Introduction

Missouri Consolidated Health Care Plan (MCHCP) is the employee health benefit program for most State of Missouri employees, retirees, and their dependents covering more than 88,000 members (lives). An additional 1,200 non-state local government members are covered through their public entity employer.

This document constitutes a request for sealed proposals from qualified organizations to provide third party administrative (TPA) services for MCHCP's self-insured health plans for medical coverage. Bids are requested for:

- Third Party Administrator (TPA) to administer a self-insured health plan(s) for medical coverage, available to enrolled State and Public Entity members who have not been enrolled in MCHCP's group Medicare Advantage Plan. These plans may include PPOs, HDHPs, or any plan design determined by MCHCP. Proposals for TPA services shall include a fixed price for CY2025 and guaranteed not-to-exceed prices for CY2026-CY2029.
- Medically Supervised Weight Loss Program is encouraged to be included as a component of any proposal. A Medically Supervised Weight Loss Program as an adjunct to weight loss drugs or diabetes management must be itemized separately, and MCHCP reserves the right to annually elect or exclude this option.
- Member Reward Incentive Program is encouraged to be included as a component of any proposal. Member Reward Incentive Program must be itemized separately, and MCHCP reserves the right to annually elect or exclude this option.
- Musculoskeletal Management is encouraged to be included as a component of any proposal. Musculoskeletal Management must be itemized separately, and MCHCP reserves the right to annually elect or exclude this option.
- Bidder Supplemental Optional Services are encouraged to be included as a component of any proposal. Supplemental Optional Services must be itemized separately, and MCHCP reserves the right to annually elect or exclude these optional services.

Contracts awarded from this RFP will be effective January 1, 2025. MCHCP reserves the right to award multiple contracts from this RFP. MCHCP intends to limit the number of contract awards to a minimum number of contractors providing the maximum level of access to health care providers.

MCHCP has the following overarching goal for this Request for Proposal (RFP):

- To partner with a contractor who shares a vision of providing the most cost effective and efficient methods of providing health benefits to our members. This includes but is not limited to identifiable and measurable performance standards by the contractor in the areas of:
    - Claims administration
    - Benefit administration
    - Account management
    - Customer service
    - Utilization management

  - Care management
  - Financial management
  - Provider network administration

- Bidders should understand that MCHCP views the foremost obligation as providing efficient and effective services to its membership. MCHCP will aggressively pursue and implement measures toward meeting this goal. Bidders are strongly encouraged to demonstrate in their response to this RFP that they share a common vision and commitment.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- Licensing – The bidder must hold a certificate of authority to do business in the State of Missouri and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Commerce and Insurance. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business on their own behalf and on behalf of a covered entity.
- Benefits – Bidders shall not mandate specific benefits, and contractor(s) must be flexible and demonstrate the ability to administer benefits. This includes the ability to offer multiple plan designs and benefit options as well as interacting with other MCHCP vendor partners.
- Discount Arrangements - As part of the evaluation process for this bid, bidders shall agree to share all provider discount arrangements by network, as described in Attachment 4 and Exhibit A-4 with MCHCP's consultant, Segal, prior to the award of the contract.
- Data Transfer – Bidder shall agree to provide claim-level data electronically to MCHCP or designated data vendor (currently Merative) on a monthly basis, including twenty-four (24) run-out months (i.e. months following contract expiration). Bidders may be required to demonstrate the ability to provide such data before a contract award is made.
- Size and Experience – The bidder must currently provide service to clients that have at least 250,000 covered lives combined and have at least two (2) clients with 50,000 covered lives. The bidder must be willing to disclose the name of the large clients if requested. Experience with public sector health plans is preferred. The bidder must have been in operation and performing the services requested in this RFP for a minimum of five (5) years.
- Networks – Bidders must offer contracted provider networks capable of delivering benefits as described in the RFP. MCHCP requires a broad network that provides national coverage.
- Contract – Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products, or contracts. Any bid proposal containing any contingency based upon actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.
- Rates – Bidders shall not be permitted to alter their rate or fees after submission except with agreement by MCHCP.

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. Submissions after respective deadlines have passed may be rejected. All bidder documents and complete proposals must be received by the proposal deadline of March 1, 2024, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.
- Data exchange – Bidder must be capable of establishing a relationship with MCHCP's pharmacy benefit manager, which allows the contractor to communicate deductible and out-of-pocket information on a daily basis and potentially with other MCHCP contractors to communicate eligibility, participation or claims data.
- Performance Bond - The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $5,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $5,000,000.

Background Information

- MCHCP is governed by the provisions of Chapter 103 of the Revised Statutes of Missouri. Under the law, MCHCP is directed to procure health care benefits for most State employees. The law also authorizes non-state public entities to participate in the plan. Rules and regulations governing the plan can be found by following this link http://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp.
- Current MCHCP total state membership is over 88,000 covered persons; however, there are some MCHCP members enrolled in a fully-insured group Medicare Advantage Plan administered by UnitedHealthcare. These 17,000 members will not be part of this contract award.
- Current total public entity membership is over 1,200 covered persons.
- MCHCP currently contracts with Anthem who provides administrative services for two PPO plans and one HSA Plan nationwide. The contract expires December 31, 2024.
- The State of Missouri through MCHCP currently contributes a portion of the premium for active state employees, retirees and their dependents. Decisions impacting the contribution level are reviewed annually by the MCHCP Board of Trustees and are subject to change.
- All public entities currently enrolled or joining MCHCP are required to contribute a minimum of 50 percent of the active employee only premium. Additionally, 75 percent of all eligible public entity employees (those without Medicare, Medicaid or other group coverage) must join the plan.

- The contractor will not be responsible for administering prescription drug benefits, as MCHCP has contracted for these services separately.

Assumptions and Considerations

Please submit your proposal using the Optavise online submission tool no later than Friday, March 1, 2024, 5 p.m. CT (6 p.m. ET). Bidders must also submit the claims re-pricing information along with Exhibit A-4 directly to Segal no later than Friday, March 1, 2024, 5 p.m. CT (6 p.m. ET).

The MCHCP Board of Trustees has final responsibility for all MCHCP contracts. Responses to the RFP and all proposals will remain confidential until awarded and contracts are executed by the MCHCP Board of Trustees or their respective designees or until all proposals are rejected.

Do not contact MCHCP directly regarding this RFP. Questions about the technical procedures for participating in this online RFP process should be addressed to Optavise. Any questions concerning the content of the RFP should be submitted via the messaging tool of Optavise.

Proposal Instructions

NOTE: READ THESE INSTRUCTIONS COMPLETELY PRIOR TO RESPONDING TO THE RFP

To be considered, you must respond to all required sections of this RFP. Bidders are strongly encouraged to read the entire RFP prior to the submission of a proposal. The bidder must comply with all stated requirements. Bidders are expected to provide complete and concise answers to all questions. Your responses to all questions must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your current capabilities.

If any information contained in the proposal is found to be falsified, the proposal will immediately be disqualified.

Proposals must be valid until October 1, 2024. If a contract is awarded, prices shall remain firm for the specified contract period.

A proposal may only be modified or withdrawn by signed, written notice which has been received by MCHCP prior to the official filing date and time specified.

Contract Term

The initial agreement is for the period of January 1, 2025 through December 31, 2025, with up to four additional one-year contracts renewable at the sole option of the MCHCP Board of Trustees.

Clarification of Requirements

It is assumed that bidders have read the entire RFP prior to the submission of a proposal and, unless otherwise noted by the bidder, a submission of a proposal and any applicable amendment(s) indicates that the bidder will meet all requirements stated herein.

The bidder is advised that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP as a RFP and any amendments and/or clarifications thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

Schedule of Events

The following timeline for the procurement is provided below. No pre-bid conference has been scheduled.

Activity	Timing
Online RFP Released	Wednesday, February 7, 2024 8 a.m. CT (9 a.m. ET)
Intent to Bid Document Due	Tuesday, February 13, 2024 5 p.m. CT (6 p.m. ET)
Bidder Question Submission Deadline	Tuesday, February 13, 2024 5 p.m. CT (6 p.m. ET)
MCHCP Responses to Submitted Questions	Tuesday, February 20, 2024 5 p.m. CT (6 p.m. ET)

Activity	Timing
Proposals Due	Friday, March 1, 2024 5 p.m. CT (6 p.m. ET)
Provider Discount Analysis Due to Segal	Friday, March 1, 2024 5 p.m. CT (6 p.m. ET)
Finalist Presentation	Early April, 2024
Final Vendor Selection	Late April, 2024
Program Effective Date	January 1, 2025

Questions

During this bidding opportunity, MCHCP will be using the online messaging module of the Optavise application for all official answers to questions from bidders, amendments to the RFP, exchange of information and notification of awards. It is the bidder's responsibility to notify MCHCP of any change in contact information of the bidder. During the bidding process you will be notified via the messaging module of the posting of any new bid-related information.

Any and all questions regarding specifications, requirements, competitive procurement process, etc., must be in writing and submitted through the online messaging module of the Optavise application by **Tuesday, February 13, 2024, 5 p.m. CT**. Questions received after February 13, 2024, will be answered and posted through the messaging module as time permits, but there is no guarantee of a response to these questions. For step-by-step instructions, please refer to the *Downloads* section of the Optavise application, and click on *User Guides*.

Questions deemed universally applicable will be answered in writing and shared with all vendors who have indicated they are quoting. The team will respond to your questions via the messaging module, with a summary of all questions and answers provided by **Tuesday, February 20, 2024.**

Bidders or their representatives may not contact other MCHCP employees or any member of the MCHCP Board of Trustees regarding this bidding opportunity or the contents of this RFP. If any such contact is discovered to have occurred, it may result in the immediate disqualification of the bidder from further consideration.

Proposal Deadline

ALL questionnaires and pricing proposals must be submitted no later than 5 p.m. CT (6 p.m. ET), **Friday, March 1, 2024**.

Bidders are required to complete a re-pricing exercise as described in Attachment 4 which must be submitted directly to Segal, no later than 5 p.m. CT (6 p.m. ET), **Friday, March 1, 2024**. This information will be kept confidential and will remain with Segal. This information should not be sent to MCHCP or uploaded to Optavise. Submissions received after that time will not be accepted.

Disclaimers

MCHCP will not be liable under any circumstances for any expenses incurred by any respondent in connection with the selection process.

The description of coverage and plan design contained in this RFP is solely intended to allow for the preparation and submission of proposals by respondents and does not constitute a promise or guarantee of benefits to any individual.

Confidentiality and Proprietary Materials

Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all proposals and related documents.

MCHCP is a governmental body under Missouri Sunshine Law (Chapter 610 RSMo). Section 610.011 requires that all provisions be "liberally construed and their exceptions strictly construed to promote" the public policy that records are open unless otherwise provided by law. Regardless of any claim by a bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Only information expressly permitted by the provisions of Missouri's Sunshine Law to be closed – strictly construed – will be redacted by MCHCP from any public request submitted to MCHCP after an award is made. Bidders should presume information provided to MCHCP in a proposal will be public following the award of the bid and made available upon request in accordance with the provisions of state law.

Evaluation Process

Any apparent clerical error may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, MCHCP shall contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

Any pricing information submitted by a bidder must be disclosed on the pricing pages as designated in this RFP. Any pricing information which appears elsewhere in the bidder's proposal shall not be considered by MCHCP.

Awards shall only be made to the bidder(s) whose proposal(s) complies with all mandatory specifications and requirements of the RFP. MCHCP reserves the right to evaluate all offers and based upon that evaluation to limit the number of contract awards or reject all offers.

MCHCP reserves the right to request written clarification of any portion of the bidder's response to verify the intent of the bidder. The bidder is cautioned, however, that its response shall be subject to acceptance or rejection without further clarification.

MCHCP reserves the right to consider historic information and fact, whether gained from the bidder's proposal, question and answer conferences, references, or any other source, in the evaluation process. The bidder is cautioned that it is the bidder's sole responsibility to submit information related to the evaluation categories and that MCHCP is under no obligation to solicit such information if it is not included with the bidder's proposal. Failure of the bidder to submit such information may cause an adverse impact on the evaluation of the bidder's proposal.

After determining that a proposal satisfies the mandatory requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal in relationship to the published evaluation criteria shall be made by using subjective judgment. The award(s) of a contract resulting from this RFP shall be based on the lowest and best proposal(s) received in accordance with the following evaluation criteria:

Evaluation Criteria

Financial:	
Network discounts	350 points
Administration fees	
• TPA Administrative Services (inclusive of charges passed through claims wire and quality initiatives and other arrangements)	135 points
• Member Reward Incentives Fees	5 points
• Musculoskeletal Management Fees	5 points
• Medically Supervised Weight Loss Program	5 points
Total Administrative Fees	150 points
Total Financial	500 points
Non-financial:	
Questionnaire Responses	500 points
Total – Non-Financial points	500 points
Bonus Points:	
Section 29: MBE/WBE Participation Commitment	10 points

MCHCP will limit the number of finalists to the bidders receiving 85 percent (425 points) of the possible 500 non-financial points available or the top two bidders if less than two bidders receive 85 percent of the possible 500 non-financial points.

The bidder's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process. A maximum of MBE/WBE participation points of 10 points will be awarded based on the participation amount proposed by the bidder. Awarded MBE/WBE participation points will be added to the non-financial points earned by the bidder and will be included to determine if a bidder meets the 85 percent threshold to obtain finalist status.

Minority Business Enterprise (MBE)/Women Business Enterprise (WBE) Participation

The bidder should secure participation of certified MBEs and WBEs in provider products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10 percent MBE and 5 percent WBE of the total dollar value of the contract.

a) These targets can be met by a qualified MBE/WBE vendor themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.

b) The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the bidder's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

c) In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). See below for a definition of a qualified MBE/WBE.

d) If the bidder is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the bidder must provide the following information with the proposal:

    a. Participation Commitment - If the bidder is proposing MBE/WBE participation, the vendor must complete Section 29 of the TPA RFP Questionnaire (MBE-WBE Participation Commitment), by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the vendor submitting the proposal is a qualified MBE and/or WBE, the vendor must include the vendor in the appropriate table on the Participation Commitment Form.

    b. Documentation of Intent to Participate – The bidder must either provide a properly completed Exhibit A-9, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed or must provide a letter of intent signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE certificate issued by the Missouri OEO). If the bidder submitting the proposal is a qualified MBE and/or WBE, the bidder is not required to complete Exhibit A-9, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

e) Commitment – If the bidder's proposal is awarded, the percentage level of MBE/WBE participation committed to by the bidder on Exhibit A-9, Participation Commitment, shall be interpreted as a contractual requirement.

<u>Definition -- Qualified MBE/WBE:</u>

In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) by the proposal opening date.

MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or more minorities or women who own it.

Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington D.C.

A listing of several resources that are available to assist bidders in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)
Harry S Truman Bldg., Room 630, P.O. Box 809, Jefferson City, MO 65102-0809
Phone: (877) 259-2963 or (573) 751-8130
Fax: (573) 522-8078
Web site: http://oeo.mo.gov

Finalist Presentation

After an initial screening process, a Finalist Presentation may be scheduled, if deemed necessary by MCHCP, to allow the bidder to present their strengths of their proposal and for MCHCP to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP may ask additional questions and/or conduct a site visit of the bidder's service center or other appropriate location.

Negotiation and Contract Award

The bidder is advised that under the provisions of this RFP, MCHCP reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply:

- Negotiations may be conducted in person, in writing, or by telephone.
- Negotiations will only be conducted with bidders who provide potentially acceptable proposals. MCHCP reserves the right to limit negotiations to those bidders which received the highest rankings during the initial evaluation phase. All bidders involved in the negotiation process will be invited to submit a best and final offer.
- Terms, conditions, prices, methodology, or other features of the bidder's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.
- The mandatory requirements of the RFP shall not be negotiable and shall remain unchanged unless MCHCP determines that a change in such requirements is in the best interest of MCHCP and its members.
- Bidder understands that the terms of any negotiation are confidential until an award is made or all proposals are rejected.

Any award(s) of a contract(s) resulting from this RFP will be made only by written authorization from MCHCP.

Access to Demographic and Claim Files

To gain access to the demographic file (Attachment 3), bidders must complete and sign Exhibit A-2 Limited Data Use Agreement. Once the completed and signed document has been uploaded to Optavise, access to Attachment 3 will be granted through Optavise.

Pricing

The bidder must utilize Exhibit A-3 to provide a firm, fixed per employee per month cost for providing administrative services as described in this RFP. It is expected that the total monthly administrative charge will be broken down to reflect specific costs associated with claims administration, network administration, medical management, and other services listed throughout this RFP.

Proposals shall include a fixed price for CY2025 with guaranteed not-to-exceed maximum prices for CY2026 through CY2029.

Bidders are required to complete a re-pricing project as described in Attachment 4 and Exhibit A-4, which must be submitted directly to Segal, no later than 5 p.m. CT (6 p.m. ET), **Friday, March 1, 2024**. This information will be kept confidential and will remain with Segal. This information should not be sent to MCHCP or uploaded to Optavise. Submissions received after that time will not be accepted.

Any cost and/or pricing data submitted or related to the bidder's proposal including any cost and/or pricing data related to contractual extension options, whether required or voluntary, shall be subject to evaluation if deemed by MCHCP to be in the best interest of MCHCP members.

In determining pricing points for administrative fees, MCHCP will consider the potential five-year cost of the contract including the full not-to-exceed price for Years 2-5 of the contract. The contractor shall understand that annual renewal rates for subsequent years of the contract will be negotiated, but must be within the not-to-exceed prices submitted within this bid.

Plan Design

The plan designs included with this RFP are for sample purposes only. MCHCP reserves the right to modify the plan design to meet its needs. Additionally, MCHCP may offer multiple plan designs to its members.

Renewal of Contract

The initial agreement is for the period of January 1, 2025 through December 31, 2025, with up to four (4) additional one year renewals available at the sole option of the MCHCP Board of Trustees.

Proposed pricing arrangements for Years 2-5, not-to-exceed the allowed maximum shall be submitted to MCHCP prior to May 15 of the next plan year.

Using Optavise

The 2025 MCHCP Third Party Administrator (TPA) RFP contains two broad categories of items that you will need to work on via the Optavise application:

1) Items Requiring a Response:

a) Questionnaires (e.g., TPA RFP Questionnaire) are online forms to collect your responses to our questions about your capabilities.

b) Response Documents (e.g., Exhibit A-1 Intent to Bid) are attachment files (e.g., MS Word or Excel) that are posted to the Optavise website. They should be downloaded, completed by your organization, and then posted/uploaded back to the Optavise application. When you upload your response, from the dropdown menu, identify each uploaded document as a Response document and associate it to the appropriate document by name. For step-by-step instructions, please refer to the *How to Download and Attach Files* User Guide located in the *Downloads* section on the application homepage. Note: Exhibit A-4 should be submitted directly to Segal and not uploaded to Optavise.

2) Reference Files from Event Administrator:

a) Documents (e.g., Exhibit B – Scope of Work) that you should download and read completely before submitting your RFP response.

These components can be found in the Optavise application under the 2025 MCHCP Third Party Administrator (TPA) RFP on the Event Details page of the application.

Note that as you use the Optavise application to respond to this RFP, User Guides are accessible throughout the application by clicking on the help icon or from the *Downloads* area of the Optavise application homepage. For help with data entry and navigation throughout the application, you can contact the Optavise staff:

- Phone: 800-979-9351
- E-mail: systemsupport@optavise.com

Responding to Questionnaires

We have posted two forms for your response.

- TPA RFP Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to Optavise by **Friday, March 1, 2024, 5 p.m. CT (6 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains the items you and your team are required to access and respond to. For step-by-step instructions, please refer to the *How to Submit a Questionnaire* User Guide located in the *Downloads* section of the Optavise application homepage. You have the option to "respond online" or through two different off-line (or desktop) tools.

Completing Response Documents

The following exhibits must be completed, signed and unless otherwise noted, uploaded to Optavise:

- Exhibit A-1 – Intent to Bid (due 5 p.m. CT, February 13, 2024)
- Exhibit A-2 – Limited Data Use Agreement (due 5 p.m. CT, February 13, 2024)

- Exhibit A-3 – Third Party Administrative Fees (due 5 p.m. CT, March 1, 2024)
- Exhibit A-4 – Repricing Summary (due 5 p.m. CT, March 1, 2024, submitted to Segal)
- Exhibit A-5 – Discount Guarantees (due 5 p.m. CT, March 1, 2024)
- Exhibit A-6 – Proposed Bidder Modifications (due 5 p.m. CT, March 1, 2024)
- Exhibit A-7 – Confirmation Document (due 5 p.m. CT, March 1, 2024)
- Exhibit A-8 – Contractor Certification (due 5 p.m. CT, March 1, 2024)
- Exhibit A-9 – MBE-WBE Intent to Participate Document (due 5 p.m. CT, March 1, 2024)

The following exhibits must be reviewed and the bidder provide any suggested red-lined changes to the documents using Microsoft Word Track Changes functionality. Changes proposed may or may not be accepted by MCHCP.

- Exhibit A-10 – Sample MCHCP Contract (due 5 p.m. CT, March 1, 2024)
- Exhibit A-11 – MCHCP Business Associate Agreement (due 5 p.m. CT, March 1, 2024)

Completing Pricing Worksheets (Exhibit A-3)

The financial worksheet (Exhibit A-3) may be accessed in *Items Requiring a Response*.

Fee quotes should assume:

- Plan effective date: January 1, 2025
- Submitted prices for 2025 shall be firm, while prices for 2026, 2027, 2028, and 2029 shall be submitted as "not-to-exceed" amounts. Proposed prices are subject to negotiation prior to the award of a contract by MCHCP. Fees must be quoted on a mature basis. No fees will be paid for processing run-out claims.
- Annual renewals are solely at the option of MCHCP. Renewal prices are due by May 15 of each year and are subject to negotiation.

RFP Checklist

Prior to the March 1, 2024, close date, be sure you have completed and/or reviewed each of the following listed documents.

Type	***Document Name***
Questionnaire	TPA RFP Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Response	Exhibit A-1 Intent to Bid.docx **DUE: February 13, 2024**
Response	Exhibit A-2 Limited Data Use Agreement.docx **DUE: February 13, 2024**
Response	Exhibit A-3 Third Party Administrative Fees.xlsx **DUE: March 1, 2024**
Response	Exhibit A-4 Repricing Summary.xlsx **DUE: March 1, 2024, and submitted to Segal**
Response	Exhibit A-5 Discount Guarantees.xlsx **DUE: March 1, 2024**
Response	Exhibit A-6 Proposed Bidder Modifications.docx **DUE: March 1, 2024**
Response	Exhibit A-7 Confirmation Document.docx **DUE: March 1, 2024**
Response	Exhibit A-8 Contractor Certification.docx **DUE: March 1, 2024**

Type	***Document Name***
Response	Exhibit A-9 MBE-WBE Intent to Participate Document.docx **DUE: March 1, 2024**
Response	Exhibit A-10 Sample Contract.docx **DUE: March 1, 2024**
Response	Exhibit A-11 Business Associate Agreement.docx **DUE: March 1, 2024**
Reference	Introduction and Instructions – 2025 Third Party Administrator (TPA) RFP.pdf
Reference	Exhibit B – Scope of Work (2025 TPA RFP).docx
Reference	Exhibit C – General Provisions.docx
Reference	Attachment 1 – Enrollee file layout.docx
Reference	Attachment 2 – Provider file layout.docx
Reference	Attachment 3 – MCHCP Enrollee File.xlsx
Reference	Attachment 4 – Medical Claim Detail for Repricing.xlsx

Contact Information

We understand that content and technical questions may arise. All questions regarding this document and the selection process must be submitted through the online messaging module of the Optavise application by **Tuesday, February 13, 2024, 5 p.m. CT (6 p.m. ET)**.

For technical questions related to the use of Optavise, please contact Optavise customer support team at systemsupport@optavise.com, or by calling Optavise Customer Support at 1-800-979-9351.

EXHIBIT B
SCOPE OF WORK

B1 **ADMINISTRATIVE SERVICES:** The contractor understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and contractor expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. The contractor shall provide administrative services and administer benefits for the members of MCHCP in accordance with the provisions and requirements of this contract on behalf of MCHCP. The contractor must administer benefits and services as determined by MCHCP and as promulgated by rule in Title 22 of the Missouri Code of State Regulations. The contractor is obligated to follow the performance standards as agreed to in Section 21 of the Third Party Administrator (TPA) RFP Questionnaire. The contractor is also obligated to follow all items listed in Mandatory Contract Provisions Questionnaire of the TPA RFP. The administrative services that are included in the contract include, but are not limited to:

B1.1 TPA administrative services that include, but are not limited to, account management, claim services, member services, broad national network access for medical services (inclusive of mental health and substance abuse services), telehealth services (inclusive of primary and urgent care, mental health and substance abuse services, physical therapy, and other services that may be optimized on a telehealth platform), care management (inclusive of utilization management and case management); coordination with MCHCP business associates; reporting; banking; and web and consumer tools. Other optional services, if offered by the contractor and accepted by MCHCP, may include, musculoskeletal management, medically supervised weight loss program as an adjunct to weight loss drugs or diabetes management, member incentive reward program to encourage utilization of lower cost providers, or other contractor supplemental optional services.

B1.2 Subrogation and overpayment recovery services. The contractor shall not levy any applicable overpayment recovery fees for overpayments resulting from contractor payment errors.

B2 **COORDINATION WITH MCHCP BUSINESS ASSOCIATES**: The contractor must coordinate, cooperate, and electronically exchange information with MCHCP's business associates as identified by MCHCP. Necessary information can include, but is not limited to, the deductible and out-of-pocket accumulators, participation in care management or claims. Frequency of electronically exchanged information can be daily.

B3 **ACCOUNT MANAGEMENT**: The contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a designated account executive, a member service manager, medical director, a clinical contact, a person responsible for preparing the reports and a management information system representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

B3.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP.

B3.2 Be extremely responsive.

B3.3 Be comprised of individuals with specialized knowledge of contractor's networks, functions, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, standard and banking arrangements, and relations with third parties.

B3.4 Act on behalf of MCHCP in navigating through the contractor's organization. The account management team must be able to effectively advance the interest of MCHCP through the contractor's corporate structure.

B3.5 The contractor agrees to provide MCHCP with at least thirty (30) days advance notice of any material change to its account management and servicing methodology and at least ten (10) days advanced notice of a personnel change in the contractor's account management and servicing team.

B3.6 The contractor agrees to allow MCHCP to complete an annual formal performance evaluation of the assigned account management team.

B4 **MEETINGS:** The contractor agrees to meet with MCHCP staff and Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members. The contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted. The contractor must also present benchmark data by using the contractor's entire book of business, a comparable client(s) to MCHCP, or some other comparable industry norm.

B5 **NETWORKS:** The contractor must have in place a network which will offer access to MCHCP members nationwide. The contractor shall maintain network(s) that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay or unreasonable travel. The contractor shall comply with state and federal requirements regarding network adequacy, including but not limited to, The No Surprises Act.

B5.1 The contractor shall annually provide no later than January 15 of each year, a network adequacy analysis that details the sufficiency of the network as compared to the standards set forth in 20 CSR 400-7.095 Provider Network Adequacy Standards. If the contractor utilizes more than one network, such analysis shall be prepared for each network it utilizes in fulfillment of the requirements herein. For any deficiencies identified as part of the analysis, the contractor shall provide a plan for how members will access services in deficient access areas and a plan for bringing network adequacy into compliance.

B5.2 Including primary care medical homes is highly encouraged. The primary care medical home is accountable for meeting most of each patient's physical and mental health care needs, including prevention and wellness, acute and chronic care. This team of care approach brings together providers to meet the needs of their patients. The contractor shall include in its network adequacy plans, an analysis of the locations of primary care medical homes and plans for expansion.

B5.3 The contractor shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the networks to meet the health care needs of the enrolled members within reasonable geography and reasonable time. In January and July of each year, the TPA shall provide a network adequacy analysis including geographic access report to MCHCP. In addition to looking at the

needs from an overall member population standpoint, the contractor shall ensure the networks are able to address the needs of those with special needs including but not limited to, visually or hearing impaired, limited English proficiency, and low health literacy. The contractor shall notify MCHCP within five business days if the networks' geographic access changes from what was proposed by the contractor.

B5.4 The contractor shall require that network providers be responsible for obtaining all necessary pre-certifications and prior authorizations and holding the member harmless for failure to obtain necessary authorizations.

B5.5 The contractor shall agree to provide written notice to affected members when providers leave the network. The contractor shall provide continuation of care in accordance with The No Surprises Act, RSMo Chapter 354.612 and MCHCP regulations.

B5.5.1 For facility terminations or non-renewals, contractor must, at a minimum, notify all subscribers residing within a 40-mile radius of the facility at least 31 days prior to the termination or non-renewal or as soon as possible after non-renewal.

B5.5.2 For non-facility provider terminations or non-renewals, contractor must, at a minimum, notify all members who received care from the provider within the last 90 days and from primary care providers within the last 365 days.

B5.5.3 MCHCP reserves the right to expand continuation of care beyond regulatory requirements.

B5.6 The contractor shall notify MCHCP of alternative provider arrangements that it has in place, (including but not limited to, accountable care organization, primary care case management, patient-centered medical home, or other value-based payment arrangement not specifically mentioned) that provide providers a risk-based payment arrangement whether upside, downside or both in recognition of achievement of specified benchmarks or goals. For each alternative provider arrangement, the contractor shall annually report on the locations of each arrangement, the number of MCHCP members potentially impacted, the financial arrangement in such detail as to provide MCHCP with an understanding of its potential financial obligation as a self-insured plan and how each is monitored for effectiveness from both quality and financial aspects. The contractor shall notify MCHCP of all alternative provider arrangements that it has in place by January 15 of each year.

B5.7 The contractor shall have the ability to provide administrative services to support network or provider arrangements that MCHCP have directly contracted for outside the arrangement offered by the contractor. Such administrative support may include, but not be limited to, claims processing in accordance with the underlying plan design, utilization management, and appeals processing.

B5.8 The contractor shall obtain discounts and other reductions, including through secondary networks as much as is possible for non-network claims.

B5.9 Provider network management strategies shall include areas of focus on ensuring provider directory data is up-to-date and accurate. The contractor shall remove terminated providers from the directory at the time of termination of contract or when a provider is no longer providing direct patient care. The contractor shall provide a quarterly review of the accuracy of the provider directory. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will contact the contractor immediately. The contractor must correct inaccuracies within ten (10) days of being notified by MCHCP.

B5.10 In alignment with the No Suprises Act, the contractor shall require providers and health care facilities to promptly refund enrollees amounts paid in excess of network cost-sharing amounts with interest, if the enrollee inadvertently received non-network care due to inaccurate provider

directory information or the provider billed the enrollee for an amount in excess of network cost-sharing amounts and the enrollee paid the bill.

B6 **MEMBER SERVICE**: The contractor must provide a high quality and experienced member service department. The contractor's member service representatives (MSRs) must be fully trained in the MCHCP benefits, plan designs and other options.

B6.1 The contractor shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified MSRs. At a minimum, member service must be available between the hours of 8:00 a.m. and 8:00 p.m. central time (CT), Monday through Friday except for designated holidays.

B6.2 Member calls to contractor must be recorded and retained for a minimum of five (5) years. If prior to the recording being purged, the contractor is notified of litigation by MCHCP, call recordings must be provided to MCHCP upon request.

B6.3 The member services department shall include access to member advocates who are trained to meet member health care and benefit needs. The member advocate must be trained to be proactive and work with members to improve their health, their understanding and usage of benefits and how to find and get care. Examples of advocacy, include but are not limited to helping members find health care providers and schedule appointments, resolve claims and benefit issues, navigating choices for care, access personalized care and services to meet specific needs, and to connect to care teams for chronic and complex conditions.

B6.4 The contractor is responsible for developing, printing, and mailing identification cards directly to the member's home. The contractor is responsible for all associated production and mailing costs.

B6.5 The contractor shall provide a quality-of-care initiative focused on preventive care each year. The initiative must include a minimum quarterly communication created and mailed to members. Selection of topics, content, timing, and draft language will be developed in coordination with MCHCP.

B6.6 The contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by the contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to such items as provider directories and plan-wide newsletters as long as they do not contain MCHCP-specific information such as eligibility, enrollment, benefits, or rates which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits contractor from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.).

B6.7 The contractor(s) shall have a variety of tools and information sources for MCHCP members. This may include, but is not limited to, the following:

- B6.7.1 New member information;
- B6.7.2 Health price transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary;
- B6.7.3 Member ability to view claim status;
- B6.7.4 Member information to track deductible, coinsurance and out-of-pocket maximum status;
- B6.7.5 Explanation of benefits; and
- B6.7.6 Ability to query and download up to twenty-four (24) months of claims data.

B7 **IMPLEMENTATION:** Upon award, a final implementation schedule must be agreed to by MCHCP and the contractor within 30 days of contract award. In addition, a final implementation schedule must be agreed to by MCHCP and the contractor within 30 days of the Board of Trustee approval of each upcoming plan year benefits and plan designs. The contractor shall implement any eligibility, plan designs and benefits as directed by MCHCP. Failure on MCHCP's part to complete, by the agreed upon dates, the MCHCP key dependent tasks associated with the implementation may necessitate changes to the implementation schedule.

B7.1 At a minimum, the schedule must include the following activities as necessary:
- B7.1.1 Testing of eligibility file and other files to and from MCHCP and/or its business associates;
- B7.1.2 Acceptable date for final eligibility file and other files to and from MCHCP and/or its business associates;
- B7.1.3 ID card production and distribution;
- B7.1.4 Finalization of benefits, plan designs, and other key elements;
- B7.1.5 Testing of appropriate files to and from MCHCP business associate(s), if necessary; and
- B7.1.6 Testing of claim file to data warehouse vendor.

B7.2 At least forty-five (45) days prior to the January 1, 2025, effective date, MCHCP will have a readiness review/pre-implementation audit of the contractor(s), including an on-site review of the contractor's facilities if MCHCP deems it necessary. The contractor shall participate in all readiness review/pre-implementation audit activities conducted by MCHCP staff or its designee to ensure the contractor's operational readiness. MCHCP or its designee will provide the contractor with a summary of findings as well as areas requiring corrective action. The contractor is responsible for all costs associated with this review/audit/corrective action, including travel expenses of the MCHCP review team or its designee.

B8 **REPORTING REQUIREMENTS**: The contractor agrees that all data required by MCHCP shall be confidential and will not be public information. The contractor further agrees not to disclose this or similar information to any competing company, either directly or indirectly. The contractor shall comply with the following:

B8.1 MCHCP reserves the right to retain a third-party contractor to receive claims-level data from the contractor and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of the contractor's duties under this contract, including the provision of data as specified without constraint on its use. The contractor shall agree to:
- B8.1.1 Provide claims, person-level utilization data to MCHCP and/or MCHCP's data vendor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;
- B8.1.2 Provide data in an electronic form and within a time frame specified by MCHCP;
- B8.1.3 Place no restraints on use of the data provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and
- B8.1.4 This obligation continues for a period of two (2) years following contract termination at no additional cost to MCHCP.

B8.2 The contractor shall provide quarterly reports detailing customer service telephone answer time and abandonment. The reports shall be submitted to MCHCP quarterly and are due within 30

days of the end of the quarter reported. The cost for providing this report must be included in the PEPM fees for administration services and cannot be listed in Supplemental Pricing.

B8.3 The contractor shall provide a monthly report of cases that have the potential to incur large expenditures (over $50,000). The report shall include the patient's name, diagnosis, prognosis, a brief clinical summary, and the amount paid to date. The report is due monthly and is to be provided no later than the 15th of each month.

B8.4 The contractor shall provide the contractor's standard reporting package on a timely basis.

B8.5 At the request of MCHCP and at the contractor's expense, the contractor agrees to participate in an annual customer satisfaction survey, such as the current version of the National Committee for Quality Assurance (NCQA) *Consumer Assessment of Health Plan Survey (CAHPS)* or a similar survey tool identified by MCHCP, using the established guidelines. A third party must conduct any such survey.

B8.6 The contractor shall provide, at the contractor's expense, an annual report which details how MCHCP performs on HEDIS® measures as developed and maintained by the NCQA for each year. At a minimum, the items to be reported must include measures in the following domains of care: Effectiveness of Care, Access/Availability of Care, Utilization, Risk Adjusted Utilization, and Measures Collected Using Electronic Clinical Data Systems. The annual report shall define the measures and compare the MCHCP rate against the HEDIS® book of business rate and the national benchmark rate. The report shall be provided no later than July 15 of each year for the prior year's data.

B8.7 At the request of MCHCP, the contractor shall submit additional ad hoc reports on information and data readily available to the contractor. Fair and equitable compensation will be negotiated with the contractor.

B8.8 MCHCP will determine the acceptability of all claim files and reports submitted based upon timeliness, format, and content. If reports are not deemed to be acceptable or have not been submitted as requested, the contractor will receive written notice to this effect and the applicable liquidated damages, as defined in Section 21 of the TPA RFP Questionnaire, will be assessed.

B8.9 TPA shall consult on federal and state legislation, judicial rulings and other changes in rules or statutes that may affect MCHCP as needed and provide potential impact including fiscal impact to MCHCP upon request. TPA must respond within the timeframe specified as requested.

B9 **ELIGIBILITY FILES**: The contractor shall be able to accept, via secure file transfer, all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply specific record set information in an electronic format and the contractor must process such information within 24 hours of receipt. The contractor must provide a dedicated technical contact that will provide support to MCHCP Information Technology Department for any EDI issues. MCHCP is willing to work with the contractor on these requirements after the contract is awarded.

B9.1 It is MCHCP's intent to send a transactional based (change only) eligibility file weekly and a periodic full eligibility reconciliation file.

B9.2 Contractor will further develop an out of sequence (ad hoc) methodology for updating records outside of the normal schedule.

B9.3 MCHCP will provide a recommended data mapping for the 834-transaction set.

B9.4 Within two business days after processing any eligibility-related file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error

message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

B9.5 The contractor shall provide access to view data on its system via a web-based "Employer Portal" to ensure MCHCP provided eligibility files are correctly updating the contractor's system, and for MCHCP member support to verify individual specific information on demand.

B9.6 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B9.7 The contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

B9.8 The required method for all file transfers is Secure FTP. No PGP is required but can be implemented upon request. MCHCP will provide an account for the contractor transfers at ftp.mchcp.org.

B9.9 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set and error reporting responses. MCHCP requires that the contractor accept and run an initial test record set no later than October 15, 2024. Results of the test must be provided to MCHCP by October 30, 2024. Final acceptance of all eligibility file formats and responses are expected no later than November 30, 2024.

B9.10 The contractor and all its subcontractors shall use strong encryption methods that adhere to recognized security standards, such as AES-256, RSA, or ECC, for all data in transit and at rest, including File Transfer Protocol or other use of the Internet.

B10 **WEBSITE:** The contractor must have an active, current website that is updated regularly. MCHCP members must be able to access this site to obtain current listings of active network providers, print ID cards, review benefits and plan design, review explanation of benefits, check status of deductibles, maximums or limits, research specific medical conditions, access to price transparency tools in compliance with regulatory requirements, obtain a history of medical claims, map provider locations and other information.

B10.1 The contractor shall implement a Single Sign-On (SSO) solution, enabling seamless access to all websites and online applications via MCHCP's secure member portal and, if applicable, MCHCP's member app. The SSO solution must be compatible with prevalent protocols, including but not limited to, SAML2, OpenID and OAuth2, and must comply with recognized security standards. The SSO solution is expected to be fully functional and operational by Jan. 1, 2025. Testing shall be conducted and completed by Dec. 1, 2024.

B11 **APPEALS**: The contractor shall have a timely and organized system for resolving members' appeals in compliance with state and federal regulations, as amended. The system shall include, but not be limited to, two (2) levels of internal appeals, adverse benefit notices that shall be compliant with federal regulations and issued within regulatory timeframes. The contractor shall agree that MCHCP shall have the ability to review and approve all adverse benefit notice templates prior to their use. The contractor shall fully cooperate with the external appeal contractor (currently MAXIMUS Federal Services). Should an appeal result from an error or omission by the contractor, such as quoting a wrong benefit or failing to tell a member or provider that prior authorization is required, and benefits are paid or denied inappropriately, then contractor shall be responsible for sixty percent (60%) of the paid amount of the claims directly involved in or affected by such appeal. The contractor shall have a designated contact

person or persons to be available including after normal business hours to gather information necessary for external appeals including expedited appeals where information must be made available within the time specified by the external appeal contractor.

B12 **CLINICAL MANAGEMENT**: The contractor shall integrate and coordinate utilization management, case management, discharge planning, quality management and medical policy and technology assessment to utilize health care resources and achieve optimum patient outcome in the most cost-effective manner.

B12.1 The contractor shall prospectively and concurrently review the medical necessity, appropriate level of care and length of stay for scheduled hospital admissions, emergency hospital admissions, medical, surgical, mental health, and other health care services.

B12.2 The contractor shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. The contractor may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. The contractor shall make available its clinical review criteria upon request. The contractor is encouraged to publish its clinical review criteria on its website for full transparency.

B12.3 The contractor shall provide physician-to-physician communication. A licensed, clinical peer of the same medical specialty shall evaluate the clinical appropriateness of adverse determinations.

B12.4 The contractor shall obtain all information required to make a utilization review decision, including pertinent clinical information. The contractor shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

B12.5 Utilization management services will be conducted by licensed registered nurses and the contractor shall have available for review on a daily basis board-certified specialists representing all appropriate specialties. The utilization management staff must consult with appropriate specialists and sub-specialists in conducting utilization review of hospital, physician, mental health services, and other outpatient services. All adverse determinations shall be evaluated by a board-certified clinical peer prior to issuance of the denial.

B12.6 The prior authorization process shall have a goal to reduce the administrative burden on health care professionals and their staff and include a gold card program for providers to qualify to further recognize providers who routinely request approval of services with a high approval rate. The gold card program shall include a prospective review process for providers to annually qualify for continued status. The contractor shall educate providers on the prior authorization requirements including, but not limited to, the services needing a prior authorization, documentation requirements, attestation requirements, and peer-to-peer review procedures.

B12.7 The prior authorization process shall include means to involve patients in the process so that their voices are also captured as part of the approval process and decisions and appeal rights are communicated timely and without delay.

B12.8 The contractor shall annually provide a report of all services requiring prior authorization and the justification for including the services on the list with an estimated financial impact for inclusion and any adverse impacts for including the service on the prior authorization list. The contractor shall allow MCHCP to remove specific services from prior authorization requirements or to modify the terms under which a service is placed on a prior authorization list.

B12.9 The contractor shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management programs.

B12.10 The contractor shall identify case management opportunities and provide case management services for members with specific health care needs which will assist patients and providers in the coordination of services across the continuum of health care services, optimizing health care outcomes and quality, while minimizing cost.

B12.11 The contractor shall have a mechanism to proactively identify and target for intensified case management those cases having the potential to incur large expenditures. The large case management program shall identify potential large cases before expenses mount; mobilize local health care resources to meet the patient's long-term care needs; and coordinate the individual health needs of patients through multiple levels of care and transition the patient through appropriate levels of care as recovery milestones are met.

B12.12 The contractor shall provide case managers who will be experienced, professional registered nurses, licensed clinical social workers, and counselors who work with patients and providers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

B12.13 The contractor shall provide a toll-free line staffed by licensed registered nurses to answer medical questions from members. The nurse line must be available 24 hours a day, seven days a week.

B12.14 The contractor shall provide an intervention program for frequent users of emergency room services. The program must include, at a minimum, the following elements:

- B12.14.1 Monthly identification of members with five (5) or more emergency room visits in a 12-month rolling period including the date, location and diagnoses of the emergency room visits and whether any of the visits resulted in an inpatient admission;
- B12.14.2 Coordinate with MCHCP's pharmacy benefit manager (PBM) to obtain relevant pharmacy claims;
- B12.14.3 Perform a review of member claims to determine the appropriateness of the emergency room visits and whether the member would benefit from case management services;
- B12.14.4 A physician reviewer shall review any case initially determined not to benefit from case management services for a final determination;
- B12.14.5 Once identified for case management, member outreach efforts must include, at a minimum, one (1) introductory letter, two (2) outbound phone calls and one (1) unable to contact letter;
- B12.14.6 Once the member accepts case management, the case manager shall perform an initial assessment (including a behavioral health assessment) and review the member's history and concerns, provide a plan of care and provide ongoing case management services as necessary;
- B12.14.7 The contractor shall provide quarterly reports to MCHCP which include, at a minimum, the number of members meeting criteria, number of members engaged in the program and the outcome of the frequent emergency room user member's engagement.

B12.15 The contractor shall coordinate with the MCHCP's PBM and provide necessary case management services as part of MCHCP's Pharmacy Lock-In Program.

B13 **CLAIM PAYMENT**: The contractor shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2025 and each subsequent year of this agreement in

accordance with MCHCP regulations. The contractor shall provide a dedicated, experienced claims processing team that will be permanently assigned to the MCHCP account.

B13.1 The contractor shall process claims utilizing the contracted discount arrangements negotiated with participating providers.

B13.2 The contractor shall process claims from non-network providers utilizing secondary network discounts where available. Where secondary network discounts are not available, the contractor shall negotiate with the provider when the claim amount is over an established dollar threshold and, if no agreement reached, follow the established method as set forth in MCHCP regulations.

B13.3 Any associated TPA fees for non-network claims shall be in accordance with the RFP and any calculations to arrive at the associated fees shall be disclosed to MCHCP in detail.

B13.4 The contractor shall, at a minimum, auto-adjudicate seventy-five percent (75%) of claims.

B13.5 The contractor shall pay 90% of all clean claims within times frames specified in Chapter 376.383 of the Revised Statutes of Missouri (see Performance Guarantees included in Section 21 of the TPA RFP Questionnaire for definition and penalty).

- B13.5.1 "Clean claim" shall have the same meaning as specified in Chapter 376.383 of the Revised Statutes of Missouri.
- B13.5.2 The contractor shall maintain 97% payment accuracy in regard to their claims processing (see Performance Guarantees included in Section 21 of the TPA RFP Questionnaire for definition and penalty).
- B13.5.3 The contractor shall maintain 99% financial accuracy in regard to their claims processing (see Performance Guarantees included in Section 21 of the TPA Questionnaire for definition and penalty).
- B13.5.4 Should any payment result from an error or omission by Contractor, such as benefit not programmed correctly, quoting a wrong benefit or failing to tell a member or provider that prior authorization is required, and benefits are paid inappropriately, then contractor shall be responsible for sixty percent (60%) of the paid amount of the claims directly involved in or affected by such error.

B13.6 The contractor shall have an automated process for tracking and resolving incomplete or pended claims. The contractor shall proactively attempt to resolve issues with claims requiring additional information for proper adjudication, including member eligibility, referral, authorization, coordination of benefits, or workers' compensation information.

B13.7 The contractor shall have the capability to process both electronic and paper claims and provide a controlled process to provide electronic and manual payments and explanation of benefits (EOBs). Clear processes must be in place to handle payment reconciliation and correction accounting.

B13.8 Overpayments made by the contractor to providers shall be electronically adjudicated against future payments to same provider to ensure timely repayment to MCHCP. The contractor shall notify the provider of the overpayment amount and that the overpayment will be offset against future payments until paid in full or the provider must remit the overpayment amount to the contractor for the full amount should the provider not have sufficient future payments to refund the overpayment within ninety (90) days. If the provider fails to refund the entire amount after ninety (90) days, the contractor shall continue to bill the provider for the amount owed and offset against future payments until the amount is paid in full. Overpayment recovery service collections that were not collected by an offset of a provider payment shall be remitted to MCHCP within thirty (30) days of receipt. The contractor shall provide MCHCP supporting

documentation of the overpayment amounts and associated collections whether by offset or by provider remittance.

B13.9 The contractor's claim system must have processes and edits in place to identify improper provider billing. This includes, but is not limited to, upcoding, unbundling of services, and duplicate bill submissions.

B13.10 The contractor shall agree that if a claims payment platform change occurs throughout the course of the contract, MCHCP reserves the right to delay implementation of the new system for MCHCP members until a commitment can be made by the contractor that transition will be without significant issues. This may include requiring the contractor to put substantial fees at risk and/or agree to an implementation audit related to these services to ensure a smooth transition.

B13.11 All penalties assessed by law for failure to timely pay claims will be borne by the contractor.

B13.12 The contractor must be able to coordinate benefits in accordance with MCHCP regulations.

B13.13 After the contract terminates, the contractor is required to continue processing run-out claims for two years at no additional cost to MCHCP. Following the run-out period, the contractor must turn over to MCHCP any pending items such as outstanding claim issues, uncashed checks, and other pending items.

B13.14 The contractor's contracts with some network providers may include withholds, incentives, and/or additional payments that may be earned, conditioned on meeting standards relating to utilization, quality of care, efficiency measures, compliance with the contractor's other policies or initiatives, or other clinical integration or practice transformation standards. In January of each year, the contractor shall provide a report to MCHCP that details the providers under such arrangements, the type of arrangement and the estimated amount that may be due per provider under each arrangement, and when each payment shall be made, if earned. MCHCP will be given an exhibit that will provide the current method of attribution. MCHCP and the contractor shall agree to the reimbursement methodology to fund these payments due the network providers based upon these contractual arrangements. MCHCP shall have the right to audit such determinations and payments as outlined in Section 4 of the contract.

B13.15 Should MCHCP have a direct agreement with an accountable care organization or other direct provider or network arrangement, the contractor shall process claims and provide other necessary supportive services included in this contract and in accordance with such agreement.

B13.16 The contractor shall identify and pursue subrogation claims on behalf of MCHCP. Subrogation results whenever there is a Third Party who is liable or responsible (legally or voluntarily) to make payments in relation to an accident, illness, or injury. Subrogation seeks to recover any amount paid or payable by a Third Party through a settlement, judgment, mediation, arbitration, or other means in connection with an illness, injury, or other medical condition. The contractor shall have authority to settle claims in the amount of $25,000 or less for less than one hundred percent. Claims above $25,000 must have MCHCP approval prior to settlement. Subrogation recoveries shall be remitted to MCHCP nor more than (60) days following collection.

B13.17 The contractor shall pass through 100 percent of rebates earned as a result of members' claims. Rebate(s) mean all drug company revenues associated with other pharmaceutical manufacturer or third-party payments, including, but not limited to, base, formulary, incentive and market share rebates, payments related to administrative fees, data fees, aggregate utilization rebates (e.g., "book of business"), purchase discounts, payments due to inflation caps or other performance arrangements, educational payments, information sales, specialty rebates and all other revenues from pharmaceutical manufacturers or other third parties.

B13.18 The contractor shall notify MCHCP of the amount due to the contractor as a result of claims processing and by the contractor account to the weekly billing cycle. The contractor shall provide an electronic invoice denoting the invoice date and due date for payment. The due date for payment shall correspond to the date the payment will be withdrawn from MCHCP's bank account. The invoice shall include the following elements:

B13.18.1 Medical Claims - Medical claims shall be separately totaled by Active claims and Retiree claims and denote the time frame of the invoice period.

B13.18.2 Fee - Each fee included in the invoice must be separately totaled by Active claims and Retiree claims and further separated by the type of fees within each grouping.

B13.18.3 Grand Total - The invoice shall provide the total of claims and total of fees with a grand total of amount due for the submitted invoice.

B13.19 The contractor shall initiate an ACH demand debit transaction that will withdraw the amount due based on the submitted invoice from a designated MCHCP bank account no later than the next business day following the invoice due date. If the invoice due date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day. The contractor shall pay providers no later than one banking day from receipt of MCHCP funds to prevent nesting of funds.

B14. **PERFORMANCE STANDARDS**: Performance standards are outlined in Section 21 of the TPA RFP Questionnaire. The contractor shall agree that any liquidated damages assessed by MCHCP shall be in addition to any other equitable remedies allowed by the contract or awarded by a court of law including injunctive relief. The contractor shall agree that any liquidated damages assessed by MCHCP shall not be regarded as a waiver of any requirements contained in this contract or any provision therein, nor as a waiver by MCHCP of any other remedy available in law or in equity. The contractor is required to utilize MCHCP's vendor manager product that allows the contractor to self-report compliance and non-compliance with performance guarantees. Unless otherwise specified, all performance guarantees are to be measured quarterly, reconciled quarterly and any applicable penalties paid annually. MCHCP reserves the right to audit performance standards for compliance.

B15. **SUPPLEMENTAL OPTIONAL ADMINISTRATIVE SERVICES**: For those supplemental optional administrative services the contractor proposed to MCHCP as part of the RFP process and included in supplemental pricing, MCHCP will evaluate each proposed service individually and make an annual determination to elect such service according to the specifications provided as part of the RFP. Once elected, the contractor and MCHCP shall negotiate any necessary final programmatic details to successfully implement the chosen optional administrative service.

B16. **FUNDING**: The contractor shall provide MCHCP the funds for pre-implementation audit, an annual claims audit, and annual discretionary fund(s) as agreed to in response to the RFP.

EXHIBIT C
GENERAL PROVISIONS

C1 TERMINOLOGY AND DEFINITIONS

Whenever the following words and expressions appear in this Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

C1.1 **Amendment** means a written, official modification to an RFP or to a contract.

C1.2 **Bidder** means a person or organization who submitted an offer in response to this RFP.

C1.3 **Breach** shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

C1.4 **Contract** means a legal and binding agreement between two or more competent parties, in consideration for the procurement of services as described in this RFP.

C1.5 **Contractor** means a person or organization who is a successful bidder as a result of an RFP and/or who enters into a contract or any subcontract of a successful bidder.

C1.6 **Employee** means a benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan eligibility requirements.

C1.7 **May** means that a certain feature, component, or action is permissible, but not required.

C1.8 **Member** means any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

C1.9 **Must** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a proposal being considered non-responsive.

C1.10 **Off-shore** means outside of the United States.

C1.11 **Participant** has the same meaning as the word member.

C1.12 **PHI** shall mean Protected Health Information, as defined in 45 C.F.R. 160.103, as amended.

C1.13 **Pricing Pages** apply to the form(s) on which the bidder must state the price(s) applicable for the services required in the RFP. The pricing pages must be completed and uploaded by the bidder prior to the specified proposal filing date and time.

C1.14 **Privacy Regulations** shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

C1.15 **Proposal Filing Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of proposals by the Optavise system.

C1.16 **Provider** means a physician, hospital, medical agency, specialist or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2010(20). Other providers include but are not limited to:

C1.16.1 Audiologist (AUD or PhD);
C1.16.2 Certified Addiction Counselor for Substance Abuse (CAC);
C1.16.3 Certified Nurse Midwife (CNM) – when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
C1.16.4 Certified Social Worker or Masters in Social Work (MSW)
C1.16.5 Chiropractor;
C1.16.6 Licensed Clinical Social Worker
C1.16.7 Licensed Professional Counselor (LPC);
C1.16.8 Licensed Psychologist (LP);
C1.16.9 Nurse Practitioner (NP);
C1.16.10 Physician Assistant (PA);
C1.16.11 Occupational Therapist;
C1.16.12 Physical Therapist;
C1.16.13 Speech Therapist;
C1.16.14 Registered Nurse Anesthetist (CRNA);
C1.16.15 Registered Nurse Practitioner (ARNP); or
C1.16.16 Therapist with a PhD or Master's Degree in Psychology or Counseling.

C1.17 **Request for Proposal (RFP)** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.

C1.18 **Respondent** means any party responding in any way to this RFP.

C1.19 **Retiree** means a former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(D) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

C1.20 **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature, which govern the operations of all agencies of the State of Missouri. Chapter 103 of the statutes is the primary chapter governing the operations of MCHCP.

C1.21 **Shall** has the same meaning as the word must.

C1.22 **Should** means that certain feature, component and/or action is desirable but not mandatory.

C1.23 **Subscriber** means the employee or member who elects coverage under the plan.

C2 GENERAL BIDDING PROVISIONS

C2.1 It shall be the bidder's responsibility to ask questions, request changes or clarification, or otherwise advise MCHCP if any language, specifications, or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from bidders regarding specifications, requirements, competitive procurement process, etc., must be directed to MCHCP via the messaging tool on the Optavise web site, as indicated on the last page of the *Introduction and Instructions* document of the RFP. Such communication must be received no later than Tuesday, February 13, 2024, 5 p.m. CT (6 p.m. ET).

Every attempt shall be made to ensure that the bidder receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all bidders will be advised, via the issuance of an amendment or other official notification to the RFP, of any relevant or pertinent information related to the procurement. Therefore, bidders are advised that unless specified elsewhere in the RFP, any questions received by MCHCP after the date noted above might not be answered.

It is the responsibility of the bidder to identify and explain any part of their response that does not conform to the requested services described in this document. Without documentation provided by the bidder, it is assumed by MCHCP that the bidder can provide all services as described in this document.

C2.2 Bidders are cautioned that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

C2.3 MCHCP monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among bidders, price-fixing by bidders, or any other anticompetitive conduct by bidders, which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.

C2.4 No contract shall be considered to have been entered into by MCHCP until the contract has been awarded by the MCHCP Board of Trustees and all material terms have been finalized. The contract is expected to be finalized and signed by a duly authorized representative of Contractor in less than fifteen (15) days from MCHCP's initial contact to negotiate a contract. An award will not be made until all contract terms have been accepted.

C3 PREPARATION OF PROPOSALS

C3.1 Bidders must examine the entire RFP carefully. Failure to do so shall be at the bidder's risk.

C3.2 Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.

C3.3 Unless otherwise specifically stated in the RFP, any manufacturer's names, trade names, brand names, and/or information listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. Proposals that do not comply with the requirements and specifications are subject to rejection without clarification.

C4 DISCLOSURE OF MATERIAL EVENTS

C4.1 The bidder agrees that from the date of the bidder's response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to MCHCP:

C4.1.1 Any material adverse change to the financial status or condition of the bidder;

C4.1.2 Any merger, sale or other material change of ownership of the bidder;

C4.1.3 Any conflict of interest or potential conflict of interest between the bidder's engagement with MCHCP and the work, services or products that the bidder is providing or proposes to provide to any current or prospective customer; and

C4.1.4 (1) Any material investigation of the bidder by a federal or state agency or self-regulatory organization; (2) Any material complaint against the bidder filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming the bidder before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming the bidder as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against the bidder by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against the bidder as a result of any material criminal or civil action in which the bidder was a party; or (7) Any other matter material to the services rendered by the bidder pursuant to this RFP.

C4.1.4.1 For the purposes of this paragraph, "material" means of a nature, or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this RFP. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, the bidder is obligated to make its best faith efforts to disclose only those relevant matters which come to the attention of or should have been known by the bidder's personnel involved in the engagement covered by this RFP and/or which come to the attention of or should have been known by any individual or office of the bidder designated by the bidder to monitor and report such matters.

C4.2 Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to either reject the proposal or continue evaluating the proposal.

C5 COMPLIANCE WITH APPLICABLE FEDERAL LAWS

C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable Care Act (PPACA), as amended.

C5.2 Any bidder offering to provide services must be able to sign a Business Associate Agreement (BAA) (see Exhibit A-11) due to the provisions of HIPAA upon award of the contract. Any requested changes shall be noted and returned with the RFP. **The changes are accepted only upon MCHCP signing a revised BAA after contract award.**

C5.3 Upon awarding of the contract by the Board, the BAA shall be signed by both parties within five (5) working days of the request to sign, or the award of the contract may be rescinded.

Attachment 1
Layout for MCHCP Enrollee File
Enrollment as of January 1, 2024

Field Name	Description
Unique ID	Number assigned by MCHCP
Relation	Identifies if member is subscriber, spouse, or child 1 – subscriber 2 – spouse 3 – child
Plan Type	Identifies plan member is enrolled PPO 750 PPO 1250 HSA Plan PPO 750 without Contraception PPO 1250 without Contraception HSA Plan without Contraception Tricare Supplement
Cov Level	Identifies subscriber's level of coverage MI – Employee Only MS – Employee and Spouse MC – Employee and Child(ren) MF – Employee, Spouse, and Child(ren) DP – COBRA Child SC – Surviving Child
Status	Identifies status of member ACT – Active Employee RTN – Retired Employee CBR – COBRA Participant DSB – Participant on Long Term Disability SVR – Survivor VES – Terminated Vested Participant FOS – Career Foster Parent
Zip	Zip code corresponding to the member's residence
YOB	Year of birth
Gender	M – Male F – Female
Medicare Indicator	N – No Medicare Y – Medicare

Attachment 2
Provider File Layouts

Provide comma separated text files listing physicians and facilities in your network as of January 1, 2024. Limit your network files to Missouri providers. If a provider has more than one office location, provide a record for each address. If necessary, provide a crosswalk for provider specialty. The following file layout should be used:

Physician File Layout

1. NPI
2. Tax ID
3. Last Name
4. First Name
5. Middle Initial
6. Title (MD, DO, PHD, DSS, etc.)
7. Role 1 (PCP or SPEC)
8. Role 2 (PCP or SPEC)
9. Provider Specialty (Family Practice, Urology, OB/GYN, etc.)
10. Accepting New Patients (Y or N)
11. Accepts Medicare Assignment (Y or N)
12. Street 1 (street address, no P.O. Box)
13. Street 2 (suite number, etc.)
14. City
15. State
16. Zip
17. Phone (area code & 7 digits)
18. County

Facility File Layout

1. NPI
2. Tax ID
3. Facility Name
4. Type of Facility (Hospital, Surgery Center, DME Supplier, Home Health, etc.)
5. Street 1 (street address, no P.O. Box)
6. Street 2 (suite number, etc.)
7. City
8. State
9. Zip
10. Phone (area code & 7 digits)
11. County

Attachment 4

Instructions for Completing Re-Pricing File

The overall financial evaluation will include a claims repricing exercise. A repricing file containing claim-line detail for the most recent 12-month period will be made available through a secure workspace established by Segal, MCHCP's contracted actuary. Additional documents that will be provided by Segal include monthly claims and enrollment by plan and high cost claimant information for 2021-2023.

The tab in this workbook labeled "Repricing File Format" provides a layout of the data fields that will be included in the Re-Pricing File. To gain access to the data file(s), interested bidders responding to the RFP must upload a signed Exhibit A-1 Intent to Bid to Optavise no later than Tuesday, February 13, 2024. Upon receipt of the Intent to Bid exhibit, Segal will determine if there is a current Global or Bid-Related NDA/Confidentiality Agreement on file. No data will be issued without first having a signed NDA/Confidentiality Agreement on file. If there is no NDA/Confidentiality Agreement on file with Segal, a document will be issued to the interested Bidder for signature. Verbiage is non-negotiable. Upon receipt of the newly signed NDA or confirmation of an existing NDA on file, Segal will establish a secure workspace and upload the data file(s). A system-generated e-mail will be sent to the Bidder's designated data recipient, containing a link to instructions for accessing the workspace.

Bidders are expected to reprice each claim to represent most accurately the contractual arrangement in place, or under a "letter of intent", at the time of proposal. The claims re-pricing amounts should be based on actual data and should not include any assumptions regarding projected discounts or expected increases in eligible charges. Three (3) fields/columns at the end of the file are to be populated by the Bidder. If more than one (1) network is being proposed, the three (3) fields/columns must be replicated and populated appropriately for each network proposed:

1. Allowed/Contract Amount (based on provider contracts in place at the time of proposal)

2. Network Status – Y/N/L
Y – Currently under contract (Network provider)
N – Not under contract (Non-Network provider)
L – Letter of intent (Signed letter of intent to contract at a date in the near future)

3. Type of Contract – A/B/C/D/F/O
A - Ambulatory Payment Classification
B - Bundled Payment
C - Capitated
D - Discount off eligible charges
F - Fee Schedule
O - Other

Notes

1. If Payment Type indicator "C (Capitated)", provide enough detail to sufficiently evaluate the effect on MCHCP's costs, including services, payments and provider types. Include description as a separate attachment with your response.

2. If Payment Type indicator "O (Other)", provide a description of the payment type along with enough detail to sufficiently evaluate the effect on MCHCP's costs, including services, payments and provider types. Include description as a separate attachment with your response.

When completed, Bidders must upload the full file, in the same order and format as received, to the Segal secure workspace no later than the bid due date of 5 p.m. CT, Friday, March 1, 2024. **Do not upload this information to Optavise.**

Attachment 4

MCHCP Non-Medicare Medical Claims Repricing File Layout

Time Period: Paid claims January 2023 through December 2023

Field Name	Field Description	Notes
MEMBER_ID	De-identified member number	
MEMBER_GENDER	Gender of member	
MEMBER_AGE	Member's age in years at date of service	
MEMBER_ZIPCODE	5-digit zip code of member	
PROVIDER_TIN_BILL	Billing Provider Tax Identification Number (TIN)	
PROVIDER_NPI_BILL	Billing Provider National Provider Identifier (NPI)	
PROVIDER_NPI_RENDER	Rendering Provider National Provider Identifier (NPI)	
PROVIDER_NAME	Name of the rendering provider	
PROVIDER_ADDRESS_1	1st part of rendering provider address where available	
PROVIDER_ADDRESS_2	2nd part of rendering provider address where available	
PROVIDER_CITY	City of rendering provider	
PROVIDER_ZIPCODE	5 digit zip code of rendering provider	
PROVIDER_STATE	The abbreviation of the state or providence of the rendering provider	
PLACE_OF_SERVICE	Place of service code	
BILL_TYPE_CODE	Bill type code where applicable	
CLAIM_NUMBER	De-identified identifier for the claim	
CLAIM_PAID_DATE	Claim payment date (YYYYMMDD)	
CLAIM_SERVICE_START	Service begin date (YYYYMMDD)	
CLAIM_SERVICE_END	Service end date (YYYYMMDD)	
PRIMARY_DIAGNOSIS_CODE	ICD code used to denote the PRIMARY disease or condition being treated by the services rendered on the claim	
DIAGNOSIS_CODE_2	ICD code used to denote the SECONDARY disease or condition being treated by the services rendered on the claim	
DIAGNOSIS_CODE_3	ICD code used to denote the TERTIARY disease or condition being treated by the services rendered on the claim	
DIAGNOSIS_CODE_4	ICD code used to denote the QUATERNARY disease or condition being treated by the services rendered on the claim	
DIAGNOSIS_CODE_5	ICD code used to denote the QUINARY disease or condition being treated by the services rendered on the claim	
DRG	DRG (Diagnosis Related Group) code (where available)	
REVENUE_CODE	Hospital billing code submitted on the claim where applicable	
PROCEDURE_CODE	Code used to denote a health care service that a member receives from a provider	
SERVICE_MODIFIER_CODE	Code used to further define or clarify the procedure code on the claim line	
DISCHARGE_CODE	Hospital discharge status code (where available)	
SERVICE_UNIT_COUNT	The number of service units on the claim line that have been approved for payment	
CHARGED_AMOUNT	Total charges for the services rendered on the claim line	
SG_ROW_ID	Segal internal line number. Bidders must provide this data element with repriced file	**Must be returned with repriced file**
Network Status*	Network status	Y (Contracted network provider - "in-network") N (No contract with provider - "out of network") L (Bidder has, in hand, a signed "Letter of Intent" to contract with provider)
Allowed Amount*	Contracted reimbursement amount	
Payment Type*	Type of payment	A (Ambulatory Payment Classification) B (Bundled Payment) C (Capitated) D (Discount off eligible charges) F (Fee Schedule) O (Other)

* To be populated by vendor