:

	YES	NO
To maintain historical eligibility information and positive record of the subscriber's eligibility status?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
To separate eligibility dates for employees and each covered dependent?	<input type="checkbox"/>	<input type="checkbox"/>
To carry employee and dependent information including individual PCP selection on the eligibility file?	<input type="checkbox"/>	<input type="checkbox"/>
On-line enrollment and eligibility capabilities	<input type="checkbox"/>	<input type="checkbox"/>
On-line access for clients to update eligibility?	<input type="checkbox"/>	<input type="checkbox"/>
On-line access for client reporting?	<input type="checkbox"/>	<input type="checkbox"/>
On-line access for members to enroll or change specific member data?	<input type="checkbox"/>	<input type="checkbox"/>
On-line access for members to communicate with customer service representatives?	<input type="checkbox"/>	<input type="checkbox"/>
Can you accept current eligibility records electronically for initial enrollment?	<input type="checkbox"/>	<input type="checkbox"/>
Provide automated, interactive telephone service for members	<input type="checkbox"/>	<input type="checkbox"/>

29. Indicate what health management services you provide as part of your coverage.

30. NEW HORIZON wants to partner with their carriers to provide health management and wellness programs to their employees and retirees that will help address the underlying cost drivers of the medical plan. Confirm you are willing to partner with NEW HORIZON and explain your ideas for making this a successful program. Are you willing to provide funds to sponsor wellness initiatives at NEW HORIZON? If so, how will you determine the level of funding that you are willing to provide?

C. REPORTING

31. Please provide a sample of your standard management reports and the frequency of distribution.

32. Please provide a sample of your claims data reports.

33. Will New Horizons have access to claim reporting on a regular basis? Please indicate what frequency the reports are available.

34. If reports do not accurately reflect “paid” claims, will you provide additional reports, at no cost, to reflect accurate claims payment?

D. FINANCIALS

35. Please provide a copy of your most recent audited financial statement.

36. Indicate your trend factors both rating and actual observed, label accordingly for your PPO, and HMO plans for the last three years for dental. Specify the location/region on which these trend factors are based. If available provide for the Hampton Roads service area.

	PPO	HMO
Observed Trend 2007		
Observed Trend 2008		
Observed Trend 2009		
Rating Trend 2010		

37. Will you guarantee a maximum first year renewal increase? A second year?
38. Indicate any and all advantages (fees savings or discounts) applicable to the medical plan if you are awarded the dental and vision plans.

E. FUNDING AND PLAN DESIGN ALTERNATIVES

45. Please provide Price Quotations exhibits can be found in Attachment F. Complete all sections of the Price Quotation exhibits that are applicable to the services you will provide. Write an “N/A” in all sections that are not appropriate for your pricing.
46. Confirm your willingness to provide renewal information no later than March 1 of each year.
47. NEW HORIZON wishes to analyze cost containment programs recommended by offeror(s). Offeror(s) are requested to outline what programs are recommended, and how these programs would impact overall quality and cost. A chart has been included in the financial exhibits (Attachment F “other retention fees or utilization review fees”) to facilitate this request. Offeror(s) are encouraged to make recommendations in addition to what has been outlined in the exhibit.
48. Review and detail deviations from the current plan designs shown in the plan design.
49. Currently the HMO plans do not include a gatekeeper referral function. Please provide a projection to the Fully insured rates if a gatekeeper required referral is added to these programs.
50. Please provide two alternative plan designs which you can support that are similar to the current plan designs but exhibit innovative ideas for cost containment. Label this attachment Plan Design Alternatives and include in Tab V.

F. NETWORKS

49. Answer for each of your networks included in quotations. Label your response clearly for each network, if applicable. Specifically address the following criteria answering yes or no for each:

NETWORK	HMO	POS	PPO
Do you require Board Certifications?			
Do you require providers to be Board Eligible?			
Do you require a degree from a U.S. Medical/Dental School?			
Do you check with the Federation of State Medical/Dental Boards?			
Do you check the status of the narcotics license, both federal/state?			
Is the level of the physician's fees considered in the selection process?			
Do you perform pre-contracting on-site reviews?			
Do you check credentials by practicing providers in the community?			
Do you require malpractice insurance? What amounts? \$			

50. Please complete the charts in Attachment G.

51. What percent and what number of Primary Care Physicians or Dentists in Hampton Roads have left your plan in the last three (3) years?

	HMO	POS	PPO
% of Physicians who left plan			
# of Physicians who left plan			

52. List the 5 largest Family practices in Hampton Roads that have terminated from one or all of your networks in the most recent 12 months. Indicate the reason for the terminations.

53. What is your process for notifying members when a provider leaves the network. If a provider fails to renew their network contract, how would transition care be handled? Confirm your compliance with Commonwealth of Virginia continuity of care mandates, regardless of NEW HORIZONS' funding arrangement.

54. Please describe the quality assessment tools you currently use with each of your networks. Indicate how often you perform quality assessments, and how the results are reported. How is information about malpractice or complaints used?

55. Describe your referral process by plan option in detail (if applicable). Include your time limits for referrals to specialist.

56. Explain how you handle out-of-area emergency and non-emergency care. Define "out-of-area" and "emergency".

57. How are employees or dependents (i.e., retirees, child attending school, COBRA enrollees) that reside outside your service area covered?

58. How and how often is patient satisfaction measured with providers? Please provide a sample of your measurement tool and indicate results for the last two years. What regions/networks are included?

G. UCRs

64. What data do you use to develop your UCR profile? How often is it updated?

65. What standards are used (e.g., 90th percentile) to determine usual and customary rates (UCR)? How often are UCR profiles updated?

66. Will you provide UCR information to employees and/or their dependents upon request?

67. It is very important that you describe reimbursement levels for all of the dental plans you quote. Please list the percentile of HIAA, etc., in which you reimburse, whether you pay out-of-network dentists at that same level, whether out-of-network claims are paid to the provider or the subscriber, etc.

68. Describe how you would handle any services in progress upon takeover for all plans you quote.

69. Does your plan give deductible credit for those employees that have met their calendar year deductible since October 1, 2008?

70. Please provide a list of standard limitations and exclusions for each plan quoted. Specify any waiting periods which apply.

71. Please complete the following UCR chart for the zip code areas: 230, 231, 233, 235 and 236.

ADA CODE	PROCEDURE	ALLOWANCE FOR PROPOSED PLANS
00120	Periodic Oral Exam	
01110	Prophylaxis, Adult	
0272	Bitewing x-rays; 2 films	
1203	Topical Fluoride	
1351	Sealant; per tooth	
02140	Amalgam, 1 Surface, Permanent	
03310	Root Canal Therapy, Anterior	
02752	Porcelain Crown, 1 Tooth	
07110	Extraction, Single Tooth	
4210	Gingivectomy/Gingivoplasty – Per Quadrant	

7220	Removal of Impacted Tooth-Soft Tissue	
5110	Complete Upper Denture	

72. Describe how you would handle orthodontia or other services in progress upon takeover.

73. Describe your pre-treatment estimate process. What is the turnaround time for such reviews? Is there a penalty for members who do not receive a pre-treatment estimate prior to receiving services? When do you recommend members receive a pre-treatment estimate?

K. NETWORK CONTRACTING AND GEOACCESS SUMMARY – HMO AND PPO

74. Conduct a GeoAccess analysis comparing your DHMO network to the residential census/zip code information provided. Use the following GeoAccess standards:

- **Primary Dentist:** 2 providers within 10 miles
- **Specialists:** 2 providers within 10 miles

Indicate the total number of eligible employees with the desired access.

75. Conduct a GeoAccess analysis comparing your PPO network to the residential census/zip code information provided. Use the following GeoAccess standards:

- **Primary Dentist:** 2 providers within 10 miles
- **Specialists:** 2 providers within 10 miles

Indicate the total number of eligible employees with the desired access.

PLEASE INCLUDE YOUR PROVIDER NETWORK WEBSITE ADDRESS!

