Missouri Consolidated Health Care Plan
832 Weathered Rock Court
PO Box 104355
Jefferson City, MO 65110
Phone: 800-701-8881
www.mchcp.org

Judith Muck, *Executive Director*

my health. my choice. myMCHCP

March 18, 2019

TO: Invited Vendors

FROM: Judith Muck, Executive Director

RE: Health Plan Administrator Request for Proposal

Missouri Consolidated Health Care Plan (MCHCP) will be working with DirectPath, an online request for proposal (RFP) system, in the marketing of the 2020 MCHCP Health Plan RFP for a January 1, 2020 effective date. You are invited to submit a proposal for these services. We believe that you will find this RFP a great potential opportunity for your organization.

MCHCP provides the health benefit program for most State of Missouri employees, retirees, and their dependents covering over 94,000 members (lives). An additional 1,000 non-state members are covered through their public entity employer.

Bids are requested for:

- Health Plan Administrator (ASO) to administer self-insured health plan(s)
- Disease Management is encouraged to be included as a component of any proposal. Disease management must be itemized separately, and MCHCP reserves the right to annually elect or exclude this option.
- Member Advocacy Model is encouraged to be included as a component of any proposal. Member advocacy 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.
- 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.

Contract Term

The term of the contract will be one year with an additional four (4) one-year renewal options available at the sole option of the MCHCP Board of Trustees. Bidders are required to provide the following pricing:

- Health Plan Administrator – CY2020, with not-to-exceed pricing for CY2021-CY2024
- Disease Management – CY2020, with not-to-exceed pricing for CY2021-CY2024
- Member Advocacy – CY2020, with not-to-exceed pricing for CY2021-CY2024
- Musculoskeletal Management – CY2020, with not-to-exceed pricing for CY2021-CY2024
- Member Reward Incentive Program – CY2020, with not-to-exceed pricing for CY2021-CY2024

Current Contracts

MCHCP currently contracts with:

- UMR – contract expires Dec. 31, 2019
    - Provides administrative services for two PPO plans and one HSA Plan nationwide. All plans offered provide benefit options in accordance with the code of state regulations (CSR) Title 22 – Missouri Consolidated Health Care Plan.

- Aetna – contract expires Dec. 31, 2019
    - Provides administrative services for two PPO plans and one HSA Plan in the Southwest and South Central areas of Missouri. All plans offered provide benefit options in accordance with the CSR Title 22 – Missouri Consolidated Health Care Plan.

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 Insurance, Financial Institutions and Professional Registration (DIFP). 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 with MCHCP's consultant, Willis Towers Watson, 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 IBM Watson Health) on a monthly basis, including twelve (12) 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. MCHCP encourages high performance networks to be offered in addition to a broad national network.

- 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 April 30, 2019, 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.

Intent to Bid

Once the RFP is released, bidders who are interested in submitting a proposal must complete the Intent to Bid (available as a response document within the DirectPath system). The Intent to Bid is due at 4 p.m. CT, Tuesday, April 9, 2019.

Use of DirectPath

During this RFP process you will find DirectPath's internet-based application offers an opportunity to streamline information exchange. We are confident your organization will find the process straight forward and user-friendly. DirectPath will be contacting you within the next two to three days to establish a contact person from your organization and to set up a training session, if necessary. To assist you in preparing for the online proposal process, we have outlined below some important information about this event.

General Instructions

Your proposal will be submitted over the Internet, through an anonymous online bidding process. DirectPath will assign a unique user name, which will allow you to view the information pertinent to the bidding process, submit response documents, communicate directly with MCHCP through the application's messaging component, and respond to our online questionnaires. In addition, DirectPath will provide a user guide with instructions for setting up your account.

You may wish to have other people in your organization access this online event to assist in the completion of the RFP. Each member of your response team must secure a unique username and password from DirectPath by way of a provider contact spreadsheet, e-mailed directly to you by DirectPath. There is no cost to use the DirectPath system.

System Training

DirectPath offers all participants of a DirectPath-hosted event access to their downloadable *User Guides* and *Pre-Recorded Training Sessions*. These guides are located on the homepage of the *vendor-user* view and provide an overview of the application's functionality. We recommend that you and your response team take advantage of this opportunity in order to realize the full benefit of the application. In addition to this self-help option, DirectPath's experienced support personnel will offer an application overview via a web-cast session.

DirectPath support is also available Monday through Friday from 8 a.m. to 6 p.m. ET to help with any technical or navigation issues that may arise. The toll-free number for DirectPath is 800-979-9351. Support can also be reached by e-mail at support@directpathhealth.com.

Key Event Information

Online RFP Released	Tuesday, April 2, 2019 8 a.m. CT (9 a.m. ET)
Intent to Bid Document Due	Tuesday, April 9, 2019 4 p.m. CT (5 p.m. ET)
Question Submission Deadline	Tuesday, April 9, 2019 4 p.m. CT (5 p.m. ET)
MCHCP Responses to Submitted Questions	Tuesday, April 16, 2019 4 p.m. CT (5 p.m. ET)
All Questionnaires and Pricing Due	Tuesday, April 30, 2019 4 p.m. CT (5 p.m. ET)
Claim Cost Submission due to Willis Towers Watson	Tuesday, April 30, 2019 4 p.m. CT (5 p.m. ET)
Finalist Presentations/Site Visits	June, 2019
Final Vendor Selection/Contract Award	Late June, 2019
Program Effective Date	January 1, 2020

If this notice should have been sent to a different individual within your organization, please contact Tammy Flaugher by phone at 573-526-4922 or by e-mail at tammy.flaugher@mchcp.org.

We look forward to working with you throughout this process.

HSA Plan Design

	In Network	Non-Network
Deductible - Individual	$1,650	$3,300
Deductible - Family	$3,300	$6,600
Out-of-Pocket Maximum - Individual	$4,950 including deductible	$9,900 including deductible
Out-of-Pocket Maximum - Family	$9,900 including deductible	$19,800 including deductible
Preventive Services	MCHCP pays 100%	40% coinsurance after deductible
Office Visits - Primary Care	20% coinsurance after deductible	40% coinsurance after deductible
Office Visits - Specialist	20% coinsurance after deductible	40% coinsurance after deductible
Chiropractic Care	20% coinsurance after deductible	40% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible
Hospital - Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
Lab and X-ray	20% coinsurance after deductible	40% coinsurance after deductible
Surgery	20% coinsurance after deductible	40% coinsurance after deductible

PPO 1250 Plan Design

	In Network	Non-Network
Deductible - Individual	$1,250	$2,500
Deductible - Family	$2,500	$5,000
Out-of-Pocket Maximum - Individual	$3,750 including deductible	$7,500 including deductible
Out-of-Pocket Maximum - Family	$7,500 including deductible	$15,000 including deductible
Preventive Services	MCHCP pays 100%	40% coinsurance after deductible
Office Visits - Primary Care	$25 copayment	40% coinsurance after deductible
Office Visits - Specialist	$40 copayment	40% coinsurance after deductible
Chiropractic Care	$20 copayment	40% coinsurance after deductible
Urgent Care	$50 copayment	$50 copayment
Emergency Room	$250 copayment plus 20% coinsurance after deductible	$250 copayment plus 20% coinsurance after deductible
Hospital - Inpatient	$200 copayment plus 20% coinsurance after deductible	$200 copayment plus 40% coinsurance after deductible
Lab and X-ray	20% coinsurance after deductible	40% coinsurance after deductible
Surgery	20% coinsurance after deductible	40% coinsurance after deductible

PPO 750 Plan Design

	In Network	Non-Network
Deductible - Individual	$750	$1,500
Deductible - Family	$1,500	$3,000
Out-of-Pocket Maximum - Individual	$2,250 including deductible	$4,500 including deductible
Out-of-Pocket Maximum - Family	$4,500 including deductible	$9,000 including deductible
Preventive Services	MCHCP pays 100%	40% coinsurance after deductible
Office Visits - Primary Care	20% coinsurance after deductible	40% coinsurance after deductible
Office Visits - Specialist	20% coinsurance after deductible	40% coinsurance after deductible
Chiropractic Care	20% coinsurance after deductible	40% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	$250 copayment plus 20% coinsurance after deductible	$250 copayment plus 20% coinsurance after deductible
Hospital - Inpatient	$200 copayment plus 20% coinsurance after deductible	40% coinsurance after deductible
Lab and X-ray	20% coinsurance after deductible	40% coinsurance after deductible
Surgery	20% coinsurance after deductible	40% coinsurance after deductible

2020 MCHCP Health Plan RFP
Pricing

Instructions

	Comments
Administration Fees	
ASO Fee	The bidder must complete the ASO Fee worksheet in its entirety. The PEPM amount listed must be on a mature basis. No fees will be paid to process run-out claims at contract termination.
Enrollment Bands	Bidders should provide separate pricing for each enrollment band.
Supplemental Pricing	Bidders may use the Supplemental Pricing worksheet for any optional service that is not included in the proposed ASO Fee. MCHCP reserves the right to consider these fees in the projected cost of the contract if services listed here should have been included in the PEPM.
Optional Services	Optional services to be listed in Supplemental Pricing could include an on-line reporting utility, ad-hoc reporting, on-line eligibility access, etc. Include the basis for payment (PEPM, one-time fee, etc.) in the Basis for Payment column.
Pricing	The bidder must provide guaranteed pricing for 2020, and not-to-exceed pricing for 2021 - 2024.

ASO Fee

	Describe Service	2020	2021	2022	2023	2024
1 - 15,000 Subscribers						
General Administration						
Implementation						
Claim Services						
Member Services						
Network Access Fee						
Care Management Fee						
Consumer Tools						
Reporting						
Behavioral Health						
Other 1 (please specify)						
Other 2 (please specify)						
Other 3 (please specify)						
Other 4 (please specify)						
Other 5 (please specify)						
Total ASO Fee (PEPM)	N/A	=SUM('W2'!B2:B15)	=SUM('W2'!C2:C15)	=SUM('W2'!D2:D15	=SUM('W2'!E2:E15)	=SUM('W2'!F2:F15)
15,001 - 30,000 Subscribers						
General Administration						
Implementation						
Claim Services						
Member Services						
Network Access Fee						
Care Management Fee						
Consumer Tools						
Reporting						
Behavioral Health						
Other 1 (please specify)						
Other 2 (please specify)						
Other 3 (please specify)						
Other 4 (please specify)						
Other 5 (please specify)						
Total ASO Fee (PEPM)	N/A	=SUM('W2'!B18:B3	=SUM('W2'!C18:C3	=SUM('W2'!D18:D3	=SUM('W2'!E18:E31	=SUM('W2'!F18:F31

30,001 - 45,000 Subscribers						
General Administration						
Implementation						
Claim Services						
Member Services						
Network Access Fee						
Care Management Fee						
Consumer Tools						
Reporting						
Behavioral Health						
Other 1 (please specify)						
Other 2 (please specify)						
Other 3 (please specify)						
Other 4 (please specify)						
Other 5 (please specify)						
Total ASO Fee (PEPM)	N/A	=SUM('W2'!B34:B4	=SUM('W2'!C34:C4	=SUM('W2'!D34:D4	=SUM('W2'!E34:E47	=SUM('W2'!F34:F47
> 45,000 Subscribers						
Implementation						
General Administration						
Claim Services						
Member Services						
Network Access Fee						
Care Management Fee						
Consumer Tools						
Reporting						
Behavioral Health						
Other 1 (please specify)						
Other 2 (please specify)						
Other 3 (please specify)						
Other 4 (please specify)						
Other 5 (please specify)						
Total ASO Fee (PEPM)	N/A	=SUM('W2'!B82:B9	=SUM('W2'!C82:C9	=SUM('W2'!D82:D9	=SUM('W2'!E82:E95	=SUM('W2'!F82:F95

Supplemental Pricing

	Describe Service	Fees	Basis for Payment
Program Services			
High Performance Network			
Member Reward Incentive Program			
Member Advocacy Model			
Musculoskeletal Management			
Disease Management			
Service 1			
Service 2			
Service 3			
Service 4			
Service 5			
Service 6			
Service 7			
Service 8			
Service 9			
Service 10			
Service 11			
Service 12			
Service 13			
Service 14			
Service 15			
Service 16			
Service 17			
Service 18			
Service 19			
Service 20			

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 94,000 members (lives). An additional 1,000 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 health plan administrative services for MCHCP's self-insured health plans. Bids are requested for:

- Health Plan Administrator (ASO) to administer a self-insured health plan(s), 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 ASO services shall include a fixed price for CY2020 and guaranteed not-to-exceed prices for CY2021-CY2024;
- High Performance Network is encouraged to be included as a component of any proposal. High Performance Networks/Narrow Networks 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.
- Member Advocacy Model is encouraged to be included as a component of any proposal. Member advocacy 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; and
- Disease Management is encouraged to be included as a component of any proposal. Disease management must be itemized separately, and MCHCP reserves the right to annually elect or exclude this option;

Contracts awarded from this RFP will be effective January 1, 2020. 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 Insurance, Financial Institutions and Professional Registration (DIFP). 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, as described in Exhibits A-3, A-4 and A-5, with MCHCP's consultant, Willis Towers Watson, 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 IBM Watson Health) 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. MCHCP encourages high performance networks to be offered in addition to a broad national network.
- 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 April 30, 2019, 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 94,000 covered persons; however, there are some MCHCP members enrolled in a fully-insured group Medicare Advantage Plan administered by UnitedHealthcare. These 15,800 members will not be part of this contract award.
- Current total public entity membership is 1,057 covered persons.
- MCHCP currently contracts with UMR and Aetna, as follows:
    - UMR – provides administrative services for two PPO plans and one HSA plan nationwide. The contract expires Dec. 31, 2019.
    - Aetna – provides administrative services for two PPO plans and one HSA plan in the Southwest and South Central areas of Missouri. The contract expires Dec. 31, 2019.
- The State of Missouri through MCHCP currently contributes a portion of the premium for active state employees, retirees and their dependents. MCHCP generally provides a financial incentive to state subscribers to choose the low cost PPO plan. 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 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 DirectPath online submission tool no later than Tuesday, April 30, 2019, 4 p.m. central time (CT) (5 p.m. eastern time (ET)). Bidders must also submit the claims information (Exhibits A-3, A-4 and A-5) directly to Willis Towers Watson no later than Tuesday, April 30, 2019, 4 p.m. CT (5 p.m. ET).

NOTE: Bidders who currently have a global agreement to provide this information to Willis Towers Watson on a regular basis do not need to complete Exhibit A-3, Exhibit A-4, and Exhibit

A-5. Please confirm with Mr. Hingst your organization's participation. Mr. Hingst can be contacted by email at brian.hingst@willistowerswatson.com.

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 DirectPath. Any questions concerning the content of the RFP should be submitted via the messaging tool of DirectPath.

Proposal Instructions

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

In order 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, 2019. 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, 2020 through December 31, 2020, 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:

Activity	Timing
Online RFP Released	Tuesday, April 2, 2019 8 a.m. CT (9 a.m. ET)
Intent to Bid Document Due	Tuesday, April 9, 2019 4 p.m. CT (5 p.m. ET)

Activity	Timing
Bidder Question Submission Deadline	Tuesday, April 9, 2019 4 p.m. CT (5 p.m. ET)
MCHCP Responses to Submitted Questions	Tuesday, April 16, 2019 4 p.m. CT (5 p.m. ET)
Proposals Due	Tuesday, April 30, 2019 4 p.m. CT (5 p.m. ET)
Provider Discount Analysis Due to Willis Towers Watson	Tuesday, April 30, 2019 4 p.m. CT (5 p.m. ET)
Finalist Presentations/Site Visits	June, 2019
Final Vendor Selection	Late June, 2019
Program Effective Date	January 1, 2020

Questions

During this bidding opportunity, MCHCP will be using the online messaging module of the DirectPath 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 DirectPath application by **Tuesday, April 9, 2019, 4 p.m. CT**. Questions received after April 9, 2019 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 DirectPath 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 as they are submitted via the messaging module, with a summary of all questions and answers provided by **Tuesday, April 16, 2019.**

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 4:00 p.m. Central Time (5:00 p.m. Eastern Time), **Tuesday, April 30, 2019**.

Bidders are required to submit provider discount information (Exhibit A-3, Exhibit A-4, and Exhibit A-5) which must be e-mailed directly to Brian Hingst with Willis Towers Watson at brian.hingst@willistowerswatson.com, no later than 4 p.m. CT (5 p.m. ET), **Tuesday, April 30, 2019**. This information will be kept confidential and will remain with Willis Towers Watson. This information should not be sent to MCHCP or uploaded to DirectPath. Submissions received after that time will not be accepted.

NOTE: Bidders who currently have a global agreement to provide this information to Willis Towers Watson on a regular basis do not need to complete Exhibit A-3, Exhibit A-4, and Exhibit A-5. Please confirm with Mr. Hingst your organization's participation. Mr. Hingst can be contacted by email at brian.hingst@willistowerswatson.com.

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 in order 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		150 points
		500 points
Non-financial:		
Section 2:	Vendor Profile	30 points
Section 3:	Account Management and Implementation	20 points
Section 4:	Member Services and Plan Administration	50 points
Section 5:	Technology and Security	40 points
Section 6:	Reporting	10 points
Section 7:	Claim Payment Services	35 points
Section 8:	Fraud and Abuse Management	20 points
Section 9:	Banking Arrangements	15 points
Section 10:	Customer Tools	25 points
Section 11:	Benefits	25 points
Section 12:	Utilization Management	25 points

Section 13:	Care Management	25 points
Section 14:	National Provider Network	50 points
Section 15:	Health Care Delivery: Networks and Solutions	15 points
Section 16:	Emerging Care Delivery Models	5 points
Section 17:	Behavioral Health/Substance Use Disorder	20 points
Section 18:	Network Financial Information	25 points
Section 19:	Telehealth	5 points
Section 20:	Denials/Appeals Procedures	5 points
Section 21:	Performance Guarantees	40 points
Section 22:	Financial	15 points
	Sub-total – Non-financial points	500 points

Bonus Points:

Section 23:	High Performance Network	15 Points
Section 24:	Member Incentives	10 points
Section 25:	Member Advocacy	5 points
Section 26:	Musculoskeletal Care Management (MCM) Program	5 points
Section 27:	Disease Management	5 points
Section 28:	MBE/WBE Participation Commitment	10 points

Finalist Bonus Points:

References	40 points
Finalist Interview	60 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% MBE and 5% 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 28 of the Health Plan 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 Interview

After an initial screening process, a technical question and answer conference or interview may be conducted, if deemed necessary by MCHCP, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP also reserves the right to interview the proposed account management team. 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 in order 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.

Pricing

The bidder must provide a firm, fixed per subscriber per month cost for providing 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 CY2020 with guaranteed not-to-exceed maximum prices for CY2021 through CY2024.

Bidders are required to submit provider discount information (Exhibit A-3, Exhibit A-4, and Exhibit A-5) which must be e-mailed directly to Brian Hingst with Willis Towers Watson at brian.hingst@willistowerswatson.com, no later than 4 p.m. CT (5 p.m. ET), **Tuesday, April 30, 2019**. This information will be kept confidential and will remain with Willis Towers Watson. This information should not be sent to MCHCP or uploaded to DirectPath. Submissions received after that time will not be accepted.

NOTE: Bidders who currently have a global agreement to provide this information to Willis Towers Watson on a regular basis do not need to complete Exhibit A-3, Exhibit A-4, and Exhibit A-5. Please confirm with Mr. Hingst your organization's participation. Mr. Hingst can be contacted by email at brian.hingst@willistowerswatson.com.

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, 2020 through December 31, 2020, 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 DirectPath

The 2020 MCHCP Health Plan RFP contains two broad categories of items that you will need to work on via the DirectPath application:

1) Items Requiring a Response:
    a) Pricing Form (e.g., Health Plan Pricing) is an online input form to collect your rate proposals as requested by MCHCP. This pricing form also calculates based on the rates you input.
    b) Questionnaires (e.g., Health Plan RFP Questionnaire) are also online forms to collect your responses to our questions about your capabilities.
    c) Response Documents (e.g., Exhibit A-1 Intent to Bid) are attachment files (e.g., MS Word or Excel) that are posted to the DirectPath website. They should be downloaded, completed by your organization, and then posted/uploaded back to the DirectPath 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.
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.

All of these components can be found in the DirectPath application under the 2020 MCHCP Health Plan RFP on the Event Details page of the application.

Note that as you use the DirectPath 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 DirectPath application homepage. For help with data entry and navigation throughout the application, you can contact the DirectPath staff:

- Phone: 800-979-9351
- E-mail: support@directpathhealth.com

Responding to Questionnaires

We have posted two forms for your response.

- Health Plan RFP Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to DirectPath by **Tuesday, April 30, 2019, 4 p.m. CT (5 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains all of 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 DirectPath application homepage. You have the option to "respond online" or through the use of two different off-line (or desktop) tools.

Completing Response Documents

The following exhibits must be completed, signed and uploaded to DirectPath:

- Exhibit A-1 – Intent to Bid (due 4 p.m. CT, April 9, 2019)
- Exhibit A-2 – Limited Data Use Agreement (due 4 p.m. CT, April 9, 2019)
- Exhibit A-3 – Broad Network Provider Discount Analysis Template (due 4 p.m. CT, April 30, 2019 to Willis Towers Watson)
- Exhibit A-4 – Narrow (High-Performing) Network Provider Discount Analysis Template (due 4 p.m. CT, April 30, 2019 to Willis Towers Watson)
- Exhibit A-5 – Provider Discount Actuarial Attestation Form (due 4 p.m. CT, April 30, 2019 to Willis Towers Watson)
- Exhibit A-6 – Proposed Bidder Modifications (due 4 p.m. CT, April 30, 2019)
- Exhibit A-7 – Confirmation Document (due 4 p.m. CT, April 30, 2019)
- Exhibit A-8 – Contractor Certification (due 4 p.m. CT, April 30, 2019)
- Exhibit A-9 – MBE-WBE Intent to Participate Document (due 4 p.m. CT, April 30, 2019)

The follow 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 4 p.m. CT, April 30, 2019)
- Exhibit A-11 – MCHCP Business Associate Agreement (due 4 p.m. CT, April 30, 2019)

Completing Pricing Worksheets

The financial worksheet (Health Plan Pricing) may be accessed in *Items Requiring a Response*. The *Pricing* or *Bid* contains worksheets to collect fee quotations based on the stated benefit plan designs. For step-by-step instructions, please refer to the *How to Submit a Bid* User Guide

located in the *Downloads* section of the DirectPath application homepage. Please be certain to complete all worksheets.

The final bid deadline is Tuesday, April 30, 2019, 4 p.m. CT (5 p.m. ET). Further detail on how to submit your bid is outlined in the Submitting Bids section of these Instructions.

Notes Regarding Pricing

Fee quotes should assume:

- Plan effective date: January 1, 2020
- Submitted prices for 2020 shall be firm, while prices for 2021, 2022, 2023, and 2024 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.

Submitting Bids

The pricing function allows you to work on a bid submission in draft form. You can enter your rates and *Save* without submitting your proposal to DirectPath. Save frequently in order to avoid losing work. When you have finished entering all of your rates, *Save* and then *Calculate*. If you have missed any required fields, you will be notified with an error message. If there are no errors, you can *Submit* your proposal to DirectPath.

Once you have submitted your bid, you can make adjustments at any time up until the bids are due. Simply select the pricing/bid and choose *Edit* to make changes. Follow the steps above to save, calculate, and re-submit.

Please refer to the following list of instructions before attempting to input/submit a bid:

- Enter your rates well in advance of the required bid date. Please do NOT wait until the last minute to work on the pricing model worksheets because your bids must comply with the automated rules and data validation checks that have been implemented by MCHCP.
- Partial data entries can be saved; however, the validation rules (error checking) will not be run against your data until you complete the worksheet and either *Calculate* or *Submit* your data.
- To check that your data have been accurately entered for all worksheets, you should press the *Calculate* button at the top of the page. If your input complies with the validation rules, all of the rates will be calculated and totaled. Otherwise, the calculation and validation rules will not properly execute even if you press the *Calculate button*.

- You will be able to view your final rate submission prior to submitting to DirectPath.
- If your data are accurate and complete, click on the *Submit Bid* icon to submit your bid to DirectPath.
- Data that are submitted incorrectly will receive error messages when calculated or submitted.
- All data fields that are marked as a number or currency must be filled with a numerical value or 0. Blanks and text such as "n/a" are not permitted. If you attempt to *Submit* or *Calculate* your data with incomplete fields, you will receive an error message.
- Be sure to save your data often. Periodic saves will prevent you from losing data in the event the application times-out (for security purposes the system will automatically log you out after a specified time if there is no activity).

RFP Checklist

Prior to the April 30, 2019, close date, be sure you have completed and/or reviewed each of the following listed documents.

Type	***Document Name***
Questionnaire	Health Plan RFP Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Pricing/Bid	Health Plan Pricing
Response	Exhibit A-1 Intent to Bid.docx **DUE: April 9, 2019**
Response	Exhibit A-2 Limited Data Use Agreement.docx **DUE: April 9, 2019**
Response	Exhibit A-3 Broad Network Provider Discount Analysis Template.xlsx **DUE: April 30, 2019 and emailed to Willis Towers Watson**
Response	Exhibit A-4 Narrow (High-Performing) Network Provider Discount Analysis Template.xlsx **DUE: April 30, 2019 and emailed to Willis Towers Watson**
Response	Exhibit A-5 Provider Discount Actuarial Attestation Form.docx **DUE: April 30, 2019 and emailed to Willis Towers Watson**
Response	Exhibit A-6 Proposed Bidder Modifications.docx
Response	Exhibit A-7 Confirmation Document.docx
Response	Exhibit A-8 Contractor Certification.docx
Response	Exhibit A-9 MBE-WBE Intent to Participate Document.docx
Response	Exhibit A-10 Sample Contract.docx
Response	Exhibit A-11 Business Associate Agreement.docx
Reference	Introduction and Instructions – 2020 Health Plan RFP.pdf
Reference	Exhibit B – Scope of Work (TPA).docx
Reference	Exhibit C – General Provisions.docx
Reference	Attachment 1 – Enrollee file layout.docx
Reference	Attachment 2 – Regional Map.pdf
Reference	Attachment 3 – Provider file layout.docx

Type	***Document Name***
Reference	Attachment 4 – Account Reconciliation File Layout.xlsx
Reference	Attachment 5 – MCHCP Enrollee File.xlsx
Reference	Attachment 6 – Definitions.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 DirectPath application by **Tuesday, April 9, 2019, 4 p.m. CT (5 p.m. ET)**.

For technical questions related to the use of DirectPath, please contact DirectPath customer support team at support@directpathhealth.com, or by calling the Customer Support Line 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 Health Plan RFP Questionnaire. The administrative services that are included in the contract include, but are not limited to:

B1.1 Administrative Services Only (ASO) functions that include account management, claim services, member services, broad national network access for medical services (inclusive of mental health and substance abuse services), care management (inclusive of utilization management and case management); coordination with MCHCP business associates; reporting; banking; and web and consumer tools. Other services, if offered by the contractor and accepted by MCHCP, include disease management, member incentive reward programs, high performance network access, or other unique program contractor offerings.

B1.2 Subrogation and overpayment recovery services.

B1.3 Contractor agrees that any and all subcontracts entered into by the contractor for the purpose of meeting the requirements of this contract are the responsibility of the contractor. MCHCP will hold contractor responsible for assuring that subcontractors meet all of the requirements of this contract and all amendments thereto. Contractor must provide complete information regarding each subcontractor used by the contractor to meet the requirements of this contract.

B1.4 The contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement.

B1.5 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.

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 customer 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.

B3.7 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 in order 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 to MCHCP, or some other comparable industry norm.

B4 **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.

B4.1 The contractor should provide MCHCP access to high performance provider networks as a plan option in addition to a broad national network. The goal is to offer members a lower cost plan option. If the contractor provides such access, the contractor shall describe in detail the geographic location where each high performance network(s) is offered and the overall cost differential between each high performance network offered and the broad national network. The contractor shall designate any geographic locations where there is no high performance network available. It is at MCHCP's option to annually elect to offer members a plan that includes a high performance network.

B4.2 The contractor should provide MCHCP access to centers of excellence (COE) and/or specialty networks for services such as, but not limited to, organ transplants, musculoskeletal procedures, or bariatric procedures. If the contractor provides such access, the contractor shall describe in detail the services included in the COE, geographic location of each COE or specialty network and the overall cost differential between each COE or specialty network offered and the broad national network. The contractor shall designate any geographic locations where there is no COE or specialty network available.

B4.3 The contractor shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the networks (whether broad national or high performance) to meet the health care needs of the enrolled members within reasonable geography and reasonable time. 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.

B4.4 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.

B4.5 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 RSMo Chapter 354.612 and MCHCP regulations.

B4.5.1 For facility terminations or non-renewals, contractor must 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.

B4.5.2 For non-facility provider terminations or non-renewals, contractor must notify all members who received care from the provider within the last 90 days.

B4.6 The contractor shall notify MCHCP of all alternative provider arrangements that it has in place, including but not limited to, accountable care organization, primary care case management, or patient-centered medical home. 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 October 1, 2019 and for future arrangements, within 30 days of implementing such an arrangement and annually thereafter.

B4.7 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.

B4.8 The contractor shall obtain discounts and other reductions, including through secondary networks as much as is possible for non-network claims.

B4.9 The contractor must distribute printed provider directories including lists of participating hospitals, primary care providers, specialists, and mental health providers to all members that request such information. These printed directories must be mailed to the member within three (3) business days of receipt of such request. The contractor bears all costs for printing and mailing these materials. The contractor is also required to provide this information via their website.

B4.10 No provider may be listed on the contractor's website or distributed to the membership unless a signed contract is in place.

B5 **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.

B5.1 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 5:00 p.m. central time (CT), Monday through Friday except for designated holidays. Upon award of the contract and annually thereafter, the contractor shall specify the hours and days the member service department is available.

B5.2 Member calls to contractor must be recorded and retained for a minimum of one year. If prior to the recording being purged, the contractor is notified of litigation by MCHCP, call recordings must be provided to MCHCP upon request.

B5.3 The contractor shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

B5.4 The contractor is responsible for developing, printing and mailing identification cards directly to the member's home. The contractor is responsible for these production and mailing costs.

B5.5 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.

B5.6 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.).

B5.7 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:

- B5.7.1 New member information;
- B5.7.2 Cost transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary;
- B5.7.3 Member ability to view claim status;
- B5.7.4 Member information to track deductible, coinsurance and out-of-pocket maximum status;
- B5.7.5 Explanation of benefits; and
- B5.7.6 Ability to query and download up to twenty-four (24) months of claims data

B6 **IMPLEMENTATION:** Upon award, a final implementation schedule must be agreed to by MCHCP and the contractor within 30 days and annually thereafter, prior to January 1 of each plan year. The contractor shall implement any eligibility, plan design and benefit changes as directed by MCHCP. A final implementation schedule must be agreed to by MCHCP and the contractor within 30 days of the notification of change. 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.

B6.1 At a minimum, the schedule must include the following activities as necessary:

- B6.1.1 Testing of eligibility file and other files to and from MCHCP and/or its business associates;

B6.1.2 Acceptable date for final eligibility file and other files to and from MCHCP and/or its business associates;
B6.1.3 ID card production and distribution;
B6.1.4 Finalization of benefits, plan designs, and other key elements; and
B6.1.5 Testing of claim file to data warehouse vendor.

B6.2 At least forty-five (45) days prior to January 1, 2020 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.

B7 **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:

B7.1 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:

B7.1.1 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;
B7.1.2 Provide data in an electronic form and within a time frame specified by MCHCP;
B7.1.3 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
B7.1.4 This obligation continues for a period of two (2) years following contract termination at no additional cost to MCHCP.

B7.2 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.

B7.3 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.

B7.4 The contractor shall provide the contractor's standard reporting package on a timely basis.

B7.5 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.

B7.6 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.

B7.7 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.

B7.8 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 Health Plan RFP Questionnaire, will be assessed.

B8 **ELIGIBILITY**: The contractor shall agree that eligible MCHCP members are those employees, retirees and their dependents who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining member eligibility. The contractor shall not regard a member as terminated until the contractor receives an official termination notice from MCHCP.

B8.1 The contractor shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply this 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 EDI issues.

B8.1.1 It is MCHCP's intent to send a transactional based (change only) eligibility file weekly and a periodic full eligibility reconciliation file.

B8.1.2 Contractor will further develop an out of sequence (ad hoc) methodology for updating records outside of the normal schedule.

B8.1.3 MCHCP will provide a recommended data mapping for the 834 transaction set.

B8.1.4 After processing each file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The file will be in a format that is agreeable by both parties so that MCHCP can compare the errors and exceptions with data in its system. 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.

B8.1.5 The contractor shall provide access to view data on its system to ensure the file MCHCP sends is correctly updating the contractor's system.

B8.1.6 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B8.1.7 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.

B8.1.8 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that the contractor accept and run an initial test record set no later than September 27, 2019. Results of the test must be provided to MCHCP by October 11, 2019. Implementation of the Single-Sign-On portal is to be completed no later than December 15th, 2019.

B8.1.9 The contractor and all its subcontractors will maintain encryption standards of 1024 bit encryption or higher for the encryption of confidential information for transmission via non secure methods including File Transfer Protocol or other use of the Internet.

B9 **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 card, review benefits and plan design, review explanation of benefits, check status of deductibles, maximums or limits, research specific medical conditions, obtain a history of medical claims, map provider locations and other information. 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. The contractor must be able to support single sign-on from MCHCP's Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML)

B10 **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 in compliance 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. 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 cost of the member's claims directly involved in or affected by such appeal.

B11 **CLINICAL MANAGEMENT**: The contractor shall integrate and coordinate utilization management, case management, discharge planning, quality management and medical policy and technology assessment in order to utilize health care resources and achieve optimum patient outcome in the most cost effective manner.

B11.1 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.

B11.2 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.

B11.3 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.

B11.4 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.

B11.5 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.

B11.6 The contractor shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

B11.7 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.

B11.8 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.

B11.9 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.

B11.10 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.

B11.11 The contractor shall provide an intervention program for frequent users of emergency room services. The program must include, at a minimum, the following elements:

- B.11.11.1 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;
- B11.11.2 Coordinate with MCHCP's pharmacy benefit manager (PBM) to obtain relevant pharmacy claims;
- B11.11.3 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;
- B11.11.4 A physician reviewer shall review any case initially determined not to benefit from case management services for a final determination;
- B11.11.5 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;
- B11.11.6 Once the member accepts case management, the case manager shall perform an initial assessment and review the member's history and concerns, provide a plan of care and provide ongoing case management services as necessary;
- B11.11.7 The contractor shall provide quarterly reports to MCHCP which include 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.

B11.12 The contractor shall coordinate with the MCHCP's PBM and provide necessary case management services as part of MCHCP's Pharmacy Lock-In Program.

B12 **CLAIM PAYMENT**: The contractor shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2020 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.

B12.1 The contractor shall process claims utilizing the contracted discount arrangements negotiated with participating providers.

B12.2 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.

B12.3 Any associated ASO fees for processing non-network fees shall be in accordance with the RFP and any calculations to arrive at the associated fees shall be disclosed to MCHCP in detail.

B12.4 The contractor shall, at a minimum, auto-adjudicate seventy-five percent (75%) of claims.

B12.5 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 Health Plan RFP Questionnaire for definition and penalty).

B12.5.1 "Clean claim" shall have the same meaning as specified in Chapter 376.383 of the Revised Statutes of Missouri.

B12.5.2 The contractor shall maintain 97% payment accuracy in regard to their claims processing (see Performance Guarantees included in Section 21 of the RFP Questionnaire for definition and penalty).

B12.5.3 The contractor shall maintain 99% financial accuracy in regard to their claims processing (see Performance Guarantees included in Section 21 of the Questionnaire for definition and penalty).

B12.5.4 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 cost of the member's claims directly involved in or affected by such error.

B12.6 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.

B12.7 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.

B12.8 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.

B12.9 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, "diagnosis creep", and duplicate bill submissions.

B12.10 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.

B12.11 All penalties assessed by law for failure to timely pay claims will be borne by the contractor.

B12.12 The contractor must be able to coordinate benefits in accordance with MCHCP regulations.

B12.13 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.

B12.14 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.

B12.15 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.

B12.16 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 of collection.

B13 **BANKING**: The contractor shall agree that payment of claims incurred by participating MCHCP members shall be paid by the contractor from the MCHCP banking account(s) established by MCHCP for that purpose. Such account(s) shall be solely owned by MCHCP and shall be located at the bank that conducts all of MCHCP's banking activities (currently, Central Bank). The contractor shall make member and provider reimbursements from this account on at least a weekly basis. The contractor shall offer the ability to pay claims via electronic payment (ACH). MCHCP has familiarity and customization available utilizing file submission with control totals or the use of a 1031 drawdown process. Processes must ensure that MCHCP funds do not "nest" outside MCHCP accounts to the detriment of investment return.

B13.1 The contractor shall provide evidence of adequate bonding of employees who are authorized to make reimbursements from the MCHCP claims payment account.

B13.2 Internal controls must meet the requirements of generally accepted accounting practice for this type of operation and must be reviewed regularly by an independent third party to assure compliance with industry standards.

B13.3 The contractor shall provide MCHCP with a numerically-sequenced monthly check ledger/register reflecting payments made from the first through the last day of the month.

B13.3.1 The check register/ledger shall include the following required information – check number or ACH designation if paid electronically, date of issuance, payee and amount. The contractor must also report voided items.

B13.3.2 The check register/ledger shall be due in the offices of MCHCP no later than five (5) business days from the end of the month of activity. The register/ledger shall be submitted electronically in a Microsoft Excel compatible format to MCHCP's Chief Financial Officer each month. Failure to

meet this requirement shall result in a performance penalty as outlined in Section 21 of the Questionnaire.

B13.4 The contractor shall submit a positive pay file of all activity to the MCHCP contracted bank. The file must be received no later than 4 p.m. CT via FTP. The file shall be sent within the necessary timeframe with the data elements as required by the bank conducting MCHCP business. A layout of the account reconciliation file is provided in Attachment 4.

B13.4.1 The file submitted must populate all fields defined within the layout.

B13.4.2 The contractor shall provide a primary and secondary contact available in the case of transmission issues.

B13.4.3 File transmission not meeting the above guidelines shall result in a performance penalty as determined by MCHCP and outlined in the Performance Guarantees included in Section 21 of the Questionnaire.

B13.4.4 The contractor shall agree that the final testing of the positive pay file shall be successfully completed no later than November 1, 2019. Failure to meet this requirement shall result in a performance penalty as outlined in Section 21 of the Questionnaire.

B14. **PERFORMANCE STANDARDS**: Performance standards are outlined in Section 21 of the Health Plan 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. **OPTIONAL ADMINISTRATIVE SERVICES**: For those optional administrative services the contractor proposed to MCHCP as part of the RFP process and including 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 contract 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 DirectPath 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 DirectPath 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, April 9, 2019, 4 p.m. CT (5 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

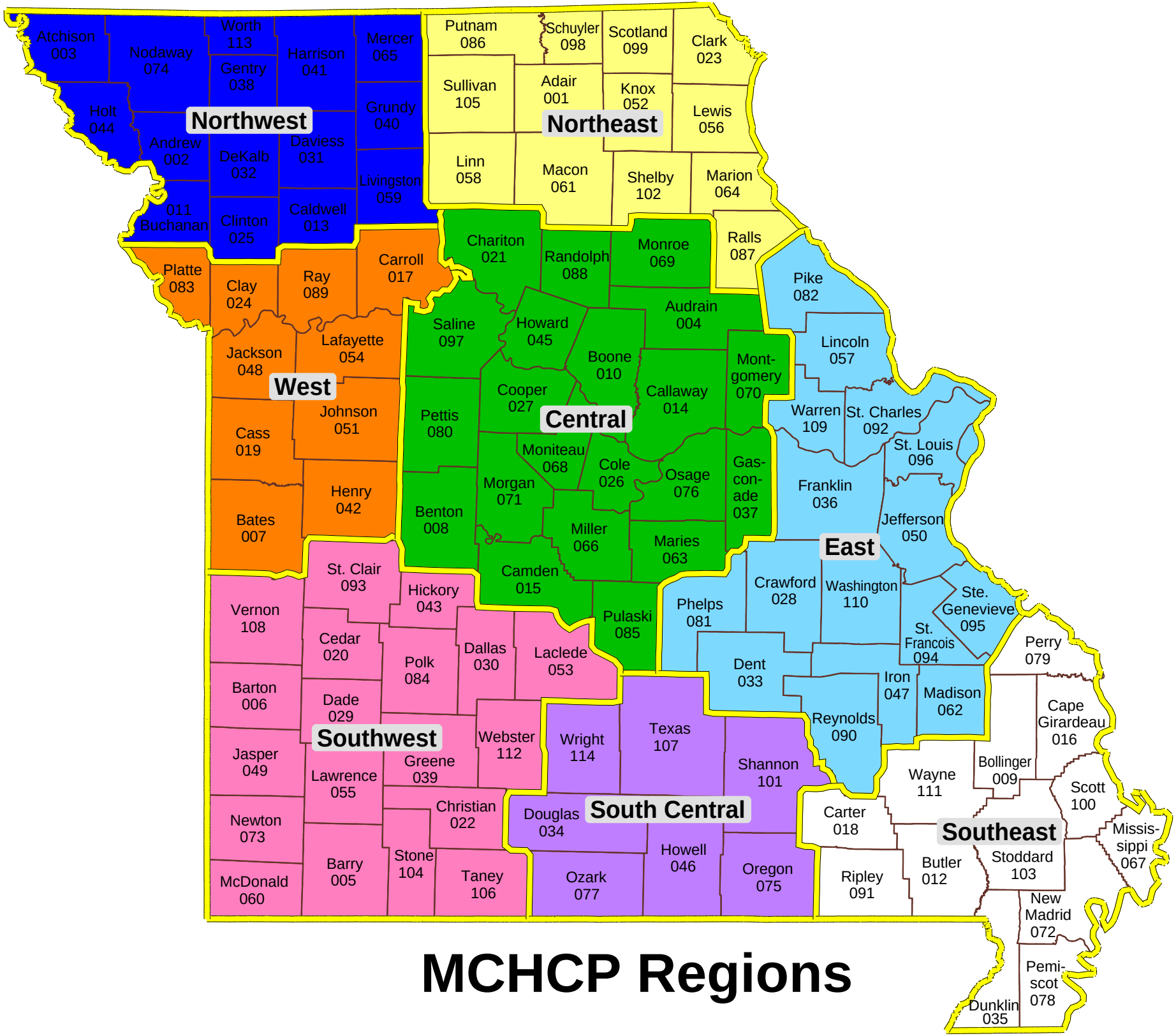
C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable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

Field Name	Description
Unique ID	Number assigned by MCHCP
Relation	Identifies if member is subscriber, spouse, or child 01 – subscriber 02 – spouse 03 – child
Plan Type	Identifies plan type member is enrolled PPO 750 PPO 1250 HDHP Tricare Supplement Plan
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
Employer	S – State P – Public Entity



MCHCP Regions

Attachment 3
Provider File Layouts

Provide comma separated text files listing physicians and facilities in your network as of January 1, 2019. Limit your network files to Missouri providers. If a provider has more than one office location, provide a record for each address. 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
Account Reconciliation File Layout

AR STANDARD Issue Layout - 01		
Field Name	**Picture**	**Position & Length**
Bank Number – required	9(3)	1 – 3
Account Number – required	9(9)	4 – 9
Serial (check) Number – required	9(9)	13 – 9
Issue (check) Amount – required	S9(9)V99	22 – 11
Date Issued – YYYYMMDD	9(8)	33 – 8
Disposition – required Space or I = Issued V = Void	X(1)	41 – 1
Payee Name (left justified – no fill at end)	X(30)	42 – 30
Filler – spaces	X(9)	72 – 9

AR STANDARD Paid Layout		
**80-byte unpacked*		
Field Name	**Picture**	**Position & Length**
Bank Number	9(3)	1 – 3
Account Number	9(9)	4 – 9
Serial (check) Number	9(9)	13 – 9
Issue (check) Amount	S9(9)V99	22 – 11
Date Issued – YYYYMMDD	9(8)	33 – 8
Disposition – C (cleared)	X(1)	41 – 1
Payee Name (left justified – no fill at end)	X(30)	42 – 30
Filler – spaces	X(9)	72 – 9
Record Delimiter - *	X(1)	80 - 1

All numeric fields are right justified. Zero fill at left of data.

Attachment 6
Definitions for Section 15 of Questionnaire

Patient - Centered Medical Home	Patient has an ongoing relationship with a primary physician, physician extenders like nurse practitioners, physicians assistants, etc., or physician practice, that coordinates care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. Physician incentives and incremental reimbursement are aligned with activity and outcomes; proactive coordination of services and preventive care; improved quality through evidence-based medicine (EBM), technology and data sharing; improved access, performance measurement and improvement, and an enhanced consumer experience. Typically includes a specific, incremental payment for care coordination.
Accountable Care Organizations	An organized, delivery system for an attributed/selected population; may or may not include facilities such as hospitals. Accountability for overall performance, cost and quality reside with the provider and the delivery system, including shared risk. Population health management provided across all levels of care. Responsible for all of the health care and related expenditures for a defined population of patients.
Narrow Network	A smaller panel of providers structured to deliver reduced unit cost through plan design steerage and contract improvements.
High Performance Network	A subset of the broad provider panel identified through the evaluation of cost and quality metrics, may or may not include separate contract arrangements. Plan design steerage is optional.
Centers of Excellence	Hospitals that have been identified as delivering high quality services and superior outcomes for specific procedures or conditions. May incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments).

Exhibit A-1
Intent to Bid – 2020 MCHCP Health Plan RFP

(Signing this form does not mandate that a vendor must bid)

Please complete this form following the steps listed below:

1) Fill this form out electronically and sign it with your electronic signature.

2) Upload the completed document to the Response Documents area of the RFP no later than Tuesday, April 9, 2019 at 4 p.m. CT (5 p.m. ET).

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 Insurance, Financial Institutions and Professional Registration (DIFP). 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, as described in Exhibits A-3, A-4 and A-5, with MCHCP's consultant, Willis Towers Watson, 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 IBM Watson Health) on a monthly basis, including twelve (12) 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. MCHCP encourages high performance networks to be offered in addition to a broad national network.
- 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 April 30, 2019, 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.

This form will serve as confirmation that our organization has received the 2020 MCHCP Health Plan RFP.

☐ We intend to submit a complete proposal.

☐ We decline to submit a proposal for the following reason(s):

Name of Organization

Signature of Plan Representative

Title of Plan Representative

Date

EXHIBIT A-2
LIMITED DATA USE AGREEMENT

In order to secure data that resides with Missouri Consolidated Health Care Plan (MCHCP) and in order to ensure the integrity, security, and confidentiality of information maintained by MCHCP, and to permit appropriate disclosure and use of such data as permitted by law, MCHCP and _____ enter into this Agreement to comply with the following specific paragraphs.

1. This Agreement is by and between MCHCP, a covered entity under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and _____, hereinafter referred to as "User".

2. This Agreement addresses the conditions under which MCHCP will disclose and the User will obtain and use MCHCP's file(s) specified in this agreement. This Agreement supersedes any and all agreements between the parties with respect to the use of MCHCP's file(s), and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any prior communication from MCHCP with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement, or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by MCHCP's Executive Director.

3. Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

4. The parties mutually agree that MCHCP retains all ownership rights to the claims file referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by MCHCP.

5. The parties mutually agree that the following named individual is designated as "Custodian" of the file on behalf of the User, and will be personally responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify MCHCP within five (5) days of any change of custodianship. The parties mutually agree that MCHCP may disapprove the appointment of a custodian, or may require the appointment of a new custodian at any time.

   Name of Custodian: _____
   Name of Company: _____
   Street Address:_____
   City, State and Zip Code:_____
   Phone Number w/ Area Code:_____
   E-mail Address:_____

6. The User represents and warrants, and in furnishing the claims file(s), MCHCP relies upon such representation and warranty, that these files will be used solely for the purposes outlined below. The User agrees not to use or further disclose the data covered by this Agreement other than as provided for by this Agreement. The parties agree that no provision of this Agreement permits the User to use or disclose protected health information (PHI) in a manner that would violate HIPAA if used or disclosed in like manner by MCHCP. MCHCP's demographic and claims files are used solely for the following:

   - Modeling of potential claim volume related to a self-insured contract with MCHCP for health benefits; and/or
   - Network analysis and evaluation of proposed network's geographic accessibility to MCHCP members for purposes of bidding on a contract with MCHCP for health benefits.

   The User represents and warrants further that the User shall not disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement to any person(s) other than as allowed by this Agreement. The User agrees that, within the User organization, access to the data covered by this Agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section and to those individuals on a need-to-know basis only. The User agrees to ensure that any individual(s) or agent(s) the User discloses or allows to access the data covered by this Agreement will be bound to the same restrictions and conditions that apply to the User. Disclosure of this data is made pursuant to 45 CFR §§ 164.514(e)(1).

7. MCHCP will provide the User with the file, which is a subset of MCHCP's master records. MCHCP warrants that the file is accurate to the extent possible. The file shall not contain any prohibited items.

8. The parties mutually agree that the aforesaid file (and/or any derivative file(s) [includes any file that maintains or continues identification of individuals]) may be retained by the User only for the period of time required for any processing related to the purposes outlined in section 6 above. After the process is complete, the User agrees to promptly destroy such data. The User agrees that no data from MCHCP records, or any parts thereof, shall be retained when the aforementioned file(s) are destroyed unless authorization in writing for the retention of such file(s) has been received from MCHCP's Executive Director. The User acknowledges that stringent adherence to the aforementioned information outlined in this paragraph is required. The User further acknowledges that MCHCP's demographic file received for any previous periods, and all copies thereof, must be destroyed upon receipt of an updated version. The User agrees that for any data covered by this Agreement, in any form, that the User maintains after the bidding process is complete, the User agrees to: (i) refrain from any further use or disclosure of the PHI; (ii) continue to safeguard the PHI thereafter in accordance with the terms of this Agreement; and (iii) not attempt to de-identify the PHI.

9. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the privacy and security of the data, and to prevent any unauthorized use or disclosure. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by HIPAA. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, including protected health information, or deducible information derived from the file(s) specified above in section 6 is strictly prohibited. Further, the User agrees that the data must not be physically moved or transmitted in any way from the site indicated above in section 5, without written approval from MCHCP.

10. The User agrees that the authorized representatives of MCHCP and the Department of Health and Human Services ("HHS") will be granted access to the premises where the aforesaid file(s) are kept for the purpose of inspecting security arrangements and confirming whether the User is in compliance with the privacy and security requirements specified in this Agreement.

11. The User agrees that no findings, listing, or information derived from the file(s) specified in section 7, with or without identifiers, may be released if such findings, listing, or information contain any combination of data elements that might allow the deduction of a MCHCP member's identification (Examples of such data elements include, but are not limited to, address, zip code, sex, age, etc.) The User agrees further that MCHCP shall be the sole judge as to whether any finding, listing, or information, or any combination of data extracted or derived from MCHCP's files identifies or reasonably could identify an individual or to deduce the identity of an individual.

12. The User agrees that the User shall make no attempt to link records included in the file(s) specified in section 7 to any other identifiable source of information or attempt to identify the information or individual(s) contained in the data. This includes attempts to link to other MCHCP data files. In addition, the User agrees not to contact the individual(s) who are the subject of the data covered by this Agreement.

13. The User understands and agrees that it may not reuse original or derivative data file(s) without prior written approval from MCHCP's Executive Director.

14. The User agrees to immediately report to MCHCP any use or disclosure of PHI not authorized or provided for by this Agreement in accordance with the notice provisions prescribed in this Section 14.

    14.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of the User's first discovery, meaning the first day on which such unauthorized use or disclosure is known to the User, or by exercising reasonable diligence, would have been known to the User, of the unauthorized use or disclosure.

    14.2 The notice shall be in writing and shall include a complete description of the unauthorized use or disclosure, and if applicable, a list of affected individuals and a copy of the template breach notification letter to be sent to affected individuals.

15. The User agrees that in the event MCHCP determines or has a reasonable belief that the User has made or may have used or disclosed the aforesaid file(s) that is not authorized by this Agreement, or other written authorization from MCHCP's Executive Director, MCHCP in its sole discretion may require the User to: (a) promptly investigate and report to MCHCP the User's determinations regarding any alleged or actual unauthorized use or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by MCHCP, submit a formal written response to an allegation of unauthorized use or disclosure; (d) if requested by MCHCP, submit a corrective action plan with steps designed to prevent any future unauthorized uses or disclosures; and (e) if requested by MCHCP, destroy or return data files to MCHCP immediately. The User understands that as a result of MCHCP's determination or reasonable belief that unauthorized uses or disclosures have taken place, MCHCP may refuse to release further MCHCP data to the User for a period of time to be determined by MCHCP. Further, the User agrees that MCHCP may report the problem to the Secretary of HHS.

16. The User agrees to assume all costs and responsibilities associated with any breach, as defined in the HIPAA breach notification provisions, of any protected health information obtained from MCHCP's demographic file caused by the User organization. Such costs and responsibilities include: determining if and when a breach has occurred, however, all final decisions involving questions of a breach shall be made by MCHCP; investigating the circumstances surrounding any possible incident of breach; providing on behalf of MCHCP all notifications legally required of a covered entity in accordance with HIPAA breach notification laws and regulations; paying for the reasonable and actual costs associated with such notifications; The User further agrees to indemnify and hold MCHCP harmless from any and all penalties or damages associated with any breach caused by the User organization.

17. The User hereby acknowledges the criminal and civil penalties for violations under HIPAA. If User is a covered entity under HIPAA, its receipt of MCHCP's limited data set and violation of this data use agreement may cause the User to be in noncompliance with the standards, implementation specifications, and requirements of 45 CFR § 164.514 (e).

18. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement for protection of the data file specified in section 7, and acknowledges having received notice of potential criminal and civil penalties for violation of the terms of the Agreement.

19. On behalf of the User, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein. This Agreement shall be effective upon signature by both parties. The duration of this Agreement is one year from the effective date. The User also acknowledges that this Agreement may be terminated at any time with the consent of both parties involved. Either party may independently terminate the Agreement upon written request to the other party, in which case the termination shall be effective 60 days after the date of the notice, or at a later date specified in the notice.

_____
(Name/Title of Individual)

_____
(State Agency/Organization)

_____
(Street Address)

_____
(City/State/ZIP Code)

_____
(Phone Number Including Area Code)

_____
(E-mail Address)

Signature _____ Date

20. On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

_____ _____
Judith Muck, Executive Director Date
Missouri Consolidated Health Care Plan

Exhibit A-3
Broad Network - Provider Discount Analysis - Facility and Professional

This template will cover your national book-of-business for the product being proposed, by member 3-digit zip code for incurred claims for the 12 month period ending 12-31-18 with 3 months runout. Note that it does not request any facility specific discount data, therefore we expect it to be completed in full. Below are the definitions and data requirements for this template.

Definition of Terms for National Provider Discount Template

3-Digit Zip Code – Data to be provided by 3-digit zip code is based upon the employee's home address zip code, not the provider's zip code.

Time Period - Data should represent incurred claims for the 12 month period ending 12/31/18 with 3 months runout.

Contracted - Claims from providers contracted to provide services for the product being quoted.

Pct of Claims with Contracted Providers – Based on Eligible Billed Charges for that 3-digit zip.

Non-contracted Provider Discount – Non-contracted provider Eligible Billed Charges and Allowed Amount claims are combined for all services. R&C savings generally cannot be accurately excluded, so they should be included in this discount calculation.

Eligible Billed Charges – The amount billed by the provider for benefits eligible for payment under the benefit contract. The Eligible Billed Charges exclude duplicate claims, pended claims, and not covered claims. Capitations should be excluded.

Allowed Amount - Eligible Billed Charges reduced by negotiated provider contract terms, prior to reduction for member plan cost-sharing (e.g. copays). Capitations should be excluded.

Inpatient and Outpatient Facility - Include all services billed by the facility, but exclude physician services (e.g. hospital visits by admitting physician, surgeons' fees). Lab and x-ray services done in a free-standing facility would be included here.

Professional – Include all other medical expenses not included in the Inpatient and Outpatient services except outpatient drugs. For example, professional claims include but are not limited to physician, therapist, chiropractor, injections, supplies, x-ray and lab (performed in the physician office, not performed in a hospital or free-standing facility).

Rented networks, Shared Service Arrangements, Network Access Fees - Any such fees that are included in claims should be included in this data request. Any non-claim fees should be described and disclosed separately.

Provider Withholds - assume that withholds are paid in full to the provider.

Exclusions - Data should exclude the following:
> Non-group (e.g. individual, Medicare, Medicaid) coverage
> Client-specific networks
> Claims for Medicare-eligible individuals
> All secondary payor claims

> Savings such as hospital bill audit, medical management, prompt pay discounts, and any other savings not directly associated with the negotiated provider contract
> Duplicate, pended, and not covered claims
> Capitations

Inclusions - Data should include the following:
> Outlier claims and claims over stop loss thresholds
> Any performance-based fees or bonuses paid to providers that are captured in claims data
> Claims for which the provider intentionally billed your negotiated rate

Optional - You are invited to provide the following data in addition to the basic data above, if you wish:
> A separate, full dataset for claims for which a contracted provider intentionally bills your negotiated amount
> A separate, full dataset with adjustments to reflect known future contracting events (please provide a list of the events reflected)
> Other data that you wish Willis Towers Watson to consider in evaluating your historical or expected future discounts

Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with Contracted Providers	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Broad National Discount Analysis

Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

Carrier:
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3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

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Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

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Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Broad National Discount Analysis

Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Broad National Discount Analysis

Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Exhibit A-4
Narrow/High-Performing Network - Provider Discount Analysis - Facility and Professional

This template will cover your national book-of-business for the product being proposed, by member 3-digit zip code for incurred claims for the 12 month period ending 12-31-18 with 3 months runout. Note that it does not request any facility specific discount data, therefore we expect it to be completed in full. Below are the definitions and data requirements for this template.

Definition of Terms for Narrow/High-Performing Provider Discount Template

3-Digit Zip Code – Data to be provided by 3-digit zip code is based upon the employee's home address zip code, not the provider's zip code.

Time Period - Data should represent incurred claims for the 12 month period ending 12/31/18 with 3 months runout.

Contracted - Claims from providers contracted to provide services for the product being quoted.

Pct of Claims with Contracted Providers – Based on Eligible Billed Charges for that 3-digit zip.

Non-contracted Provider Discount – Non-contracted provider Eligible Billed Charges and Allowed Amount claims are combined for all services. R&C savings generally cannot be accurately excluded, so they should be included in this discount calculation.

Eligible Billed Charges – The amount billed by the provider for benefits eligible for payment under the benefit contract. The Eligible Billed Charges exclude duplicate claims, pended claims, and not covered claims. Capitations should be excluded.

Allowed Amount - Eligible Billed Charges reduced by negotiated provider contract terms, prior to reduction for member plan cost-sharing (e.g. copays). Capitations should be excluded.

Inpatient and Outpatient Facility - Include all services billed by the facility, but exclude physician services (e.g. hospital visits by admitting physician, surgeons' fees). Lab and x-ray services done in a free-standing facility would be included here.

Professional – Include all other medical expenses not included in the Inpatient and Outpatient services except outpatient drugs. For example, professional claims include but are not limited to physician, therapist, chiropractor, injections, supplies, x-ray and lab (performed in the physician office, not performed in a hospital or free-standing facility).

Rented networks, Shared Service Arrangements, Network Access Fees - Any such fees that are included in claims should be included in this data request. Any non-claim fees should be described and disclosed separately.

Provider Withholds - assume that withholds are paid in full to the provider.

Exclusions - Data should exclude the following:
> Non-group (e.g. individual, Medicare, Medicaid) coverage
> Client-specific networks
> Claims for Medicare-eligible individuals
> All secondary payor claims

> Savings such as hospital bill audit, medical management, prompt pay discounts, and any other savings not directly associated with the negotiated provider contract
> Duplicate, pended, and not covered claims
> Capitations

Inclusions - Data should include the following:
> Outlier claims and claims over stop loss thresholds
> Any performance-based fees or bonuses paid to providers that are captured in claims data
> Claims for which the provider intentionally billed your negotiated rate

Optional - You are invited to provide the following data in addition to the basic data above, if you wish:
> A separate, full dataset for claims for which a contracted provider intentionally bills your negotiated amount
> A separate, full dataset with adjustments to reflect known future contracting events (please provide a list of the events reflected)
> Other data that you wish Willis Towers Watson to consider in evaluating your historical or expected future discounts

Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with Contracted Providers	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

Carrier:
Product:
Time Period of data:

3-Digit Member Zip	% of claims with	Inpatient Days	Out of Network Discount	Contracted Providers Billed Charges			Contracted Providers Allowed Amounts		
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Book of Business Results

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Time Period of data:

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				Inpatient Facility	Outpatient Facility	Professional	Inpatient Facility	Outpatient Facility	Professional
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Book of Business Results

Carrier:
Product:
Time Period of data:

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Book of Business Results

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Time Period of data:

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Exhibit A-5
Provider Discounts
Attestation of Accuracy Form

Carrier Name: _____ Contact: _____

We certify that we have reviewed the information contained in the Willis Towers Watson Provider Discount Templates and delivered with our response to the Request for Proposal. Upon review and to the best of our knowledge the information provided is an accurate and complete representation of results for our organization and is not in any material way false, invalid or misleading.

We confirm that our organization has followed the instructions provided and has identified any deviations from specifications within our response. We confirm that any instructions or specifications that we felt were unclear have been questioned in advance of this response.

Two authorized officers of the organization must sign this Attestation. One signature must be of the official responsible for coordinating plan responses to this RFP (e.g. Senior Account Management). The second should be the actuary or underwriter who certifies the method used to determine and report requested discount information.

It is acceptable for these individuals to return this form attached to an email in lieu of a wet signature.

Date: _____ Date: _____

Signature: _____ Signature: _____

Printed Name: _____ Printed Name: _____

Title: _____ Title: _____

EXHIBIT A-6
BIDDER'S PROPOSED MODIFICATIONS TO THE RFP
2020 HEALTH PLAN RFP

The bidder must utilize this document to clearly identify by subsection number any exceptions to the provisions of the Request for Proposal (RFP) and include an explanation as to why the bidder cannot comply with the specific provision. Any desired modifications should be kept as succinct and brief as possible. **Failure to confirm acceptance of the mandatory contract provisions will result in the bidder being eliminated from further consideration as its proposal will be considered non-compliant.**

Any modification proposed shall be deemed accepted as a modification of the RFP if and only if this proposed modification exhibit is countersigned by an authorized MCHCP representative on or before the effective date of the contract awarded under this RFP.

_____
Name/Title of Individual

_____
Organization

_____
Signature

_____
Date

On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

_____
Executive Director Date
Missouri Consolidated Health Care Plan

Exhibit A-7

Confirmation Document

2020 MCHCP Health Plan RFP

Please complete this form following the steps listed below:

1) Confirm that you have read and understand all of MCHCP's instructions included in the DirectPath application.

☐ Yes

☐ No

2) Bidders are required to submit a firm, fixed price for CY2020 and not-to-exceed prices for CY2021 through CY2024. Prices will be subject to best and final offer which may result from subsequent negotiation. You are advised to review all proposal submission requirements stated in the original RFP and in any amendments, thereto. Confirm that you hereby agree to provide the services and/or items at the prices quoted, pursuant to the requirements of the RFP, including any and all RFP amendments.

☐ Yes

☐ No

3) Completion of the signature block below constitutes your company's acceptance of all terms and conditions of the original RFP plus any and all RFP amendments, and confirmation that all information include in this response is truthful and accurate to the best of your knowledge. You also hereby expressly affirm that you have the requisite authority to execute this Agreement on behalf of the Vendor and to bind such respective party to the terms and conditions set forth herein.

_____

Name/Title of Individual

_____

Organization

_____

Signature

_____

Date

EXHIBIT A-8

CONTRACTOR CERTIFICATION
OF COMPLIANCE WITH FEDERAL EMPLOYMENT LAWS
2020 MCHCP HEALTH PLAN RFP

_____ (hereafter referred to as "Contractor") hereby certifies that all of Contractor's employees and its subcontractors' employees assigned to perform services for Missouri Consolidated Health Care Plan ("MCHCP") and/or its members are eligible to work in the United States in accordance with federal law.

Contractor acknowledges that MCHCP is entitled to receive all requested information, records, books, forms, and any other documentation ("requested data") in order to determine if Contractor is in compliance with federal law concerning eligibility to work in the United States and to verify the accuracy of such requested data. Contractor further agrees to fully cooperate with MCHCP in its audit of such subject matter.

Contractor also hereby acknowledges that MCHCP may declare Contractor has breached its Contract if MCHCP has reasonable cause to believe that Contractor or its subcontractors knowingly employed individuals not eligible to work in the United States. MCHCP may then lawfully and immediately terminate its Contract with Contractor without any penalty to MCHCP and may suspend or debar Contractor from doing any further business with MCHCP.

THE UNDERSIGNED PERSON REPRESENTS AND WARRANTS THAT HE/SHE IS DULY AUTHORIZED TO SIGN THIS DOCUMENT AND BIND THE CONTRACTOR TO SUCH CERTIFICATION.

_____

Name/Title of Individual

_____

Organization

_____

Signature

_____

Date

Exhibit A-9

Documentation of Intent to Participate
2020 MCHCP Health Plan RFP

If the bidder is proposing to include the participation of a Minority Business Enterprise/Women Business Enterprise (MBE/WBE) in the provision of the products/services required in the RFP, the bidder must either provide a recently dated letter of intent, signed and dated no earlier than the RFP issuance date, from each organization documenting the following information, or complete and provide this Exhibit with the bidder's proposal.

~ Copy This Form For Each Organization Proposed ~

Bidder Name: _____

This Section To Be Completed by Participating Organization:

By completing and signing this form, the undersigned hereby confirms the intent of the named participating organization to provide the products/services identified herein for the bidder identified above.

Name of Organization: _____
(Name of MBE, WBE)

Contact Name:		Email:	
Address:		Phone #:	
City:		Fax #:	
State/Zip:		Certification #	
Type of Organization (MBE or WBE):		Certification Expiration Date:	(or attach copy of certification)

PRODUCTS/SERVICES PARTICIPATING ORGANIZATION AGREED TO PROVIDE

Describe the products/services you *(as the participating organization)* have agreed to provide:

_____
_____
_____
_____

Authorized Signature:

_____ _____
Authorized Signature of Participating Organization (MBE, WBE) — Date (Dated no earlier than the RFP issuance date)

Exhibit A-10
Sample Contract

This contract is a sample contract for review during the RFP process only. Additional clauses and obligations may be added that are consistent with the RFP and bidder's submission which is awarded by the Board of Trustees. If there is a conflict with this sample contract and the RFP materials, the RFP materials will take precedence during the bidding process.

CONTRACT # 20-010120-TPA BETWEEN
MISSOURI CONSOLIDATED HEALTH CARE PLAN
AND TPA

This Contract is entered into by and between Missouri Consolidated Health Care Plan ("MCHCP") and _____ (hereinafter "TPA" or "Contractor") for the express purpose of providing third party administrative services for MCHCP's self-funded employee benefit plans for State and Public Entity members, pursuant to MCHCP's 2020 Health Plan RFP released April 2, 2019 (hereinafter "RFP").

1. GENERAL TERMS AND CONDITIONS

1.1 Term of Contract and Costs of Services: The term of this Contract is for a period of one (1) year from January 1, 2020 through December 31, 2020. This Contract may be renewed for four (4) additional one-year periods at the sole option of the MCHCP Board of Trustees. The submitted pricing arrangement for the first year (January 1 - December 31, 2019) is a firm, fixed price. The submitted prices for the subsequent (2nd – 3rd) years of the contract period (January 1 - December 31, 2021, and January 1 - December 31, 2021, respectively) are guaranteed not-to-exceed maximum prices and are subject to negotiation. Pricing for the one-year renewal periods are due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

1.2 Contract Documents: This Contract and following documents, attached hereto and herby incorporated herein by reference as if fully set forth herein, constitute the full and complete Contract and, in the event of conflict in terms of language among the documents, shall be given precedence in the following order:

a. Any future written and duly executed renewal proposals or amendments to this Contract;

b. This written Contract signed by the parties;

c. The following Exhibits listed in this subsection below and attached hereto, the substance of which are based on final completed exhibits or attachments required and submitted by TPA in response to the RFP, finalist negotiations, and implementation meetings:

i. Pricing Pages – Exhibit 1
ii. Business Associate Agreement – Exhibit 2
iii. Performance Guarantees – Exhibit 3

iv. Confirmation Document – Exhibit 4

d. The original RFP, including any amendments, the mandatory terms of which are deemed accepted and confirmed by TPA as evidenced by TPA affirmative confirmations and representations required by and in accordance with the bidder response requirements described throughout the RFP.

Any exhibits or attachments voluntarily offered, proposed, or produced as evidence of TPA's ability and willingness to provide more or different services not required by the RFP that are not specifically described in this Section or otherwise not included elsewhere in the Contract documents are excluded from the terms of this Contract unless subsequently added by the parties in the form of a written and executed amendment to this Contract.

1.3 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

1.4 Amendments to this Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

No agent, representative, employee or officer of either MCHCP or TPA has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with this Contract, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of this Contract.

1.5 Drafting Conventions and Definitions: Whenever the following words and expressions appear in this Contract, any amendment thereto, or the RFP document, the definition or meaning described below shall apply:

- *(Definitions that are used in the RFP will be added as needed for the contract.)*
- **"Amendment"** means a written, official modification to the RFP or to this Contract.
- **"May"** means permissible but not required.
- **"Must"** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a breach.
- **"Request for Proposal" or "RFP"** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes Exhibits, Attachments, and Amendments thereto.
- **"Shall"** has the same meaning as the word must.
- **"Should"** means desirable but not mandatory.

- The terms **"include," "includes,"** and **"including"** are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation".

1.6 Notices: Unless otherwise expressly provided otherwise, all notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the course of this contract shall be in writing and shall be made by personal delivery, by prepaid overnight delivery, by United States mail postage prepaid, or transmitted by email to an authorized employee of the other party or to any other persons as may be designated by written notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355. Notices to TPA shall be addressed as follows: TPA ATTN: _____, _____.

1.7 Headings: The article, section, paragraph, or exhibit headings or captions in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract. Such headings or captions do not define, describe, extend, or limit the scope or intent of this Contract.

1.8 Severability: If any provision of this Contract is determined by a court of competent jurisdiction to be invalid, unenforceable, or contrary to law, such determination shall not affect the legality or validity of any other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if it were never incorporated into this Contract, but all other provisions will remain in full force and effect.

1.9 Inducements: In making the award of this Contract, MCHCP relies on TPA's assurances of the following:

- TPA, including its subcontractors, has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in the RFP, TPA's proposal, and this Contract, in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.
- TPA has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand MCHCP's current offerings and operating environment for the activities that are the subject of this Contract and the needs and requirements of MCHCP during the contract term.
- TPA has had the opportunity to review and fully understand MCHCP's stated objectives in entering into this Contract and, based upon such review and understanding, TPA currently has the capability to perform in accordance with the terms and conditions of this Contract.
- TPA has also reviewed and understands the risks associated with administering services as described in the RFP.

Accordingly, on the basis of the terms and conditions of this Contract, MCHCP desires to engage TPA to perform the services described in this Contract under the terms and conditions set forth in this Contract.

1.10 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

1.11 Force Majeure: Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by TPA's or its subcontractors' employees.

1.12 Breach and Waiver: Waiver or any breach of any Contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No Contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties. If any Contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the Contract terms and conditions are severable.

1.13 Independent Contractor: TPA represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, TPA hereby assumes all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. TPA assumes sole and full responsibility for its acts and the acts of its personnel.

1.14 Relationship of the Parties: This Contract does not create a partnership, franchise, joint venture, agency, or employment relationship between the parties.

1.15 No Implied Authority: The authority delegated to TPA by MCHCP is limited to the terms of this Contract. MCHCP is a statutorily created body corporate multi-employer group health plan and trust fund designated by the Missouri Legislature to administer health care services to eligible State of Missouri and public entity employees, and no other agency or entity may grant TPA any authority related to this Contract except as authorized in writing by MCHCP. TPA may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

- Make public policy;
- Promulgate, amend, or disregard administrative regulations or program policy decisions made by MCHCP; and/or

- Unilaterally communicate or negotiate with any federal or state agency, the Missouri Legislature, or any MCHCP vendor on behalf of MCHCP regarding the services included within this Contract.

1.16 Third Party Beneficiaries: This Contract shall not be construed as providing an enforceable right to any third party.

1.17 Injunction: Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, TPA shall not be entitled to make or assess claim for damage by reason of said delay.

1.18 Statutes: Each and every provision of law and clause required by law to be inserted or applicable to the services provided in this Contract shall be deemed to be inserted herein and this Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

1.19 Governing Law: This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

1.20 Jurisdiction: All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

1.21 Acceptance: No contract provision or use of items by MCHCP shall constitute acceptance or relieve TPA of liability in respect to any expressed or implied warranties.

1.22 Survival of Terms: Termination or expiration of this Contract for any reason will not release either party from any liabilities or obligations set forth in this Contract that: (i) the parties expressly agree will survive any such termination or expiration; or (ii) remain to be performed or by their nature would be intended to apply following any such termination or expiration.

2 TPA's Obligations

2.1 Security Deposit: TPA 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 $5,000,000.00. 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, TPA shall maintain the validity and enforcement of the security deposit for the renewal period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $5,000,000.00.

2.2 Confidentiality: TPA will have access to private and/or confidential data maintained by MCHCP to the extent necessary to carry out its responsibilities under this Contract. No private or

confidential data received, collected, maintained, transmitted, or used in the course of performance of this Contract shall be disseminated by TPA except as authorized by MCHCP, either during the period of this Contract or thereafter. TPA must agree to return any or all data furnished by MCHCP promptly at the request of MCHCP in whatever form it is maintained by TPA. On the termination or expiration of this Contract, TPA will not use any of such data or any material derived from the data for any purpose and, where so instructed by MCHCP, will destroy or render it unreadable.

2.3 Subcontracting: Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. TPA shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of MCHCP. TPA may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of MCHCP. TPA agrees that any and all subcontracts entered into by TPA for the purpose of meeting the requirements of this Contract are the responsibility of TPA. MCHCP will hold TPA responsible for assuring that subcontractors meet all the requirements of this Contract and all amendments thereto. TPA must provide complete information regarding each subcontractor used by TPA to meet the requirements of this Contract.

2.4 Disclosure of Material Events: TPA agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies:

- Any material adverse change to the financial status or condition of TPA;
- Any merger, sale or other material change of ownership of TPA;
- Any conflict of interest or potential conflict of interest between TPA's engagement with MCHCP and the work, services or products that TPA is providing or proposes to provide to any current or prospective customer; and
- (1) Any material investigation of TPA by a federal or state agency or self-regulatory organization; (2) Any material complaint against TPA filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming TPA before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming TPA as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against TPA by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against TPA as a result of any material criminal or civil action in which TPA was a party; or (7) Any other matter material to the services rendered by TPA pursuant to this Contract.

  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 Contract. It is further understood in that in fulfilling its ongoing responsibilities under this paragraph, TPA is obligated to make its best faith efforts to disclose only those relevant matters which to the

attention of or should have been known by TPA's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of TPA designated by TPA to monitor and report such matters.

Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

2.5 Off-shore Services: All services under this Contract shall be performed within the United States. TPA shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in TPA being in breach of this Contract.

2.6 Change in Laws: TPA agrees that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract automatically. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

2.7 Compliance with Laws: TPA shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

2.7.1 Non-discrimination, Sexual Harassment and Workplace Safety: TPA agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. TPA shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. TPA shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

2.7.2 Americans with Disabilities Act (ADA) and Americans with Disabilities Act Amendments Act of 2008 (ADAAA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA) and **Americans with Disabilities Act Amendments Act of 2008 (ADAAA)**, TPA understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, TPA agrees to comply with all regulations promulgated under ADA or ADAAA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.3 Patient Protection and Affordable Care Act (PPACA): If applicable, TPA shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations

promulgated under PPACA, which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.4 Health Insurance Portability and Accountability Act of 1996 (HIPAA): TPA shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

2.7.5 Genetic Information Nondiscrimination Act of 2008: TPA shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

2.8 Indemnification: TPA shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of TPA's, TPA's employees, or TPA's associate or any associate's or subcontractor's failure to comply with section 2.7 of this contract.

2.9 Prohibition of Gratuities: Neither TPA nor any person, firm or corporation employed by TPA in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

2.10 Solicitation of Members: TPA shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director.

2.11 Insurance and Liability: TPA must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement. TPA shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. TPA shall bear the risk of any loss or damage to any personal property in which TPA holds title.

2.12 Hold Harmless: TPA shall hold MCHCP harmless from an indemnify against any and all claims for injury to or death of any persons; for loss or damage to any property; and for infringement of any copyright or patent to the extent caused by TPA or TPA's employees or its subcontractors. MCHCP shall not be precluded from receiving the benefits of any insurance TPA may carry which provides for indemnification for any loss or damage of property in TPA's custody and control, where such loss or destruction is to MCHCP's property. TPA shall do nothing to prejudice MCHCP's right to recover against third parties for any loss, destruction, or damage to MCHCP's property.

2.13 Assignment: TPA shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by TPA made without prior written consent of MCHCP. Notwithstanding the foregoing, TPA may, without the consent of MCHCP, assign its rights to payment to be received under this Contract,

provided that TPA provides written notice of such assignment to MCHCP together with a written acknowledgment from the assignee that any such payments are subject to all of the terms and conditions of this Contract. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in TPA provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by TPA and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by TPA, following which TPA's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. TPA shall give MCHCP written notice of any such change of name.

2.14 Patent, Copyright, and Trademark Indemnity: TPA warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. TPA shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at TPA's written request, it shall be at TPA's expense, but the responsibility for such expense shall be only that within TPA's written authorization. TPA shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that TPA or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by TPA in such suit or proceeding are held to constitute infringement and the use is enjoined, TPA shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If TPA is unable to do any of the preceding, TPA agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of TPA under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of TPA without its written consent.

2.15 Compensation/Expenses: TPA shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. TPA shall be compensated only for work performed to the satisfaction of MCHCP. TPA shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

2.16 Contractor Expenses: TPA will pay and will be solely responsible for TPA's travel expenses and out-of-pocket expenses incurred in connection with providing the services. TPA will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

2.17 Tax Payments: TPA shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on TPA.

2.18 Conflicts of Interest: TPA shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, TPA shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP.

3 MCHCP'S OBLIGATIONS

3.1 Administrative Services: MCHCP shall provide the following administrative services to assist TPA

- Certification of eligibility;
- Enrollments (new, change and terminations) in an electronic format;
- Maintenance of individual eligibility and membership data;
- Payment of monies due TPA;

3.2 Eligibility: MCHCP members are those employees, retirees and their dependents who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining member eligibility. Effective and termination dates of plan participants will be determined by MCHCP. TPA shall not regard a member as terminated until the contractor receives an official termination notice from MCHCP. TPA will be notified of enrollment changes through the carrier enrollment eligibility file, by telephone or by written notification from MCHCP. TPA shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

3.3 Payment: <<Payment Terms as presented in RFP response and subsequently negotiated will be inserted into contract. >>

4 RECORDS RETENTION, ACCESS, AUDIT, AND FINANCIAL COMPLIANCE

4.1 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, TPA agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. TPA agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the ten (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

4.2 Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of Contractor involving any and all transactions related to the performance of this Contract. Contractor shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review. MCHCP and TPA shall agree to reasonable times for TPA to make such records available for audit. Audits must be conducted by a firm selected by MCHCP.

4.3 Ownership: All data developed or accumulated by TPA under this Contract shall be owned by MCHCP. TPA may not release any data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

4.4 Access to Records: Upon reasonable notice, TPA must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. TPA agrees to provide the access described wherever TPA maintains such books, records, and supporting documentation. Further, TPA agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. TPA shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by MCHCP, to audit the books, documents and records of TPA to the extent that the books, documents and records relate to costs or pricing data for this Contract. TPA agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. Also, TPA must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. To the extent described herein, TPA shall give full and free access to all records to MCHCP and/or their authorized representatives.

4.5 Financial Record Audit and Retention: TPA agrees to maintain, and require its subcontractors to maintain, supporting financial information and documents that are adequate to ensure the accuracy and validity of TPA's invoices. Such documents will be maintained and retained by TPA or its subcontractors for a period of ten (7) years after the date of submission of the final billing or until the resolution of all audit questions, whichever is longer. TPA agrees to timely repay any undisputed audit exceptions taken by MCHCP in any audit of this Contract.

4.6 Response/Compliance with Audit or Inspection Findings: TPA must take action to ensure its or its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include TPA's delivery to MCHCP, for MCHCP's approval, a corrective action plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

4.7 Inspections: Upon notice from MCHCP, TPA will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to TPA service locations, facilities, or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. TPA must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

5 Scope of Work

5.1 Administrative Services: TPA 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. TPA must administer benefits and services as determined by MCHCP and as promulgated by rule in Title 22 of the Missouri Code of State Regulations. TPA is obligated to follow the performance standards as outline in Exhibit 6. The administrative services include:

5.1.1 Administrative Services Only (ASO) functions that include account management, claim services, member services, broad national network access for medical services (inclusive of mental health and substance abuse services), care management (inclusive of utilization management and case management); coordination with MCHCP business associates; reporting; banking; and web and consumer tools.

5.1.2 Subrogation and overpayment recovery services

5.1.3 (add any additional services which are presented in the RFP, such as Centers of Excellence, Secondary Networks for out of network claims, etc.)

5.2 Coordination with MCHCP Business Associates: TPA 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.

5.3 Account Management: TPA 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 customer 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:

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

5.3.2 Be extremely responsive.

5.3.3 Be comprised of individuals with specialized knowledge of TPA'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.

5.3.4 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.

5.3.5 TPA 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 TPA's account management and servicing team.

5.3.6 TPA agrees to allow MCHCP to complete an annual formal performance evaluation of the assigned account management team.

5.4 Meetings: TPA 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 in order 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 to MCHCP, or some other comparable industry norm

5.5 Networks: TPA 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.

5.5.1 << Specific network information as presented in the RFP and as chosen by MCHCP will be inserted here. >>

5.5.2 <<Specifications concerning available Centers of Excellences will be inserted here. >>

5.5.3 TPA shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the networks (whether broad national or high performance) to meet the health care needs of the enrolled members within reasonable geography and reasonable time. In addition to looking at the needs from an overall member population standpoint, TPA 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. TPA shall notify MCHCP within five business days if the networks' geographic access changes from what was proposed by TPA.

5.5.4 TPA 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.

5.5.5 TPA shall obtain discounts and other reductions, including through secondary networks as much as is possible for non-network claims.

5.5.6 No provider may be listed on TPA's website or distributed to the membership unless a signed contract is in place.

5.6 Alternate Provider Arrangements: TPA shall notify MCHCP of all alternative provider arrangements that it has in place, including but not limited to, accountable care organization, primary care case management, or patient-centered medical home. For each alternative provider arrangement, TPA 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. TPA shall notify MCHCP of all alternative provider arrangements that it has in place by October 1, 2019 and for future arrangements, within 30 days of implementing such an arrangement and annually thereafter.

5.7 Direct Provider Arrangements: TPA shall provide administrative services to support network or provider arrangements that MCHCP have directly contracted for outside the arrangement offered by TPA. Such administrative support may include, but not be limited to, claims processing in accordance with the underlying plan design, utilization management, and appeals processing.

5.8 Provider Directories: TPA must distribute printed provider directories including lists of participating hospitals, primary care providers, specialists, and mental health providers to all members that request such information. These printed directories must be mailed to the member within three (3) business days of receipt of such request. TPA bears all costs for

printing and mailing these materials. TPA is also required to provide this information via their website.

5.9 Written Notification of Provider Leaving Network: TPA shall agree to provide written notice to affected members when providers leave the network. For facility terminations or non-renewals, TPA must 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. For non-facility provider terminations or non-renewals, TPA must notify all members who received care from the provider within the last 90 days. The contractor shall provide continuation of care in accordance with RSMo Chapter 354.612 and MCHCP regulations.

5.10 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. The contractor shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified MSRs.

5.10.1 At a minimum, member service must be available between the hours of 8:00 a.m. and 5:00 p.m. central time (CT), Monday through Friday except for designated holidays. (may insert actual times available)

5.10.2 Member calls to TPA must be recorded and retained for a minimum of one year. If prior to the recording being purged, TPA is notified of litigation by MCHCP, call recordings must be provided to MCHCP upon request.

5.10.3 TPA shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

5.11 Identification Cards: TPA is responsible for developing, printing and mailing identification cards directly to the member's home. TPA is responsible for these production and mailing costs.

5.12 Customer Satisfaction: Upon the request of MCHCP and at TPA's expense, TPA 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.

5.13 Preventive Care Initiative: TPA 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.

5.14 Communications: 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 TPA from

communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.).

5.15 Tools: TPA shall have a variety of tools and information sources for MCHCP members. This may include, but is not limited to, the following:

5.15.1 New member information;

5.15.2 Cost transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary;

5.15.3 Member ability to view claim status;

5.15.4 Member information to track deductible, coinsurance and out-of-pocket maximum status;

5.15.5 Explanation of benefits; and

5.15.6 Ability to query and download up to twenty-four (24) months of claims data

5.16 Website: TPA 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 card, review benefits and plan design, review explanation of benefits, check status of deductibles, maximums or limits, research specific medical conditions, obtain a history of medical claims, map provider locations and other information.

5.16.1 If MCHCP discovers that provider information contained at TPA's website is inaccurate, MCHCP will contact the contractor immediately. TPA must correct inaccuracies within ten (10) days of being notified by MCHCP.

5.16.2 TPA must be able to support single sign-on from MCHCP's Member Portal to TPA's Member Portal utilizing Security Assertion Markup Language (SAML)

5.17 Implementation: Prior to January 1 of each Plan year, TPA shall implement any eligibility, plan design and benefit changes as directed by MCHCP. A final implementation schedule must be agreed to by MCHCP and TPA within 30 days of the notification of change. 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. At a minimum, the timeline must include the required dates for the following activities:

5.17.1 Testing of eligibility and other files to and from MCHCP, if necessary;

5.17.2 Acceptable date for final eligibility and other files to and from MCHCP and any business associates, if necessary;

5.17.3 ID card production and distribution, if necessary;

5.17.4 Finalization of benefits, plan designs, and other key elements;

5.17.5 Finalization of benefit changes; and

5.17.6 Testing of appropriate files to and from MCHCP business associate(s), if necessary

5.17.7 Testing of claim file to data warehouse vendor.

5.18 Readiness Review: At least forty-five (45) days prior to the January 1, 2020 effective date, MCHCP will have a readiness review/pre-implementation audit of TPA, including an on-site review of the TPA's facilities if MCHCP deems it necessary. TPA 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 TPA with a summary of findings as well as areas requiring corrective action. TPA is responsible for all costs associated with this review/audit/corrective action, including travel expenses of the MCHCP review team or its designee.

5.19 Eligibility Files: TPA shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply this information in an electronic format and TPA must process such information within 24 hours of receipt. TPA must provide a dedicated technical contact that will provide support to MCHCP Information Technology Department for EDI issues. It is MCHCP's intent to send a transactional based (change only) eligibility file weekly and a periodic full eligibility reconciliation file.

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

5.19.2 MCHCP will provide a recommended data mapping for the 834 transaction set.

5.19.3 After processing each file, TPA will provide a report that lists any errors and exceptions that occurred during processing. The file will be in a format that is agreeable by both parties so that MCHCP can compare the errors and exceptions with data in its system. 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 TPA audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

5.19.4 TPA shall provide access to view data on its system to ensure the file MCHCP sends is correctly updating the contractor's system.

5.19.5 TPA shall supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

5.19.6 TPA 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.

5.19.7 TPA must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that TPA

accept and run an initial test record set no later than September 27, 2019. Results of the test must be provided to MCHCP by October 11, 2019. Implementation of the Single-Sign-On portal is to be completed no later than December 15th, 2019.

5.20 Electronic Transmission Protocols: TPA and all its subcontractors will maintain encryption standards of 1024 bit encryption or higher for the encryption of confidential information for transmission via non secure methods including File Transfer Protocol or other use of the Internet.

5.21 Appeals: TPA 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 in compliance with federal regulations and issued within regulatory timeframes. MCHCP shall have the ability to review and approve all adverse benefit notice templates prior to their use. TPA shall fully cooperate with the external appeal contractor. 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 cost of the member's claims directly involved in or affected by such appeal.

5.22 Clinical Management: TPA shall integrate and coordinate utilization management, case management, discharge planning, quality management and medical policy and technology assessment in order to utilize health care resources and achieve optimum patient outcome in the most cost effective manner.

5.22.1 TPA 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.

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

5.22.3 TPA shall provide physician-to-physician communication. A licensed, clinical peer of the same medical specialty shall evaluate the clinical appropriateness of adverse determinations.

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

5.22.5 Utilization management services will be conducted by licensed registered nurses and TPA 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.

5.22.6 TPA shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

5.22.7 TPA 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.

5.22.8 TPA 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.

5.22.9 TPA 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.

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

5.22.10.1 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;

5.22.10.2 Coordinate with MCHCP's pharmacy benefit manager (PBM) to obtain relevant pharmacy claims;

5.22.10.3 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;

5.22.10.4 A physician reviewer shall review any case initially determined not to benefit from case management services for a final determination;

5.22.10.5 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;

5.22.10.6 Once the member accepts case management, the case manager shall perform an initial assessment and review the member's history and concerns and provide a plan of care and provide ongoing case management services as necessary;

5.22.10.7 TPA shall provide quarterly reports to MCHCP which include 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.

5.22.11 TPA shall coordinate with the MCHCP's PBM and provide necessary case management services as part of MCHCP's Pharmacy Lock-In Program.

5.23 Nurse Line: TPA 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.

5.24 Claim Payments: TPA shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2020 and each subsequent year of this agreement in accordance with MCHCP regulations. TPA shall provide a dedicated, experienced claims processing team that will be permanently assigned to the MCHCP account.

5.24.1 TPA shall process claims utilizing the contracted discount arrangements negotiated with participating providers.

5.24.2 TPA shall process claims from non-network providers utilizing secondary network discounts where available. Where secondary network discounts are not available, TPA 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.

5.24.3 Any associated ASO fees for processing non-network fees shall be in accordance with the RFP and any calculations to arrive at the associated fees shall be disclosed to MCHCP in detail.

5.24.4 TPA shall, at a minimum, auto-adjudicate seventy-five percent (75%) of claims.

5.24.5 TPA shall pay 90% of all clean claims within times frames specified in Chapter 376.383 of the Revised Statutes of Missouri (see Exhibit X, Performance Guarantees for definition and penalty).

5.24.5.1 "Clean claim" shall have the same meaning as specified in Chapter 376.383 of the Revised Statutes of Missouri.

5.24.5.2 TPA shall maintain 97% payment accuracy in regard to their claims processing (see Performance Guarantees included in Section 26 of the RFP Questionnaire for definition and penalty).

5.24.5.3 TPA shall maintain 99% financial accuracy in regard to their claims processing (see Exhibit X, Performance Guarantees for definition and penalty).

5.24.5.4 Should any payment result from an error or omission by TPA, 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, TPA shall be responsible for sixty percent (60%) of the cost of the member's claims directly involved in or affected by such error.

5.24.6 TPA shall have an automated process for tracking and resolving incomplete or pended claims. TPA 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.

5.24.7 TPA 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.

5.24.8 Overpayments made by the contractor to providers shall be electronically adjudicated against future payments to same provider to ensure timely repayment to MCHCP. TPA 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, TPA 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. TPA shall provide MCHCP supporting documentation of the overpayment amounts and associated collections whether by offset or by provider remittance.

5.24.9 TPA'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, "diagnosis creep", and duplicate bill submissions.

5.24.10 TPA 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 TPA that transition will be without significant issues. This may include requiring TPA to put substantial fees at risk and/or agree to an implementation audit related to these services to ensure a smooth transition.

5.24.11 All penalties assessed by law for failure to timely pay claims will be borne by TPA.

5.24.12 TPA shall coordinate benefits in accordance with MCHCP regulations.

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

5.24.14 TPA'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, TPA 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 TPA 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 this contract.

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

5.25 Subrogation Services: TPA 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. TPA 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 of collection.

5.26 Banking: Payment of claims incurred by participating MCHCP members shall be paid by TPA from the MCHCP banking account(s) established by MCHCP for that purpose. Such account(s)

shall be solely owned by MCHCP and shall be located at the bank that conducts all of MCHCP's banking activities (currently, Central Bank). TPA shall make member and provider reimbursements from this account on at least a weekly basis. TPA shall offer the ability to pay claims via electronic payment (ACH). MCHCP has familiarity and customization available utilizing file submission with control totals or the use of a 1031 drawdown process. Processes must ensure that MCHCP funds do not "nest" outside MCHCP accounts to the detriment of investment return.

5.26.1 TPA shall provide evidence of adequate bonding of employees who are authorized to make reimbursements from the MCHCP claims payment account.

5.26.2 Internal controls must meet the requirements of generally accepted accounting practice for this type of operation and must be reviewed regularly by an independent third party to assure compliance with industry standards.

5.26.3 TPA shall provide MCHCP with a numerically-sequenced monthly check ledger/register reflecting payments made from the first through the last day of the month.

5.26.3.1 The check register/ledger shall include the following required information – check number or ACH designation if paid electronically, date of issuance, payee and amount. TPA must also report voided items.

5.26.3.2 The check register/ledger shall be due in the offices of MCHCP no later than five (5) business days from the end of the month of activity. The register/ledger shall be submitted electronically in a Microsoft Excel compatible format to MCHCP's Chief Financial Officer each month. Failure to meet this requirement shall result in a performance penalty as outlined in Exhibit X

5.26.4 TPA shall submit a positive pay file of all activity to the MCHCP contracted bank. The file must be received no later than 4 p.m. CT via FTP. The file shall be sent within the necessary timeframe with the data elements as required by the bank conducting MCHCP business.

5.26.4.1 The file submitted must populate all fields defined within the layout.

5.26.4.2 TPA shall provide a primary and secondary contact available in the case of transmission issues.

5.26.4.3 File transmission not meeting the above guidelines shall result in a performance penalty as determined by MCHCP and outlined in the Performance Guarantees included in Exhibit X.

5.26.4.4 TPA shall agree that the final testing of the positive pay file shall be successfully completed no later than November 1, 2019. Failure

to meet this requirement shall result in a performance penalty as outlined in Exhibit X

5.27 Performance Standards: Performance standards are outlined in Exhibit X. TPA 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. TPA 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. TPA 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.

5.28 Optional Administrative Services: For those optional administrative services TPA proposed to MCHCP as part of the RFP process and including 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, TPA and MCHCP shall negotiate any necessary final programmatic details to successfully implement the chosen optional administrative service and amend the contract to include such services.

6 REPORTING

6.1 Reporting Requirements: TPA agrees that all data required by MCHCP shall be confidential and will not be public information. TPA further agrees not to disclose this or similar information to any competing company, either directly or indirectly. 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. TPA agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of TPA's duties under this contract, including the provision of data as specified without constraint on its use.

6.2 Claims Data Reporting: 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. TPA shall provide data in an electronic form and within a time frame specified by MCHCP. TPA shall 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. This obligation continues for a period of two (2) years following contract termination at no additional cost to MCHCP.

6.3 Telephone Reports: TPA 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.

6.4 High Utilization: UMR 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.

6.5 Standard Reports: TPA shall provide their standard reporting package on a timely basis. (specifics as to reporting package bid will be added after award)

6.6 Annual Reporting: TPA shall provide 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.

6.7 Ad Hoc Reporting: At the request of MCHCP, TPA shall submit additional ad hoc reports on information and data readily available to TPA. Fair and equitable compensation will be negotiated with the contractor.

6.8 Acceptance of Reports: 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, TPA will receive written notice to this effect and the applicable liquidated damages, as defined in Exhibit X, will be assessed.

7 CANCELLATION, TERMINATION OR EXPIRATION

7.1 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require TPA to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination.

7.2 Termination for Cause: MCHCP may terminate this Contract, or any part of this Contract, for cause under any one of the following circumstances: 1) TPA fails to make delivery of goods or services as specified in this Contract; 2) TPA fails to satisfactorily perform the work specified in this Contract; 3) TPA fails to make progress so as to endanger performance of this Contract in accordance with its terms; 4) TPA breaches any provision of this Contract; 5) TPA assigns this Contract without MCHCP's approval; or 6) Insolvency or bankruptcy of TPA. MCHCP shall have the right to terminate this Contract, in whole or in part, if MCHCP determines, at its sole discretion, that one of the above listed circumstances exists. In the event of termination, TPA shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP, subject to any offset by MCHCP for actual damages including loss of any federal matching funds. TPA shall be liable to MCHCP for any reasonable excess costs for such similar or identical services included within the terminated part of this Contract.

7.3 Termination Right: Notwithstanding any other provisions, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days' notice, without penalty.

7.4 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

7.5 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and, if applicable, no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

7.6 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require TPA to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, TPA shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND OUR SIGNATURES BELOW SIGNIFY OUR CONSENT TO BE BOUND TO THE FOREGOING TERMS AND CONDITIONS.

Missouri Consolidated Health Care Plan	**TPA**
By: _____	By: _____
Title: Executive Director	Title: _____
Date: _____	Date: _____

EXHIBIT A-11
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") between the Missouri Consolidated Health Care Plan (hereinafter "Covered Entity" or "MCHCP") and TPA. (hereinafter "Business Associate") is entered into as a result of the business relationship between the parties in connection with services requested and performed in accordance with the MCHCP's 2020 Health Plan ("RFP") and under Contract *#XXX-XXXX*, as renewed and amended, (hereinafter the "Contract").

This Agreement supersedes all other agreements, including any previous business associate agreements, between the parties with respect to the specific matters addressed herein. In the event the terms of this Agreement are contrary to or inconsistent with any provisions of the Contract or any other agreements between the parties, this Agreement shall prevail, subject in all respects to the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"), and the HIPAA Rules, as defined in Section 2.1 below.

1 **Purpose**.

The Contract is for third party administrative services for MCHCP's self-funded employee benefit plans for State and Public Entity members.

The purpose of this Agreement is to comply with requirements of the Act and the implementing regulations enacted under the Act, 45 CFR Parts 160 - 164, as amended, to the extent such laws relate to the obligations of business associates, and to the extent such laws relate to obligations of MCHCP in connection with services performed by TPA for or on behalf of MCHCP under the Contract. This Agreement is required to allow the parties to lawfully perform their respective duties and maintain the business relationship described in the Contract.

2 **Definitions**.

2.1 For purposes of this Agreement:

"Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to this Agreement, shall mean TPA.

"Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to this Agreement, shall mean MCHCP.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules set forth in 45 CFR Parts 160 and 164, as amended.

2.2 Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules, including but not limited to: breach; data aggregation; designated record set; disclose or disclosure; electronic media; electronic protected health information ("ePHI"); family member; genetic information; health care; health information; health care operations; individual; individually identifiable health information; marketing; minimum necessary; notice of privacy practices; person; protected health information ("PHI"); required by law;

Secretary; security incident; standard; subcontractor; transaction; unsecured PHI; use; violation or violate; and workforce.

2.3 To the extent a term is defined in the Contract and this Agreement, the definition in this Agreement, subject in all material respects to the HIPAA Rules, shall govern.

2.4 Notwithstanding the forgoing, for ease of reference throughout this Agreement, Business Associate understands and agrees that wherever PHI is referenced in this Agreement, it shall be deemed to include all MCHCP-related PHI in any format or media including paper, recordings, electronic media, emails, and all forms of MCHCP-related ePHI in any data state, be it data in motion, data at rest, data in use, or otherwise.

3 **Obligations and Activities of Business Associate**.

3.1 Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as required by law.

3.2 Appropriate Safeguards. Business Associate agrees to implement, maintain, and use appropriate administrative, physical, and technical safeguards, and fully comply with all applicable standards, implementation specifications, and requirements of Subpart C of 45 CFR Part 164 with respect to ePHI, in order to: (i) ensure the confidentiality, integrity, and availability of ePHI created, received, maintained, or transmitted; (ii) protect against any reasonably anticipated threats or hazards to the security or integrity of such information; and (iii) protect against use or disclosure of ePHI by Business Associate, its workforce, and its subcontractors other than as provided for by this Agreement.

3.3 Subcontractors. Pursuant to §§ 164.308(b)(2) and 164.502(e)(1)(ii), Business Associate agrees it will not permit any subcontractors to create, receive, access, use, maintain, disclose, or transmit PHI in connection with, on behalf of, or under the direction of Business Associate in connection with performing its duties and obligations under the Contract unless and until Business Associate obtains satisfactory assurances in the form of a written contract or written agreement in accordance with §§ 164.504(e) and 164.314(a)(2) that the subcontractor(s) will appropriately safeguard PHI and in all respects comply with the same restrictions, conditions, and requirements applicable to Business Associate under the HIPAA Rules and this Agreement with respect to such information.

In addition to the forgoing, and in accordance with the Contract, Business Associate agrees it will not permit any subcontractor, or use any off-shore entity, to perform services under the Contract, including creation, use, storage, or transmission of PHI at any location(s) outside of the United States.

3.4 Reports to MCHCP. Business Associate agrees to report any use or disclosure of PHI not authorized or provided for by this Agreement, including breaches of unsecured PHI and any security incident involving MCHCP to MCHCP in accordance with the notice provisions prescribed in this Section 3.4. For purposes of the security incident reporting requirement, the term “security incident” shall not include inconsequential incidents that occur on a daily basis, such as scans, “pings,” or other unsuccessful attempts to penetrate computer networks or servers containing ePHI maintained or transmitted by Business Associate.

3.4.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of Business Associate's first discovery, as discovery is described under § 164.410, of the unauthorized use or disclosure, breach of unsecured PHI, or security incident.

3.4.2 The notice shall be in writing and sent to both of the following MCHCP workforce members and deemed delivered only upon personal confirmation, acknowledgement or receipt in any form, verbal or written, from one of the designated recipients:

- MCHCP's Privacy Officer → currently, Jennifer Stilabower, (573) 522-3242, Jennifer.Stilabower@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

- MCHCP's Security Officer → currently, Bruce Lowe, (573) 526-3114, Bruce.Lowe@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

If, and only if, Business Associate receives an email or voicemail response indicating neither of the intended MCHCP recipients are available and no designee(s) confirm receipt within eight (8) business hours on behalf of one or both of the above-named MCHCP Officers, Business Associate shall forward the written notice to their primary MCHCP contact with copies to the Privacy and Security Officers for documentation purposes.

3.4.3 The notice shall include to the fullest extent possible:

a) a detailed description of what happened, including the date, time, and all facts and circumstances surrounding the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

b) the date, time, and circumstances surrounding when and how Business Associate first became aware of the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

c) identification of each individual whose PHI has been, or is reasonably believed by Business Associate to have been involved or otherwise subject to possible breach;

d) a description of all types of PHI known or potentially believed to be involved or affected;

e) identification of any and all unauthorized person(s) who had access to or used the PHI or to whom an unauthorized disclosure was made;

f) all decisions and steps Business Associate has taken to date to investigate, assess risk, and mitigate harm to MCHCP and all potentially affected individuals;

g) contact information, including name, position or title, phone number, email address, and physical work location of the individual(s) designated by Business Associate to act as MCHCP's primary contact for purposes of the notice triggering event(s);

h) all corrective action steps Business Associate has taken or shall take to prevent future similar uses, disclosures, breaches, or incidents;

i) if all investigatory, assessment, mitigation, or corrective action steps are not complete as of the date of the notice, Business Associate's best estimated timeframes for completing each planned but unfinished action step; and

j) any action steps Business Associate believes affected or potentially affected individuals should take to protect themselves from potential harm resulting from the matter.

3.4.4 Business Associate agrees to cooperate with MCHCP during the course of Business Associate's investigation and risk assessment and to promptly and regularly update MCHCP in writing as supplemental information becomes available relating to any of the items addressed in the notice.

3.4.5 Business Associate further agrees to provide additional information upon and as reasonably requested by MCHCP; and to take any additional steps MCHCP reasonably deems necessary or advisable to comply with MCHCP's obligations as a covered entity under the HIPAA Rules.

3.4.6 Business Associate expressly acknowledges the presumption of breach with respect to any unauthorized acquisition, access, use, or disclosure of PHI, unless Business Associate is able to demonstrate otherwise in accordance with § 164.402(2), in which case, Business Associate agrees to fully document its assessment and all factors considered and provide MCHCP no later than ten (10) calendar days following Business Associate's discovery with its complete written risk assessment, conclusion reached, and all documentation supporting a conclusion that the unauthorized acquisition, access, use, or disclosure of PHI presents a low probability that PHI has been compromised.

3.4.7 The parties agree to work together in good faith, making every reasonable effort to reach consensus regarding whether a particular circumstance constitutes a breach or otherwise warrants notification, publication, or reporting to any affected individual, government body, or the public and also the appropriate means and content of any notification, publication, or report. Notwithstanding the foregoing, all final decisions involving questions of breach of PHI shall be made by MCHCP, including whether a breach has occurred, and any notification, publication, or public reporting required or reasonably advisable under the HIPAA Rules and MCHCP's Notice of Privacy Practices based on all objective and verifiable information provided to MCHCP by Business Associate under this Section 3.4

3.4.8 Business Associate agrees to bear all reasonable and actual costs associated with any notifications, publications, or public reports relating to breaches by Business Associate, any subcontractor of Business Associate, and any employee or workforce member of Business Associate and/or its subcontractors, as MCHCP deems necessary or advisable.

3.5 Confidential Communications. Business Associate agrees it will promptly implement and honor individual requests to receive PHI by alternative means or at an alternative location provided such

request has been directed to and approved by MCHCP in accordance with § 164.522(b) applicable to covered entities. If Business Associate receives a request for confidential communications directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can assess, accommodate, and coordinate reasonable requests of this nature in accordance with the HIPAA Rules and prepare a timely response to the individual.

3.6 Individual Access to PHI. If an individual requests access to PHI under § 164.524, Business Associate agrees it will make all PHI about the individual which Business Associate created or received for or from MCHCP that is in Business Associate's custody or control available in a designated record set to MCHCP or, at MCHCP's direction, to the requesting individual or his or her authorized designee, in order to satisfy MCHCP's obligations as follows:

3.6.1 If Business Associate receives a request for individual PHI in a designated record set from MCHCP, Business Associate will provide the requested information to MCHCP within five (5) business days from the date of the request in a readily accessible and readable form and manner or as otherwise reasonably specified in the request.

3.6.2 If Business Associate receives a request for PHI in a designated record set directly from an individual current or former MCHCP member, Business Associate will require that the request be made in writing and will also promptly notify MCHCP that a request has been made verbally. If the individual submits a written request for PHI in a designated record set directly to Business Associate, no later than five (5) business days thereafter, Business Associate shall provide MCHCP with: (i) a copy of the individual's request to MCHCP for purposes of determining an appropriate response to the request; (ii) the designated record sets in Business Associate's custody or control that are subject to access by the requesting individual(s) requested in the form and format requested by the individual if it is readily producible in such form and format, or if not, in a readable hard copy form; and (iii) the titles of the persons or offices responsible for receiving and processing requests for access by individual(s). MCHCP will direct Business Associate in writing within five (5) business days following receipt of the information described in (i), (ii), and (iii) of this subsection 3.6.2 whether Business Associate should send the requested designated data set directly to the individual or whether MCHCP will forward the information received from Business Associate as part of a coordinated response or if for any reason MCHCP deems the response should be sent from MCHCP or another Business Associate acting on behalf of MCHCP. If Business Associate is directed by MCHCP to respond directly to the individual, Business Associate agrees to provide the designated record set requested in the form and format requested by the individual if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by Business Associate and the individual. Business Associate will provide MCHCP's Privacy Officer with a copy of all responses sent to individuals pursuant to § 164.524 and the directives set forth in this subsection 3.6.2 for MCHCP's compliance and documentation purposes.

3.7 Amendments of PHI. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by MCHCP pursuant to § 164.526, and take other measures as necessary and reasonably requested by MCHCP to satisfy MCHCP's obligations under § 164.526.

3.7.1 If Business Associate receives a request directly from an individual to amend PHI created by Business Associate, received from MCHCP, or otherwise within the custody or control of Business Associate at the time of the request, Business Associate shall promptly refer the individual to MCHCP's Privacy Officer, and, if the request is in writing, shall forward the individual's request three (3) business days to MCHCP's Privacy Officer so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.7.2 MCHCP will direct Business Associate in writing as to any actions Business Associate is required to take with regard to amending records of individuals who exercise their right to amend PHI under the HIPAA Rules. Business Associate agrees to follow the direction of MCHCP regarding such amendments and to provide written confirmation of such action within seven (7) business days of receipt of MCHCP's written direction or sooner if such earlier action is required to enable MCHCP to comply with the deadlines established by the HIPAA Rules.

3.8 PHI Disclosure Accounting. Business Associate agrees to document, maintain, and make available to MCHCP within seven (7) calendar days of a request from MCHCP for all disclosures made by or under the control of Business Associate or its subcontractors that are subject to accounting, including all information required, under § 164.528 to satisfy MCHCP's obligations regarding accounting of disclosures of PHI.

3.8.1 If Business Associate receives a request for accounting directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.8.2 In addition to the provisions of 3.8.1, all PHI accounting requests received by Business Associate directly from the individual shall be acted upon by Business Associate as a request from MCHCP for purposes of Business Associate's obligations under this section. Unless directed by MCHCP to respond directly to the individual, Business Associate shall provide all accounting information subject to disclosure under § 164.528 to MCHCP within seven (7) calendar days of the individual's request for accounting.

3.9 Privacy of PHI. Business Associate agrees to fully comply with all provisions of Subpart E of 45 CFR Part 164 that apply to MCHCP to the extent Business Associate has agreed or assumed responsibilities under the Contract or this Agreement to carry out one or more of MCHCP's obligation(s) under 45 CFR Part 164 Subpart E.

3.10 Internal Practices, Books, and Records. Upon request of MCHCP or the Secretary, Business Associate will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of MCHCP available to MCHCP and/or the Secretary in a time and manner designated by MCHCP or the Secretary for purposes of determining MCHCP's and/or Business Associate's compliance with the HIPAA Rules.

4 **Permitted Uses and Disclosures of PHI by Business Associate**.

4.1 Contractual Authorization. Business Associate may access, create, use, and disclose PHI as necessary to perform its duties and obligations required by the Contract, including but not limited to specific requirements set forth in the Scope of Work (as such term is defined in the Contract), as amended. Without limiting the foregoing general authorization, MCHCP specifically authorizes Business Associate to access, create, receive, use, and disclose all PHI which is required to provide the services specified in the Contract. The parties agree that no provision of the Contract permits Business Associate to use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if used or disclosed in like manner by MCHCP except that:

4.1.1 This Agreement permits Business Associate to use PHI received in its capacity as a business associate of MCHCP, if necessary: (A) for the proper management and administration of Business Associate; or (B) to carry out the legal responsibilities of Business Associate.

4.1.2 This Agreement permits Business Associate to combine PHI created or received on behalf of MCHCP as authorized in this Agreement with PHI lawfully created or received by Business Associate in its capacity as a business associate of other covered entities to permit data analysis relating to the health care operations of MCHCP and other PHI contributing covered entities in order to provide MCHCP with such comprehensive, aggregate summary reports as specifically required by, or specially requested under, the Contract.

4.2 Authorization by Law. Business Associate may use or disclose PHI as permitted or required by law.

4.3 Minimum Necessary. Notwithstanding any other provision in the Contract or this Agreement, with respect to any and all uses and disclosures permitted, Business Associate agrees to request, create, access, use, disclose, and transmit PHI involving MCHCP members subject to the following minimum necessary requirements:

4.3.1 When requesting or using PHI received from MCHCP, a member of MCHCP, or an authorized party or entity working on behalf of MCHCP, Business Associate shall make reasonable efforts to limit all requests and uses of PHI to the minimum necessary to accomplish the intended purpose of the request or use. Business Associate agrees its reasonable efforts will include identifying those persons or classes of persons, as appropriate, in Business Associate's workforce who need access to MCHCP member PHI to carry out their duties under the Contract. Business Associate further agrees to identify the minimally necessary amount of PHI needed by each such person or class and any conditions appropriate to restrict access in accordance with such assessment.

4.3.2 For any type of authorized disclosure of PHI that Business Associate makes on a routine basis to third parties, Business Associate shall implement procedures that limit the PHI disclosed to the amount minimally necessary to achieve the purpose of the disclosure. For all other authorized but non-routine disclosures, Business Associate shall develop and follow criteria for reviewing requests and limiting disclosures to the information minimally necessary to accomplish the purposes for which disclosure is sought.

4.3.3 Business Associate may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose if and when:

a) Making disclosures to public officials as permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s); or

b) The information is requested by a professional who is a member of its workforce or is a business associate of MCHCP for the purpose of providing professional services to MCHCP, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).

4.3.4 Minimum necessary does not apply to: uses or disclosures made to the individual; uses or disclosures made pursuant to a HIPAA-compliant authorization; disclosures made to the Secretary in accordance with the HIPAA Rules: disclosures specifically permitted or required under, and made in accordance with, the HIPAA Rules.

5 **Obligations of MCHCP**.

5.1 Notice of Privacy Practices. MCHCP shall notify Business Associate of any limitation(s) that may affect Business Associate's use or disclosure of PHI by providing Business Associate with MCHCP's Notice of Privacy Practices in accordance with § 164.520, the most recent copy of which is attached to this Agreement.

5.2 Individual Authorization Changes. MCHCP shall notify Business Associate in writing of any changes in, or revocation of, the authorization by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 Confidential Communications. MCHCP shall notify Business Associate in writing of individual requests approved by MCHCP in accordance with § 164.522 to receive communications of PHI from Business Associate by alternate means or at alternative locations, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.4 Individual Restrictions. MCHCP shall notify Business Associate in writing of any restriction to the use or disclosure of PHI that MCHCP has agreed and, if applicable, any subsequent revocation or termination of such restriction, in accordance with § 164.522, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.5 Permissible Requests by MCHCP. MCHCP shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by MCHCP.

6 **Term and Termination, Expiration, or Cancellation**.

6.1 Term. This Agreement is effective upon signature of both parties, and shall terminate upon the termination, expiration, or cancellation of the Contract, as amended, unless sooner terminated for cause under subsection 6.2 below.

6.2 Termination. Without limiting MCHCP's right to terminate the Contract in accordance with the terms therein, Business Associate also authorizes MCHCP to terminate this Agreement immediately by written notice and without penalty if MCHCP determines, in its sole discretion, that Business Associate has violated a material term of this Agreement and termination of this Agreement is in the best interests of MCHCP or its members. Without limiting the foregoing authorization, Business Associate agrees that MCHCP may, as an alternative or in addition to termination, require Business Associate to end the violation of the material term(s) and cure the breach of contract within the time and manner specified by MCHCP based on the circumstances presented. With respect to this subsection, MCHCP's remedies under this Agreement and the Contract are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

6.3 Obligations of Business Associate Upon Termination. Upon termination, expiration, or cancellation of this Agreement for any reason, Business Associate agrees to return to MCHCP or deliver to another MCHCP business associate at MCHCP's direction all PHI received from MCHCP, any current or former Business Associate or workforce member of MCHCP, or any current or former member of MCHCP, as well as all PHI created, compiled, stored or accessible to Business Associate or any subcontractor, agent, affiliate, or workforce member of Business Associate, relating to MCHCP as a result of services provided under the Contract. All such PHI shall be securely transmitted in accordance with MCHCP's written directive in electronic format accessible and decipherable by the MCHCP designated recipient. Following confirmation of receipt and usable access of the transmitted PHI by the MCHCP designated recipient, Business Associate shall destroy all MCHCP-related PHI and thereafter retain no copies in any form for any purpose whatsoever. Within seven (7) business days following full compliance with the requirements of this subsection, an authorized representative of Business Associate shall certify in writing addressed to MCHCP's Privacy and Security Officers that Business Associate has fully complied with this subsection and has no possession, control, or access, directly or indirectly, to MCHCP-related PHI from any source whatsoever.

Notwithstanding the foregoing, Business Associate may maintain MCHCP-PHI after the termination of this Agreement to the extent return or destruction of the PHI is not feasible, provided Business Associate: (i) refrains from any further use or disclosure of the PHI; (ii) continues to safeguard the PHI thereafter in accordance with the terms of this Agreement; (iii) does not attempt to de-identify the PHI without MCHCP's prior written consent; and (iv) within seven (7) days following full compliance of the requirements of this subsection, provides MCHCP written notice describing all PHI maintained by Business Associate and certification by an authorized representative of Business Associate of its agreement to fully comply with the provisions of this paragraph.

6.4 Survival. All obligations and representations of Business Associate under this Section 6 and subsection 7.2 shall survive termination, expiration, or cancellation of the Contract and this Agreement.

7 **Miscellaneous**.

7.1 Satisfactory Assurance. Business Associate expressly acknowledges and represents that execution of this Agreement is intended to, and does, constitute satisfactory assurance to MCHCP of Business Associate's full and complete compliance with its obligations under the HIPAA Rules. Business Associate further acknowledges that MCHCP is relying on this assurance in permitting Business Associate to create, receive, maintain, use, disclose, or transmit PHI as described herein.

7.2 Indemnification. Each party shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless the other party and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of such party or any subcontractor, consultant, or workforce member of such party to the extent such acts or omissions violate the terms of this Agreement or the HIPAA Rules as applied to the Contract.

Notwithstanding the foregoing, if Business Associate maintains any MCHCP-related PHI following termination of the Contract and this Agreement pursuant to subsection 6.3, Business Associate shall be solely responsible for all PHI it maintains and, to the fullest extent permitted by law, Business Associate shall protect, defend, indemnify and hold harmless MCHCP and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of Business Associate or any subcontractor, consultant, or workforce member of Business Associate regarding such PHI to the extent such acts or omissions violate the terms of the Act or the HIPAA Rules.

7.3 No Third Party Beneficiaries. There is no intent by either party to create or establish third party beneficiary status or rights or their equivalent in any person or entity, other than the parties hereto, that may be affected by the operation of this Agreement, and no person or entity, other than the parties, shall have the right to enforce any right, claim, or benefit created or established under this Agreement.

7.4 Amendment. The parties agree to work together in good faith to amend this Agreement from time to time as is necessary or advisable for compliance with the requirements of the HIPAA Rules. Notwithstanding the foregoing, this Agreement shall be deemed amended automatically to the extent any provisions of the Act or the HIPAA Rules not addressed herein become applicable to Business Associate during the term of this Agreement pursuant to and in accordance with any subsequent modification(s) or official and binding legal clarification(s), to the Act or the HIPAA Rules.

7.5 Interpretation. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, THAT OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND THAT UPON BOTH OF OUR SIGNATURES BELOW THIS SHALL BE A BINDING AGREEMENT TO THE FOREGOING TERMS AND CONDITIONS OF THIS BUSINESS ASSOCIATE AGREEMENT.

Missouri Consolidated Health Care Plan	**Printing Company**
By: _____	By: _____
Title: Executive Director	Title: _____
Date: _____	Date: _____

Health Plan RFP Questionnaire

MCHCP requires that you provide concise responses to questions requiring explanation. Please note there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of the questionnaire.

Proprietary Statement

1.1 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 bid file material for review by appointment. Regardless of any claim by the bidder as to material being proprietary and not subject to copying or distribution, all material submitted by the bidder in conjunction with this 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). Neither MCHCP nor its consultant shall be obligated to return any materials submitted in response to this RFP. The use of MCHCP's name in any way is strictly prohibited. Confirm your agreement with the Confidentiality and Public Record Policy listed above.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

Vendor Profile

2.1 Provide the following information about your company:

Full and legal company name	
Name of parent organization (if applicable)	
Describe your company structure including subsidiaries and affiliates	
Corporate address	
Telephone	

2.2 Provide a brief history of your company, including a summary of your status with respect to any past, current, or prospective mergers and acquisitions.

Response _____

2.3 Describe your strategy towards growth and any immediate plans for expansion nationally, regionally and in Missouri.

Nationally	
Regionally	
Missouri	

2.4 How many employer groups does your organization service for Medical Benefits Administration?

Number of groups of 75,000 employees or more	
Number of groups of 60,001-75,000 employees	
Number of groups of 45,001-60,000 employees	
Number of groups of 30,001-45,000 employees	
Number of groups of 15,001-30,000 employees	
Number of groups less than 15,000 employees	

2.5 How many members does your organization service for Medical Benefits Administration?

Number of current members	
Number of new members last year	

Number of new members year to date

2.6 Provide references for three current clients (excluding MCHCP). If possible use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is critical.

	Name or industry	Services provided by your organization	Number of covered employees	Number of years working with your organization
Current Client #1				
Current Client #2				
Current Client #3				

2.7 Provide references for two clients who have terminated your services. If possible use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is critical.

	Name or industry	Services received by your organization	Number of covered employees	Number of years working with your organization	Reason for termination of relationship
Terminated Client #1					
Terminated Client #2					

2.8 Is there any significant litigation and/or government action pending against your company, or has there been any action taken or proposed against your company within the last five (5) years?

○ Yes (describe the situation prompting the suit(s) and the outcome or current status)

○ No

2.9 Identify your company's General Liability and Errors & Omissions insurer protecting your clients. Describe the type and limits of each coverage.

	Name of Insurance Carrier	Type of Coverage	Coverage Amount	Pertinent Exclusions
Insurer				
Insurer (2nd)				

2.10 Confirm you have uploaded a document to the Reference Files from Vendor section describing the insurance in force that your firm has made to cover any errors and omissions claims that may arise in connection with services on behalf of a client. Who is the carrier or what is the funding mechanism? What are the policy limits? Are all of your subcontractors and/or joint venture companies bound by such coverage? Name the file "Q2.10 E&O Insurance".

○ Document has been uploaded (list carrier name, funding mechanism, and policy limits, and describe whether subcontractors are bound by coverage)

○ Not provided (please explain)

2.11 Provide the following information for all subcontractors that will be used to fulfill the requirements of this contract:

	Company Name	Service Provided	Number of years working with your organization
Subcontractor #1			
Subcontractor #2			

Subcontractor #3			
Subcontractor #4			
Subcontractor #5			

2.12 Describe the economic advantages that will be realized as a result of your organization performing the required services by providing responses to each item below. If necessary to provide a full description, upload a document to the Reference Files from Vendor section, and name the file "Q2.12 Economic Impact".

Provide a description of the proposed services that will be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.

Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.

Provide a description of the company's economic presence within the State of Missouri (e.g. type of facilities: sales offices; sales outlets; divisions; manufacturing; warehouse; other), including Missouri employee statistics.

2.13 Confirm you have uploaded two years of your organization's audited financial statements to the Reference Files from Vendor section. Name the file "Q2.13 Audited Financial Statements".

- ○ Confirmed
- ○ Not confirmed (please explain)

2.14 Provide a brief summary of financial data and ratings for your organization.

	Current Rating	Date of Rating (MM/YYYY)	Financial Data Summary
A.M. Best			
S&P			
Duff and Phelps			
Moody's			

2.15 Provide the following information regarding any SSAE 18 standards you maintain:

Has your organization conducted a SSAE 18 audit?

What is your current SSAE 18 status?

When was your organization's last SSAE audit conducted (MM/YYYY)?

What is the frequency of your SSAE 18 audits?

Are you willing to provide a copy if awarded the contract?

2.16 Confirm you have uploaded a document to the Reference files from Vendor section confirming appropriate licensure/certification by the State of Missouri. Name the document "Q2.16 State of Missouri License".

- ○ Confirmed
- ○ Not confirmed (please explain)

Account Management and Implementation

3.1 Complete the following table regarding the team that would be compiled for MCHCP.

	Name	Role for MCHCP	Brief work experience bio	Number of years at your organization	Number of years in	Number of current accounts in	Maximum number of accounts

					their current role	this same role	
Strategic Account Executive							
Account Manager							
Clinical Resource							
Implementation Coordinator							
Claims Coordinator							
IT Resource							
Member Services							

3.2 Describe the consultative services your account team will provide to MCHCP.

Response

3.3 Confirm you have uploaded an organizational chart for the proposed account team, showing lines of authority up to and including the executive management level. Upload the file to the Reference Files from Vendor section, and name the document "Q3.3 Organizational Chart". Include all functions such as claims, member services, billing, location, etc.

- ○ Confirmed
- ○ Not confirmed (please explain)

3.4 Confirm you have uploaded a detailed implementation plan that assumes a January 1, 2020 implementation date. Upload the file to the Reference Files from Vendor section, and name the document "Q3.4 Implementation Plan". The plan must include a list of specific implementation tasks/transition protocols and a timetable for initiation and completion of such tasks.

- ○ Confirmed
- ○ Not confirmed (please explain)

3.5 What services and support are provided and what information is needed from MCHCP in order to expedite implementation? Be specific.

Response

Member Services and Plan Administration

4.1 Provide the following information about your Member Services Department(s).

Location(s)

Days and hours of operation including observed holidays

Number of member services representatives (MSR) assigned to MCHCP account

Number of other clients assigned MSRs are responsible for (average # per rep)

Experience level of staff (average # of yrs)

4.2 How can members access MSRs? What is your book of business percentage of members that utilize each method?

	Available (Yes/No)	Percent of members utilizing (X.XX)
Phone (Voice)		%
Secure email		%
Browser-based chat service		%
Smartphone-based text messaging		%
Written correspondence		%
Other (please describe)		%

4.3 Describe the structure of the member service team. Note preference is given to those organizations offering a designated team with some dedicated MSRs.

Response

4.4 Confirm that your MSRs will be trained and the toll-free line will be operational by October 1, 2019 for annual enrollment calls.

- ○ Confirmed, at no additional cost
- ○ Confirmed, at an additional cost (include cost in Supplemental Pricing)
- ○ Not confirmed (please explain)

4.5 What services are available to accommodate special populations, including non-English speaking, hearing and vision impaired, and the elderly? Please include the ability to translate member materials in either a non-English language or Braille if requested by a member.

Response

4.6 What features are available to the member via your website (check all that apply)?

- ☐ Provider directory
- ☐ Cost transparency tools
- ☐ Verify eligibility
- ☐ Print temporary ID card
- ☐ Check claim status
- ☐ Request ID card
- ☐ Review benefits and plan design
- ☐ Review Explanation of Benefits
- ☐ Check status of deductibles, maximums, or limits
- ☐ Research specific medical conditions or health information
- ☐ Research treatment descriptions
- ☐ Ask a plan nurse health questions via secure email
- ☐ Obtain a history of medical claims
- ☐ Map provider locations
- ☐ Other (please explain)

4.7 Are all calls documented and/or recorded?

	Yes (please describe, including length of time documentation/recording is retained)	No
Documented	○	○
Recorded	○	○

4.8 How are overflow calls handled during busy call times (check all that apply)?

- ☐ Calls transferred to another call center
- ☐ Voice mail
- ☐ IVR
- ☐ Other (please explain)

4.9 Provide the following statistics for the member services office to be used by MCHCP:

	2018	2019 YTD
Ratio of representatives to 1,000 members		
Blockage rate (percentage)		
Abandonment rate (percentage)		
Average speed to answer (in seconds)		
Average turnover rate (percentage)		
First call resolution rate (percentage)		

4.10 Describe any creative/innovative approaches to ensure the highest levels of member service.

Response

4.11 Confirm that you have uploaded results from your most recent member satisfaction survey. Upload the file to the Reference Files from Vendor section, and name the file "Q4.11 Satisfaction Survey Results".

- ○ Confirmed
- ○ Not confirmed (please explain)

4.12 Can ID cards be customized for MCHCP?

- ○ Yes, at no additional cost
- ○ Yes, at an additional cost (please specify cost on Supplemental Pricing)
- ○ No (please explain)

4.13 Confirm you have uploaded samples of the communications materials included in your financial proposal that you use to communicate with members. Sample materials must be uploaded to the Reference Files from Vendor section, and named "Q4.13 Member Communications".

- ○ Confirmed
- ○ Not confirmed (please explain)

Technology and Security

5.1 When was the last system/platform upgrade or migrations for each of the following systems? If an upgrade is planned within the next 24 months for any of the systems listed, provide the projected date.

Customer Relation Management (CRM) (MM/YYYY)

Eligibility (MM/YYYY)

Claims (MM/YYYY)

Financial reporting (MM/YYYY)

Other (please describe)

5.2 Will MCHCP have access to update member eligibility information online?

- ○ Yes, at no additional cost
- ○ Yes, at an additional cost (include the cost in Supplemental Pricingl)
- ○ No (please explain)

5.3 What practices do you have in place to protect the confidentiality of individual information when electronically storing and/or transferring information?

Response

5.4 Describe the HIPAA-compliant security measures you have in place.

Response

5.5 Describe your process for addressing security breaches.

Response

5.6 Have you ever experienced a security breach involving PHI?

- ○ Yes (provide details on when the breach occurred, actions taken and corrections implemented)
- ○ No

5.7 Do you adhere to the latest approved accessibility guidelines developed by the Web Accessibility Initiative of World Wide Web Consortium (W3C)?

- Yes (please describe)
- No (please explain)

5.8 Do you support modern browsers/browser versions that support HTML5 and advanced security?

- ○ Yes (please describe)
- ○ No (please explain)

5.9 Are mobile apps available for use by your membership?

- ○ Yes (please describe)
- ○ No (please explain)

5.10 Confirm your email service supports TLS (1.1 or higher) for secure email with MCHCP staff.

- ○ Confirmed (please describe, including which version)
- ○ Not confirmed (please explain)

5.11 Describe your organization's IT infrastructure and development platform.

Response

5.12 Confirm you have uploaded metrics that demonstrate the reliability of your IT systems. Upload the file to the Reference Files from Vendor section, and name the file "Q5.12 Reliability Metrics".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.13 Does your web portal support single sign-on utilizing Security Assertion Markup Language (SAML)? If not, do you support single sign-on utilizing another standard? If so, please name the standard you support.

- ○ Support single sign-on using SAML
- ○ Support single sign-on using different standard (please list)
- ○ Do not support single sign-on (please explain)

5.14 Confirm you have uploaded an executive summary of your disaster recovery and business continuity plan in the Reference Files from Vendor section, and named the document "Q5.14 Disaster Recovery Plan".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.15 Confirm you have uploaded a copy of the summary findings for your most recent testing exercise of your disaster recovery and business continuity plan. Upload the document to the Reference Files from Vendor section, and name the file "Q5.15 Disaster Recovery Plan Testing".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.16 What assurances can you provide that your cybersecurity program is adequately designed and operating effectively?

Response

5.17 Do you have a SOC cybersecurity examination or other independent examination performed? If so, are you willing to provide a copy of the report if awarded the contract?

- ○ Yes (please describe)
- ○ No (please explain)

5.18 Provide the following statistics for the most recent plan year that demonstrate level of member utilization and engagement with your online resources.

Web - unique visitors	
Mobile device app-based - unique downloads	
Registrations - percentage of total enrolled that have registered for web-based online resources	%
Web - average time spent (ATS) per visit (in minutes)	
Web bounce rate percentage - percentage of logins that results in the member getting logged out	%
Online account usage - percentage of total enrolled population who has used the online account two or three years after registering	%
Email addresses - percentage of emails obtained from the total enrolled population	%

Reporting

6.1 Does your organization currently provide data to a decision support system vendor (check all that apply)?

- ☐ IBM Watson Health
- ☐ Other decision support system vendor(s) (list other vendors)
- ☐ No

6.2 Describe your organization's ability to customize financial reports.

Response

6.3 Confirm you have uploaded copies of the standard customer service reports that will be made available to satisfy the requirements stated in Exhibit B, Section 5.3 to the Reference Files from Vendor section. Name the document "Q6.3 Customer Service Reports".

- ○ Confirmed
- ○ Not confirmed (explain)

6.4 Confirm you have provided samples of the standard (cost included in the ASO fee) reporting package (i.e., claims experience, network utilization, etc.). Upload the file to the Reference Files from Vendor section, and name the file "Q6.4 Sample Reporting Package".

- ○ Confirmed
- ○ Not confirmed (please explain)

6.5 Describe your capability to produce ad hoc reports at MCHCP's request, including average turnaround time, how such requests are typically handled and billed, and if you can send these reports via email in encrypted format.

Response

6.6 Do you have online ad hoc reporting tools for use by MCHCP?

- ○ Yes, at no additional cost (please provide the necessary credentials for the evaluation team to view the tool)
- ○ Yes, at an additional cost (please provide the necessary credentials, and include the additional cost in Supplemental Pricing)
- ○ No (please explain)

Claim Payment Services

7.1 Identify the location, hours of operation, and number of years in operation for the proposed claim center that will service the MCHCP account. List all locations if more than one location will service the MCHCP account.

Location(s)

Hours of operation

Number of years in operation

7.2 Will MCHCP have a dedicated team to process claims? If yes, please describe the structure of the dedicated team.

- ○ Yes (please describe)
- ○ No (please explain)

7.3 Do you report operating statistics on a client-specific basis? If not, please explain how statistics are reported and the basis for performance guarantees.

- ○ Yes
- ○ No (please explain)

7.4 Complete the following table based on statistics specific to the office that will be providing claim administration services to MCHCP:

	2017 (X.XX)	2018 (X.XX)
Financial Accuracy: Total dollar amount of claims paid correctly divided by total dollars paid in sample	%	%
Payment Accuracy: Total number of claims paid correctly divided by the total number of claims in sample	%	%
Overall Accuracy: Total number of claims processed correctly divided by total number of claims processed	%	%
Coding Accuracy: Total number of correct lines reviewed divided by the total number of lines of entry reviewed	%	%
Claim Turnaround Time: Measured from date claim received to date benefits are paid, a denial letter is sent or the claim is set aside pending additional information. Express as a % of claims processed within 10 business days of receipt.	%	%
Claim Turnaround Time: Measured from date claim received to date benefits are paid, a denial letter is sent or the claim is set aside pending additional information. Express as a % of claims processed within 15 business days of receipt.	%	%
Pend Ratio: % of claims received which get pended for additional information	%	%
Unforced Error Adjustments: % of claims requiring adjustment as a result of an unforced error	%	%
EDI: % of total claims received electronically; includes claims converted to electronic media by scanning, optical character recognition or intelligent character recognition	%	%
Auto-adjudication: % auto-adjudication	%	%

7.5 How often (e.g.daily, weekly, other) and from what office are electronic payments made, checks cut and Explanations of Benefits (EOBs) produced?

	Frequency	Office location
Electronic payments		
Checks		
EOBs		

7.6 What is the lag time between claim approval and payment?

Response

7.7 Confirm you have uploaded a sample of your EOB to the Reference Files from Vendor section. Name the file "Q7.7 Sample EOB".

- ○ Confirmed
- ○ Not confirmed (please explain)

7.8 Can MCHCP customize the EOB?

- ○ Yes, at no additional cost (please describe)
- ○ Yes, at an additional cost (please describe and include cost in Supplemental Pricing)
- ○ No (please explain)

7.9 Based on MCHCP's current plan designs, will all of its features (e.g., plan types, deductibles, coinsurance, copayments and benefit limitations) be automated? If not, which specific provisions will require manual intervention?

- ○ Yes
- ○ No (please explain)

7.10 Describe the capacity and limitations of the claims processing system to incorporate options to the bidder's normal course of business. Examples include but are not limited to MCHCP establishing its own list of preauthorized services, altering plan design from 2019 plan designs, establishing incentives in the form of waiving member cost sharing, or value-based designs based on diagnosis or other parameter.

Response

7.11 Should reference-based pricing be part of the offering, which procedures do you have adequate data to support this approach?

Response

7.12 Do you charge fees for reference-based pricing that are in addition to base ASO fees? If yes, please specify.

- ○ Yes (please describe and include additional cost in Supplemental Pricing)
- ○ No (please explain)

7.13 What is the medical claims processing system platform you have proposed for MCHCP? Why?

Response

7.14 Provide details on planned system enhancements and conversion in the next 36 months.

Response

7.15 How long are claims maintained on-line in full record format before being consolidated or moved to offline storage?

- ○ < 18 months
- ○ 18-24 months
- ○ 24-30 months
- ○ 30-36 months
- ○ > 36 months

7.16 What are your recovery procedures should duplicate payments or overpayments occur?

Response

7.17 Does your system maintain Coordination of Benefits (COB) information on claimants?

- ○ Yes (please describe)
- ○ No (please explain)

7.18 How frequently do you require updates to COB data?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ At point of claim
- ○ Other (please explain)

7.19 What percentage of claims per examiner is audited on a daily basis to ensure payment accuracy?

Percent %

7.20 What is the dollar amount threshold over which all claims are audited?

Dollar amount

7.21 Describe your internal audit procedures, including areas audited and frequency of audits.

Procedures

Areas audited

Frequency of audits

7.22 Does your company engage an independent auditor to evaluate internal controls?

- ○ Yes (please describe)
- ○ No (please explain)

7.23 When was the last audit? Describe the audit findings.

Enter date (MM/YYYY)

Audit Findings

Fraud and Abuse Management

8.1 MCHCP is committed to reducing member and provider fraud, waste, and abuse within the health plan. Please describe how your organization addresses this issue today, including any investments in technology to identify opportunities for improvement, root cause resolution, recovery to MCHCP, etc.

Response

8.2 Does your system have any edits that help currently identify inappropriate medical care or unnecessary medical treatment?

- ○ Yes (please describe)
- ○ No (please explain)

8.3 Describe the extent to which your claims system conforms to the National Correct Coding Initiative. Please indicate your reasoning for any variances.

Response

8.4 Confirm Fraud and Abuse Management is included in standard PEPM ASO fee.

- ○ Confirmed
- ○ Not confirmed (please explain)

8.5 Payment integrity is the process of ensuring that a healthcare claim is paid correctly by the responsible party, for eligible members, according to contractual terms. Payment integrity uses data mining and analytics to identify fraudulent, erroneous, duplicative or abusive claims. Please describe your approach to the following core areas, including; subrogation, COB/third-party liability, fraud, waste and abuse, error/clinical editing and administrative overpayment.

Subrogation

COB/third party liability

Fraud

Waste and abuse

Error/clinical editing

Administrative overpayment

8.6 For each payment integrity functional area (e.g., Subrogation, Fraud and Abuse, etc.), provide a description of specific metrics used to measure overall performance, productivity, claims identified prior to adjudication, and recovered amounts.

Subrogation
COB/third party liability
Fraud
Waste and abuse
Error/clinical editing
Administrative overpayment

Banking Arrangements

9.1 Confirm that you can support MCHCP's preferred banking arrangements.

- ○ Confirmed (please describe)
- ○ Not confirmed (please explain)

9.2 Provide a description of your preferred banking arrangement if different from MCHCP's arrangement. If necessary, upload a document to the Reference Files from Vendor section, and name the file "Q9.2 Preferred Banking Arrangement". MCHCP may not accommodate your preferred arrangement. Discuss the impact should MCHCP not deviate from its preferred banking arrangement.

Response

9.3 How are funds to be remitted:

- ○ EFT
- ○ ACH
- ○ Minimum balance
- ○ Other (please describe)

9.4 What is the timing on claim funding? MCHCP will not nest funds prior to claims settlement.

- ○ Daily
- ○ Multiple times per week
- ○ Weekly
- ○ Other (please describe)

9.5 What are the reconciliation services that are included in your standard fee?

Response

9.6 Are any alternative bank arrangements available? If so, briefly describe them.

Response

9.7 On what basis are banking reports produced?

- ○ Processed claims
- ○ Checks cleared
- ○ Checks issued
- ○ Other (please describe)

9.8 What type of financial reports will be generated in conjunction with the bank reconciliation and auditing procedures?

Response

9.9 What reconciliation services do you provide for banking reports compared to claim reports?

Response

9.10 Confirm you have uploaded samples of financial reports that will be generated in conjunction with the bank reconciliations and editing/auditing procedures. Reports to be provided must include copies of check register template or sign-on information for any online web portal where these reports can be viewed. Upload the reports to the Reference Files from Vendor section, and name the file "Q9.10 Banking Reports".

- ○ Confirmed
- ○ Not confirmed (please explain)

Customer Tools

10.1 Explain how you measure cost and quality for each of the following provider types:

	Cost	Quality
Primary care		
Specialists		
Facilities		
Other (please specify)		

10.2 How do members access the provider cost and quality information?

Response

10.3 Regarding health cost estimation or budgeting tools (i.e. transparency tools), describe in detail and identify any and all costs (including pre-implementation costs) associated with each. Also include any cost listed below in Supplemental Pricing.

	Tool offered	Identify any/all costs (also list in Supplemental Pricing)	Describe in detail
Plan design comparison			
Health cost estimation			
Budgeting tools			
Specific provider costs			
Market averages			

10.4 Is the cost and/or quality information available for network providers only or for all providers?

	Network	All providers
Cost	☐	☐
Quality	☐	☐

10.5 What percent of members used your transparency tools within the past 6 months?

- ○ Less than 5%

- ○ 5% to 24.9%
- ○ 25% to 49.9%
- ○ 50% to 74.9%
- ○ Greater than 75%
- ○ Not tracked

10.6 What is the source of your pricing and quality data, and how frequently is each data source updated?

Response

10.7 What geographies are included in the provider pricing and quality member self-service tool?

Response

10.8 Are all of your networks available through your provider pricing and quality tool?

- ○ Yes (please describe)
- ○ No (please explain)
- ○ Not applicable. No member self-service tool is currently available that displays provider cost and quality.

10.9 Are you able to incorporate pricing for client-specific provider contracting to support automatic adjudication?

- ○ Yes (please describe)
- ○ No (please explain)

10.10 Do you supplement your network pricing data with any other data sets? If yes, specify.

- ○ Yes (please describe)
- ○ No (please explain)

10.11 For what medical procedures/services do you provide cost data? Please include all that apply. If necessary to provide a complete response, upload a document to the Reference Files from Vendor section and name the file "Q10.11 Medical Procedures/Services".

Response

10.12 Is pricing based on CPT code or are you bundling in some other way?

Response

10.13 Do you incorporate episode of care pricing into your treatment cost tool?

- ○ Yes (please describe)
- ○ No (please explain)

10.14 Is your pricing the "actual projected price" for the member's health plan and employer, or is it more generic?

Response

10.15 Are you able to incorporate member-specific accumulators (cost-sharing and health account balances) into the pricing results?

- ○ Yes (please describe)

○ No (please explain)

10.16 Are there specific providers (or groups of providers) for whom you are contractually limited in sharing actual cost information with members? If so, please list the provider name, geographic market, and types of cost information that can and cannot be shared. Please describe efforts to have all of your network contracts permit the disclosure of cost data.

○ Yes (please describe)
○ No (please explain)

10.17 Are the same member services representatives available to help a member with general questions as well as price transparency?

○ Yes (please describe)
○ No (please explain)

10.18 Are you willing to let a client use their own transparency tool that uses your provider and pricing data? If yes, what is the charge for regular data feeds to keep the client's transparency tool up to date?

○ Yes (please describe and include additional cost in Supplemental Pricing)
○ No (please explain)

Benefits

11.1 Describe how new medical treatments and procedures are evaluated and recommended for coverage and how often reviews are completed. Who is involved in the evaluation process?

Response

11.2 Are you able to support MCHCP's list of covered services (22 CSR 10-2.055)?

○ Yes, with no exceptions
○ Yes, with exceptions (please describe)
○ No (please explain)

11.3 Are you able to support MCHCP's list of limitations and excluded services (22 CSR 10-2.060)?

○ Yes, with no exceptions
○ Yes, with exceptions (please describe)
○ No (please explain)

11.4 Are there recommendations you would make to MCHCP to modify its list of covered services?

○ Yes (please describe)
○ No

11.5 Are there recommendations you would make to MCHCP to modify its list of limitations and excluded services?

○ Yes (please describe)
○ No

Utilization Management

12.1 What does the Utilization Management (UM) program include? Check all that apply and provide a description.

- [ ] Dedicated MCHCP team
- [ ] Written utilization management criteria
- [ ] Criteria distributed to all network physicians
- [ ] Criteria published on internet
- [ ] Case management triggers
- [ ] Other (please explain)

12.2 Describe your medical management staffing model for UM.

Response

12.3 Describe your preauthorization program including who performs the medical review function.

Response

12.4 How are your preauthorization criteria developed?

Response

12.5 Describe how your organization utilizes physicians for case review. Be sure to include information on the following: number of physicians available for reviews, peer-to-peer, and frequency of reviews.

Description

Number of physicians available for review

Peer-to-peer (matches specialty of service being requested)

Frequency of reviews

Time to turnaround a standard review

Time to turnaround an urgent review

12.6 Confirm you have uploaded copies of standard quarterly UM reporting that would be made available to MCHCP at no additional cost. Standard reports must include program participation data, demographic information, and outreach rates. Upload the file to the Reference Files from Vendor section, and name the file "Q12.6 UM Quarterly Reporting".

- ○ Confirmed
- ○ Not confirmed (please explain)

12.7 Confirm you have uploaded copies of the standard member communications regarding the UM program that would be provided to MCHCP's members at no additional charge. Upload the file to the Reference Files from Vendor section, and name the file "Q12.7 UM Member Communications".

- ○ Confirmed
- ○ Not confirmed (please explain)

Care Management

13.1 What does the Care Management (CM) program include? Include whether MCHCP will have a dedicated team in your description.

Response

13.2 Describe your CM problem identification process, intervention process, including methods and success rates.

Response

13.3 What programs are offered through CM (e.g. large case management, maternity management, treatment decision support, Emergency Room frequent flyer management, etc.). Indicate any accreditation received and the accrediting body, if applicable.

	Name of program	Accreditation received (if applicable)	Accreditation body (if applicable)
Program 1			
Program 2			
Program 3			
Program 4			
Program 5			
Program 6			
Program 7			
Program 8			
Program 9			
Program 10			

13.4 Describe your medical management staffing model for CM including physician oversight.

Response

13.5 Is the CM program able to accept and integrate data from MCHCP's contracted PBM or other vendors?

- ○ Yes, at no additional cost (please describe)
- ○ Yes, at an additional cost (please describe, and list additional cost in Supplemental Pricing)
- ○ No (please explain)

13.6 How do you propose to transition MCHCP"s members with current CM cases?

Response

13.7 What is the average caseload (open cases) for short-term and long-term CM staffing?

Average number of cases for short-term case management

Average number of cases for long-term case management

13.8 What are the criteria for discharging a member from the CM program?

Response

13.9 Provide a description of the frequency and types of interactions you have with the member's primary care provider/treating provider once they have been enrolled in the CM program.

Describe types of interactions

Describe frequency of interactions

13.10 Provide a description of the frequency and types of interactions you have with a member once they have been enrolled in the CM program.

Describe types of interactions

Describe frequency of interactions

13.11 Provide the following information regarding your large case management (LCM) program:

Years of operaton

Staff qualifications

Percent of members managed under LCM (X.XX) %

Percent of admissions managed under LCM (X.XX) %

13.12 Describe the roles of the patient, patient's health care provider, and your CM staff in the LCM process.

Patient

Patient's health care provider

Case management staff

13.13 Confirm you have uploaded copies of standard quarterly CM reporting that would be made available to MCHCP at no additional cost. Standard reports must include program participation data, demographic information, and outreach rates. Upload the file to the Reference Files from Vendor section, and name the file "Q13.13 CM Quarterly Reporting".

- ○ Confirmed
- ○ Not confirmed (please explain)

13.14 Confirm you have uploaded copies of the standard member communications regarding the CM program that would be provided to MCHCP's members at no additional charge. Upload the file to the Reference Files from Vendor section, and name the file "Q13.14 CM Member Communications".

- ○ Confirmed
- ○ Not confirmed (please explain)

National Provider Network

14.1 Are you able to offer a broad national network and narrow/high performance networks to be offered to members as a choice?

- ○ Yes (please describe)
- ○ No (please explain)

14.2 Describe your broad national network offering. Include a discussion about the discounts generally available. Where is the network available and not available?

Response

14.3 What Missouri hospital systems are included in your broad national network?

Response

14.4 Do you supplement your proprietary provider network through third-party network management companies? If so, who are your preferred network vendors? Please list all of the vendors and locations.

- ○ Yes (list preferred network vendors and locations)
- ○ No (please explain)

14.5 Confirm you have uploaded a provider network file(s) to the Reference Files from Vendor section in the format provided in Attachment 3. Name the files "Q14.5 Provider Network - Broad".

- ○ Confirmed
- ○ Not confirmed (explain)

14.6 Confirm you have uploaded to the Reference Files from Vendor section a list of hospitals and health care facilities under contract in each of your broad network for each county in Missouri. Name the file "Q14.6 Hospital Network - Broad".

- ○ Confirmed
- ○ Not confirmed (please explain)

14.7 What is your process for providing notification to MCHCP and its members regarding provider additions, terminations or insolvencies?

Response

14.8 What is your process for assessing network adequacy? What standards do you utilize?

Response

14.9 Do you offer specialty networks (mental health, musculoskeletal, transplant, bariatric, chiropractic, etc)?

- ○ Yes (please describe all)
- ○ No (please explain)

14.10 If you answered "Yes" to the question above on specialty networks, do you use subcontractors to provide these benefits or is it done internally?

- ○ Use subcontractors (please list)
- ○ Internal (please describe when networks were developed)
- ○ Use both subcontractors and internal network (please describe)
- ○ Not applicable

14.11 Do you have a Centers for Excellence Program?

- ○ Yes (please list programs available and where available in Missouri)
- ○ No (please explain)

14.12 Is credentialing done according to NCQA standards?

- ○ Yes
- ○ No (please describe)

14.13 Please describe your payment philosophy for providers, including the criteria that are used to evaluate efficient use of care, programs in place to help ensure ongoing focus on quality care and how long these methodologies have been in place.

Response

14.14 Please describe innovations related to network configurations and access made over the last 24 months to help ensure cost effective access to quality care.

Response

14.15 Do you offer an outpatient rehabilitation network? If so, complete the following table.

	Description	Number of contracted providers in Missouri
Physical Therapy		

Occupational Therapy		
Speech Therapy		
Other		

14.16 How many years has your rehabilitation network been in place in Missouri?

No. of years

14.17 Do you measure member satisfaction with your provider network(s)?

○ Yes (provide the scores for each of the past three years and identify the survey instrument used)

○ No (please explain)

14.18 What percent of participating providers in the proposed MCHCP networks are currently closed to new patients? The term "closed" refers to an office that cannot currently accept new patients regardless of network affiliation (see definitions section). In other words, the doctor is not accepting new patients to his/her practice.

Primary care providers %

Specialists %

14.19 Using HEDIS' technical specifications, identify the percentage of contracted providers who are board certified in your network. If board certification is not tracked, enter 0.

	2018	2019
Primary care providers	%	%
Specialists	%	%

Health Care Delivery: Networks and Solutions

Please use the definitions listed in Attachment 6 when completing this section.

15.1 Please describe your Accountable Care Organization (ACO) strategy. Please include the product lines you expect to make ACOs available to (i.e., self-funded employer sponsored plans and commercial), how ACOs align with your network strategy in general, and the implications for delivery of health management services by the ACO and/or your health plan. Include how the member experience and care will differ in the ACO compared to community care. If necessary to provide a complete response, upload a file to the Reference Files from Vendor section, and name the file "Q15.1 ACO Strategy".

Response

15.2 Describe your approach to ACO contracting. Do you focus on integrated systems or large physician groups? Do you include all physicians in the system, or do you narrow it based on high performing providers?

Response

15.3 Please describe your Primary Care Medical Home (PCMH) strategy. Please include the product lines you expect to make PCMH available to (i.e., self-funded employer sponsored plans and commercial), how it aligns with your network strategy in general, and the implications for delivery of health management services by the PCMH and/or your health plan. Include how the member experience and care will differ in the ACO compared to community care, as well as how it aligns and is integrated to your ACO strategy, as described above. If necessary to provide a complete repsonse, upload a file to the Reference Files from Vendor section, and name the file "Q15.3 PCMH Strategy".

Response

15.4 Please provide the criteria you use to evaluate providers for their participation in your PCMH.

Response

15.5 For your PCMH, are Primary Care Physicians (PCPs) required to be "gatekeepers?"

- ○ Yes (please describe)
- ○ No (please explain)

15.6 How do you integrate a client's telemedicine services with your ACO, PCMH and other care delivery models?

Response

15.7 Please describe other physician extender capabilities you currently offer or are pursuing. Please include how these capabilities are integrated with your overall network strategy, are linked to ACO, PCMH or other initiatives, and the potential benefit to employers and plan participants.

Response

15.8 Will your care management programs (managing care across the continuum from wellness to chronic condition) change under bundled payment, shared risk/shared savings or similar contracting models? For example, how does your care management program align with local ACO or PCMH efforts, when explicit care management fees or a capitation is paid to providers for care coordination? How do local providers integrate their efforts with yours, and how is "double-charging" of the client avoided?

Response

15.9 Please describe who will be responsible for health management services when a member is in a health plan and an ACO or PCMH? What entity will be responsible for providing which services?

Response

15.10 Will there be coordination between the health plan and the ACO and how is this accomplished?

Response

15.11 How are specialty case management programs such as transplant and maternity coordinated?

Response

15.12 Please describe how your bundled payment approaches align with your network strategy. Include any consideration of a warranty with a bundled service.

Response

15.13 Please provide a list of conditions to which your bundled payment arrangements apply.

Response

15.14 Please describe your bundled payment arrangement for your top three conditions. For example, how do your bundled payment levels vary by severity of the specific conditions? How are bundled payment arrangements communicated to the patients before procedures, and how do you manage patients' expectations should the severity levels change during the course of treatment?

Condition 1

Condition 2

Condition 3

Emerging Care Delivery Models

Your responses in this section should reflect known provider contracts in place for 2019 and, if available, what is projected for 2020. If answers to questions reflect membership growth, steerage or migration, please note accordingly. Note that not all questions apply to each emerging delivery approach. Limit responses to Commercial Self-Funded Products.

16.1 Indicate the extent to which each reimbursement methodology will be in place for MCHCP, and explain if necessary. If yes, also answer Q16.2. Please use the categories of reimbursement methodologies provided in Attachment 8 for your response.

	Yes (please explain)	No
Discounted Fee for Service	☐	☐
Discounted Fee-for-Service with P4P or other incentives	☐	☐
Bundled payments	☐	☐
Shared Risk/Shared Savings	☐	☐
Global Capitation	☐	☐
Partial Capitation	☐	☐
Shared-risk/shared-savings - upside/downside, withholds; Pay for Performance; Performance Incentives; Quality Payments; Value-based payments; Reference-based	☐	☐
Other Claims-based or PMPM charges	☐	☐

16.2 Please answer the following questions for all emerging reimbursement models you have in place.

	DFFS	DFFS w/ P4P or other incentives	Bundled payments	Shared risk/shared savings	Partial cap	Global cap	Other claims-based or PMPM	Comments, if necessary
For Self-Funded payments (all providers), approximately what % of total contracted provider payments does each reimbursement model represent?	%	%	%	%	%	%	%	
What % of Hospital IP payments?	%	%	%	%	%	%	%	
What % of Hospital OP payments?	%	%	%	%	%	%	%	
What % of PCP payments?	%	%	%	%	%	%	%	
What % of SCP payments?	%	%	%	%	%	%	%	
What % of Lab, Diagnostic & Imaging payments?	%	%	%	%	%	%	%	
	%	%	%	%	%	%	%	

What % of "all other" payments?								

Behavioral Health/Substance Use Disorder

17.1 Who administers the behavioral health/substance use disorder benefits?

- ○ Same company as medical benefits
- ○ Subsidiary (please name)
- ○ Contract for services with specialty vendor (please name and provide date the contract will come up for renewal)

17.2 Are the behavioral health/substance use disorder claims paid on the same claims system as the medical claims?

- ○ Yes
- ○ No (please explain)

17.3 Describe the clinical guidelines you use for inpatient behavioral health/substance use disorder claims.

Response

17.4 Is the behavioral health/substance use disorder claims data integrated into the standard claim files that will be provided to MCHCP's decision support system vendor?

- ○ Yes
- ○ No (please explain)

17.5 Do you integrate behavioral/substance use disorder diagnoses into your care management programs?

- ○ Yes (please describe)
- ○ No (please explain)

17.6 How are referrals from medical management to the behavioral health/substance use disorder unit handled? Describe the process including what steps you take to ensure that there is a smooth transition?

Response

17.7 What process do you have in place to coordinate referrals from an EAP vendor?

Response

17.8 Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance: Indicate whether each of the following non-quantitative treatment limitations (NQTLs) are administered such that processes, strategies, evidentiary standards and other factors are applied to behavioral health/substance use disorder benefits in a manner that is comparable to and applied no more stringently than those applied to medical/surgical benefits.

- ☐ Utilization management timing, criteria and sanctions for inpatient as well as outpatient services
- ☐ Precertification for services in both the inpatient and outpatient classifications
- ☐ Triggers for initiating outpatient treatment review (e.g., number of outpatient visits for treatment of depression without a medication evaluation)
- ☐ Network admission requirements for practitioners (i.e., criteria required for practitioners to become network providers)

- [ ] Network fee schedules for network practitioners
- [ ] Usual and customary charges for non-network physicians
- [ ] Usual and customary charges for non-network non-physicians

17.9 Do you use psychotropic prescription drug data to trigger outpatient behavioral health/substance use disorder treatment case management?

- ○ Yes (please describe)
- ○ No (please explain)

17.10 Provide examples of your psychotropic medication outpatient review triggers.

Response

17.11 Do you use psychotropic prescription drug data to inform your medical care management program?

- ○ Yes (please describe your approach and outcomes)
- ○ No (please explain)

17.12 Do you identify members who may benefit from Medication Assisted Treatment for substance use disorder?

- ○ Yes (please describe your approach and outcomes)
- ○ No (please explain)

Broad Network Financial Information

18.1 What is the source of your Usual, Customary and Reasonable (UCR) table used to determine non-network allowable amount levels? Select all that apply and describe your approach when used.

- [ ] Leased network contracted rate
- [ ] Medicare RBRVS or other Medicare-based schedule
- [ ] Fair Health
- [ ] Individual claim negotiation
- [ ] Billed charges
- [ ] Other (please describe)

18.2 How often do you update your UCR tables?

- ○ Monthly
- ○ Quarterly
- ○ Biannually
- ○ Annually
- ○ Less frequently than annually
- ○ Other (please specify)

18.3 How are claims paid in circumstances in which a participant receives services from a non-network provider at a network hospital facility?

	Automatically treated as network	Paid at network level via manual override	Paid at network level only upon appeal	Always treated as non-network	Other (please describe)
Hospital-based physicians					

	○	○	○	○	○
Hospital-based surgeons	○	○	○	○	○
Assistant surgeons	○	○	○	○	○
Anesthesiologists	○	○	○	○	○
Pathologists/Radiologists	○	○	○	○	○
Pneumatic Compression Devices	○	○	○	○	○
Physical Therapy	○	○	○	○	○

18.4 Do you have a pre-determined dollar threshold and/or types of claims for which you will conduct negotiations for a discounted payment to non-network providers? If so, list the amount.

○ Yes (specify amount)

○ We conduct negotiations for non-network claims, but no formal policy or procedure exists to identify specific claims. Identify approximate percentage of non-network claims that are negotiated,

○ We do not typically conduct negotiations for non-network claims (please explain)

18.5 Complete the table below in regards to the negotiation of discount payments with non-network providers. In addition to listing any additional costs here, also include in Supplemental Pricing.

	Response	Impact, if any, to quoted ASO fee
What is the fee charged to MCHCP for negotiating discounted payments from non-network providers?		
How and when is it paid by MCHCP?		
Can MCHCP negotiate a different non-network provider discount savings program fee?		
Are you willing to cap the dollar amount of this fee for any one claimant? If yes, at what level?		
Can MCHCP opt out of the non-network shared savings program? If yes, indicate what impact, if any, there is to the quoted ASO fee.		

18.6 How are savings calculated in these non-network situations?

Response

18.7 Regarding services provided by a non-network provider where you are able to negotiate a discount on charges, what protection do members have against balance billing by the provider up to the original billed amount?

○ Provider agrees to refrain from balance billing

○ Other (please describe)

18.8 Confirm that the full provider discounts are passed onto plan sponsors and participating members for all eligible non-network shared savings claims. If a fee is applied, please note the percentage of savings retained by you or the vendor.

○ Confirmed

○ Not confirmed (please explain)

18.9 Provide your overall book of business trend rates (Hospital med/surg) including utilization changes, cost increases, etc.:

	2018 %	2019 YTD %	2020 Projected %
POS	%	%	%
PPO	%	%	%
HDHP	%	%	%
CDHP	%	%	%
High Performance Network	%	%	%
Medicare	%	%	%

18.10 Provide the following utilization statistics for your plan-wide commercial enrollment for the most recent calendar year based upon results reported in HEDIS outcomes. If you do not report on these HEDIS outcomes, please upload as a reference document an explanation of how you arrived at your response. Exclude mental health/substance use disorders from your response.

	Note which calendar year results are for (YYYY)	Results	Percentage change from prior year
Outpatient physician encounters/1,000 members (excluding MHSA)			%
Inpatient admits/1,000 members (excluding MHSA)			%

18.11 Complete the following table indicating your commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Visit" means each complete encounter or requisition (for lab services) consisting of the collection of procedures (excluding physician professional activity) performed as part of the encounter or requisition.

	Note which calendar year results are for (YYYY)	Visits/1000 members	Average # procedures/visit	Average charge/visit	Average allowed cost/visit
Emergency room					
Surgery					
Radiology					
Laboratory					
All other (including ambulance, PT/OT, DME)					

18.12 Complete the following table indicating your commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Procedure" means each incidence of the listed CPT code.

	Note which calendar year results are for (YYYY)	Procedures/1000 members	Average charge/procedure	Average allowed cost/procedure

CPT 29873: Knee arthroscopy/surgery				
CPT 33512: Coronary artery bypass				
CPT 36415: Drawing of blood				
CPT: 44950: Appendectomy				
CPT 45378: Diagnostic colonoscopy				
CPT 49505: Repair inguinal hernia				
CPT 55845: Extensive prostate surgery				
CPT 58150: Total hysterectomy				
CPT 59400: Obstetrical care				
CPT 59510: Cesarean delivery				
CPT 70460-26: CAT, head or brain, w contrast				
CPT 73610-26: X-Ray exam, ankle complete				
CPT 73721-26: MRI, any joint of lower extremity				
CPT 93000: Electrocardiogram, complete				
CPT 93015: Cardiovascular stress test				
CPT 98941: CMT; spinal, three to four regions				
CPT 99213: Office/outpatient visit				

Telehealth

19.1 Does your organization currently work with a preferred telemedicine provider? If so, which organizations? Check all that apply.

- ☐ Teladoc
- ☐ MDLIVE
- ☐ American Well
- ☐ Doctor on Demand
- ☐ Consult a Doctor
- ☐ Other (please specify)
- ☐ Do not currently work with a preferred telemedicine provider

19.2 Is your organization able to seamlessly integrate with a telemedicine provider of MCHCP's choosing?

- ○ Yes (please describe)
- ○ No (please explain)

19.3 Is your claims system able to receive electronic claim submissions from a telemedicine provider, adjudicate the claim against MCHCP's benefit plan, and remit payment to the telemedicine provider?

- ○ Yes, fully automated with the following telemedicine providers
- ○ No, not able to integrate with claims (please explain)
- ○ Other (please describe)

Denials/Appeals Procedures

20.1 Provide a detailed description of your internal medical appeals process including typical turnaround time for decisions. If necessary to provide a complete explanation, upload a document to the Reference Files from Vendor section, and name the file "Q20.1 Internal Appeal Process".

Response

20.2 Is there any additional cost for the appeals process? If so, indicate any cost in Supplemental Pricing.

- ○ Yes (please explain)
- ○ No

20.3 How are denials communicated to the member and MCHCP?

To the employee

To MCHCP

20.4 How will you communicate with MCHCP on problem claim issues, appeals/denials (check all that apply)?

- ☐ By Key contact
- ☐ By Email
- ☐ By Phone
- ☐ By Letter
- ☐ By Meetings as needed
- ☐ Other (please explain)

20.5 Confirm that your organization will handle two levels of appeal in accordance with federal regulation applicable to a self-funded non-federal governmental health plan.

- ○ Confirm (please describe)
- ○ Not confirmed (please explain)

20.6 Confirm that your organization will customize its grievance and appeal notification letters to both providers and members pursuant to MCHCP's specifications (i.e. deletion of ERISA language, etc.) at no additional cost.

- ○ Confirmed (please describe)
- ○ Not confirmed (please explain)

20.7 Describe your appeal process including the following information:

Describe all levels of appeals	
Appeal turnaround time	
Tracking of appeals	
Rates of denial/approval at each level	
Common reasons for appeals	
Who makes determinations at each level and what are their credentials	
Criteria used	
What is communicated to the employee	
Other (please describe)	

20.8 Do you have the capability to handle urgent appeals utilizing a physician reviewer of the same specialty as the requesting physician?

- ○ Yes (please describe)
- ○ No (please explain)

Performance Guarantees - on MCHCP's Book of Business

21.1 Claims turnaround time - The following category will be reported and measured quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of MCHCP claims processed within 10 business days	95%			For each full percentage point below standard, $5,000 plus $0.25 PEPM	

21.2 Claim processing accuracy - The following categories will be reported and measured quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of MCHCP claims free of financial error	99%			For each full percentage point below standard, $5,000 plus $0.25 PEPM	
Percent of MCHCP claims processed correctly	97%			For each full percentage point below standard, $5,000 plus $0.25 PEPM	

21.3 Member Service - Average response time. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this		Minimum amount at risk	

		standard (Yes or No)	Describe your measurement process		Maximum dollar amount at risk
Average number of seconds for MCHCP member calls to be answered by a live customer service representative	30 seconds or less			For each full second above standard, $5,000 plus $0.25 PEPM	
If utilized, average number of days for a secure message from MCHCP member to be responded to	1 business day or less			For each full day above standard, $5,000 plus $0.25 PEPM	

21.4 Member Service - Average abandonment rate. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of MCHCP calls abandoned	4%			For each full percentage point above standard, $5,000 plus $0.25 PEPM	

21.5 Member service - Response to written inquiries. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Average number of business days within which MCHCP member written inquiries will be responded to	5 business days or less			For each business day above standard, $2,000 plus $0.25 PEPM	

21.6 Member Service - Call quality score. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Minimum call quality satisfaction	90%			For each full percentage point below standard, $5,000 plus $0.25 PEPM	

21.7 Written communication with MCHCP membership. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk

		standard (Yes or No)			
MCHCP requires approval of all written communications and marketing material used by the contractor to communicate with MCHCP members, excluding provider directories	MCHCP must approve 100% of written communications			For each instance when material was not submitted to MCHCP for approval, $5,000 plus $0.25 PEPM	

21.8 ID Card Distribution - Initial/New Contract Year Distribution. The following category will be measured January 1, 2020 and each subsequent year when ID cards are issued.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed no later than one week prior to effective date of each year	100% of all ID cards mailed one week prior to effective date			For each day after stated deadline, $2,000 plus $0.25 PEPM	

21.9 ID Card Distribution - Ongoing. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed within 10 business days of receipt of eligibility data (for monthly changes) or request for replacement card	100% of all ID cards mailed within 10 days of receipt of eligibility file or request			For each business day beyond the 10th business day, $2,000 plus $0.25 PEPM	

21.10 Implementation - Positive pay file testing. This category will be measured January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
All testing of positive pay file transmission must be successfully completed no later than November 1, 2019.	All testing completed by November 1, 2019		MCHCP's contracted bank will report to MCHCP	Contractor must agree to place three (3) percent of annual administrative fees at risk across all implementation performance guarantees for the successful implementation of MCHCP's plan on January 1, 2020.	

21.11 Implementation - Claim readiness. The following category will be measured January 1, 2020.

	Guarantee	Will you guarantee		Minimum amount at risk	Maximum dollar

		this standard (Yes or No)	Describe your measurement process		amount at risk
Claim Readiness - Benefit profile and eligibility information loaded and tested on claims processing system a minimum of one month prior to the effective date	No later than one month prior to effective date			Contractor must agree to place three (3) percent of annual administrative fees at risk across all implementation performance guarantees for the successful implementation of MCHCP's plan on January 1, 2020.	

21.12 Implementation - Member Services Center. The following category will be measured January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Member Service Center ready to respond to member inquiries prior to open enrollment	No later than stated deadline			Contractor must agree to place three (3) percent of annual administrative fees at risk across all implementation performance guarantees for the successful implementation of MCHCP's plan on January 1, 2020.	

21.13 Implementation - Data Transfer Setup. The following category will be measured January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
All data transfer setup requirements with MCHCP's data vendor (currently IBM Watson Health) completed by January 1, 2020	100%		MCHCP's data vendor will report to MCHCP	Contractor must agree to place three (3) percent of annual administrative fees at risk across all implementation performance guarantees for the successful implementation of MCHCP's plan on January 1, 2020.	

21.14 Eligibility - Timeliness of installations. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Electronic eligibility files will be installed and eligibility status will be effective within an	95% loaded within 24 hours			For each full hour beyond 24 hours, $2,000	

average of 24 hours of receipt				plus $0.25 PEPM	

21.15 Eligibility - Accuracy of installations. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Electronic eligibility records loaded with 99.5% accuracy. This standard is contingent upon receipt of clean eligibility data delivered in an agreed upon format.	99.5%			For each full percentage point below standard, $5,000 plus $0.25 PEPM	

21.16 Provider directory on website - The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
No provider shall be listed on the contractor's website that is not under contract	All providers listed on website are currently in network and have completed credentialling process			For each instance when listed provider is not in the network, $5,000 plus $0.25 PEPM	

21.17 Network retention rate - The following category will be measured and reported annually beginning January, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Network provider retention rate (based on voluntary turnover)	98%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

21.18 Account management - Satisfaction. The following category will be measured and reported annually beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Contractor guarantees MCHCP's satisfaction with account management services	Satisfactory or better			$5,000 plus $0.25 PEPM	

21.19 Account management - Responsiveness. The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee				

		Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Timely issues acknowledgement by the account management team (e.g. issues resolvable by account management are acknowledged and responded to within 8 business hours)	Acknowledgement within 8 business hours			For each incident not acknowledged within 8 business hours, $2,000 plus $0.25 PEPM	
Timely issues resolution by the account management team (e.g. issues resolvable by account management are resolved within 10 business days	Resolution within 10 business days			For each incident not resolved within 10 business days, $2,000 plus $0.25 PEPM	

21.20 Reporting - The following categories will be reported and measured quarterly beginning January 1, 2020. Penalties will be applied for each month the contractor fails to meet these standards.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Claim file must be submitted to MCHCP's data vendor no later than 15th of the month for prior month's services	100%		MCHCP's data vendor will report to MCHCP	For each incident, $5,000 plus $0.25 PEPM	
Claim file must be submitted to MCHCP's data vendor in proper format on first submission of the month	100%		MCHCP's data vendor will report to MCHCP	For each incident, $5,000 plus $0.25 PEPM	
Data submission to MCHCP's data vendor must include 99 percent of all required financial fields	99%		MCHCP's data vendor will report to MCHCP	For each incident, $5,000 plus $0.25 PEPM	
Data submission to MCHCP's data vendor must include all required fields (subscriber SSN, member DOB, and member gender)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $5,000 plus $0.25 PEPM	
Data submission to MCHCP's data vendor must include all required key fields (diagnostic coding, provider type, provider ID, etc.)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $5,000 plus $0.25 PEPM	

21.21 Reporting - Member Service and Case Management. The following categories will be reported and measured quarterly beginning on January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Member service reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $5,000 plus $0.25 PEPM	
Case management reporting must be submitted to MCHCP in the agreed upon format and no later than the 15th of each month.	Due within 15 days of end of month. Penalty will be applied for each month contractor fails to meet standard.		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $5,000 plus $0.25 PEPM	
Intervention program for frequent users of emergency room services report must be submitted to MCHCP in the agreed upon format and within 30 days of the end of the quarter.	Due within 30 days of end of the quarter.		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $5,000 plus $0.25 PEPM	
Pharmacy lock-in program case management reporting must be submitted to MCHCP in the agreed upon format and no later than the 15th of each month.	Due within 15 days of the end of the month. Penalty will be applied for each month contractor fails to meet standard.		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $5,000 plus $0.25 PEPM	

21.22 Positive pay file submission to MCHCP's designated bank - The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Positive pay file must be available to MCHCP's bank no later than 4:00 pm CT on the day payments are released	File available by 4:00 pm CT each day payments are released		MCHCP's contracted bank will report to MCHCP	For each incident file was not transmitted on time, $5,000 plus $0.25 PEPM	

21.23 Monthly payment register - The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Payment register must be available in	Register available within		MCHCP will determine	For each day file was not	

the proper format no later than five business days from the end of the month	5 business days of end of month		acceptability of register	transmitted on time, $5,000 plus $0.25 PEPM	

21.24 Monthly eligibility audit file - The following category will be measured and reported quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Eligibility audit file must be provided on the second Thursday of each month in the agreed upon format	Audit file available by the second Thursday of each month		MCHCP will determine acceptability of file	For each day file was not transmitted on time, $5,000 plus $0.25 PEPM	

21.25 Reporting - HEDIS. The following category will be reported and measured annually beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
HEDIS reporting on results in standard HEDIS measurements to include measures from these domains of care: Effectiveness of Care; Access/Availability of Care; Utilization, Risk Adjusted Utilization; and Measures Collected Using Electronic Clinical Data Systems must be submitted to MCHCP in the agreed upon format.	Due no later than July 15 of each year for the prior year's data		MCHCP will determine acceptability and timeliness of reports	For each day beyond deadline for submission, $5,000 plus $0.25 PEPM	

21.26 Quality of care initiative - Preventive care. The following category will be reported and measured quarterly beginning January 1, 2020.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Maintain at least one quality of care initiative focused on preventive care. Topics and content to be developed in coordination with MCHCP.	Communicate to members at least quarterly regarding preventive care and plan coverage of preventive care. Timing as determined by MCHCP.			For each quarter communication fails to occur, $5,000 plus $0.25 PEPM	

21.27 Confirm your willingness to submit your performance metric results via an online tool.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.28 Please provide any creative performance guarantees to help ensure MCHCP receives the highest level of customer and client service. If necessary to provide a complete response, upload a file to the Reference Files from Vendor section, and name the file "Q21.28 Additional Performance Guarantees".

Response

21.29 Please describe any ROI and/or performance guarantees you will offer regarding member incentives related to the use of transparency tools. If necessary to provide a complete response, upload a file to the Reference Files from Vendor section, and name the file "Q21.29 Member Incentive Performance Guarantees".

Response

Financial

22.1 Confirm that your fees are quoted on a mature basis for year one.

- ○ Confirmed
- ○ Not confirmed (please explain)

22.2 Confirm that you will provide a claim trend guarantee for MCHCP? If yes, upload a sample agreement outlining the guarantee to the Reference Files from Vendor section, and name the file "Q22.2 Trend Guarantee".

- ○ Confirmed
- ○ Not confirmed (please explain)

22.3 Under what conditions do you reserve the right to change your administrative fees? Specify the percentage limits you apply and the resulting change in fees.

Response

22.4 Confirm that if MCHCP's enrollment growth exceeds your expectations, your per-employee fees will decrease.

- ○ Confirmed
- ○ Not confirmed (please explain)

22.5 Confirm you have provided a detailed description of all business partners, joint ventures, outsourcing and co-sourcing relationships currently in place to support your firm's payment integrity business and legal functions. Upload the file to the Reference Files from Vendor section, and name the file "Q22.5 Business Partners".

- ○ Confirmed
- ○ Not confirmed (please explain)

22.6 Will any of your business partners, joint ventures, outsourcing and co-sourcing relationships currently in place to support your firm's payment integrity business and legal functions expire or terminate prior to the end of the proposed contract with MCHCP.

- ○ Yes (please describe)
- ○ No

22.7 Describe any financial advantages available for bundling the various products and services requested in this RFP (e.g. DM, member advocacy, MCM, etc.)

Response

22.8 Are you willing to fund up to $45,000 for a Pre-Implementation Audit to be performed by Willis Towers Watson or the auditor of choice for MCHCP?

- ○ Yes (please describe)
- ○ No (please explain)

22.9 Are you willing to fund up to $80,000 for an annual Claims Audit to be performed by the auditor of choice for MCHCP?

- ○ Confirmed (please describe)
- ○ Not confirmed (please explain)

22.10 Are you willing to fund an annual discretionary fund up to $100,000 for MCHCP to use to reimburse MCHCP for unrestricted miscellaneous expenses relating to this contract?

- ○ Yes (please describe)
- ○ No (please explain)

22.11 Are you willing to fund an annual discretionary fund up to $100,000 for MCHCP to use to reimburse MCHCP for population health initiative expenses relating to this contract?

- ○ Yes (please describe)
- ○ No (please explain)

22.12 Confirm you are willing to fund an annual or bi-annual clinical process review (clinical audit) administered by Willis Towers Watson or a third party, at a mutually agreeable fee by all parties. If yes, confirm the amount you are willing to fund for a clinical process review.

- ○ Confirmed (provide amount you are willing to fund)
- ○ Not confirmed (please explain)

High Performance Provider Network (HPN)

23.1 Will you be offering a high-performance network (HPN) to MCHCP for Plan Year 2020?

- ○ Yes (please describe)
- ○ No (please explain)

23.2 What geographic locations are the HPN available to MCHCP members? What geographic locations are the HPN not available to members?

Geographic locations available

Geographic locations not available

23.3 What Missouri hospital systems are included in your high performance network?

Response

23.4 Confirm you have uploaded a provider network file(s) to the Reference Files from Vendor section in the format provided in Attachment 3. Name the file(s) "Q23.4 Provider Network - High Performance A", "Q23.4 Provider Network - High Performance B", etc.

- ○ Confirmed
- ○ Not confirmed (explain)

23.5 Confirm you have uploaded to the Reference Files from Vendor section a list of hospitals and health care facilities under contract in each of your proposed networks for each county in Missouri.

Name the file "Q23.5 Hospital Network - High Performance A", "Q23.5 Hospital Network - High Performance B", etc.

- ○ Confirmed
- ○ Not confirmed (please explain)

23.6 What is your process for providing notification to MCHCP and its members regarding provider additions, terminations or insolvencies for each network?

Response

23.7 What is your process for assessing network adequacy for each network? What standards do you utilize?

Response

23.8 Complete the following table:

HPN name	
Number of members as of January 1, 2019	
Network structure and steerage	
Additional product fee required? If yes, include additional cost in Supplemental Pricing.	
Indicate all the plan design steerage options available for driving members toward "Tier 1" facilities or providers (e.g. facilities of providers in the HPN)	
Percent of PCPs in the broad-based PPO in this market that are also in the HPN	%
Percent of Specialists in the broad-based PPO in this market that are also in the HPN	%
Percent of Hospitals in the broad-based PPO in this market that are also in the HPN	%
Percent of total providers in the broad-based PPO in this market that are also in the HPN	%
Average HPN medical cost PCP savings compared to your broad-based PPO network in this market based on allowed claim cost only and no plan design shift (express on both a % basis and a PMPM basis)	
Average HPN medical cost Specialist savings compared to your broad-based PPO network in this market based on allowed claim cost only and no plan design shift (express on both a % basis and a PMPM basis)	
Average HPN medical cost Hospital savings compared to your broad-based PPO network in this market based on allowed claim cost only and no plan design shift (express on both a % basis and a PMPM basis)	
Average HPN medical cost all provider savings compared to your broad-based PPO network in this market based on allowed claim cost only and no plan design shift (express on both a % basis and a PMPM basis)	
Physician participation based on:	
Hospital participation based on:	

23.9 List the top 5 hospitals (by claim volume) considered Tier 1, per each market, including TINs:

	Market name	Hospital name 1 and TIN	Hospital name 2 and TIN	Hospital name 3 and TIN	Hospital name 4 and TIN	Hospital name 5 and TIN

Market 1						
Market 2						
Market 3						
Market 4						
Market 5						

23.10 List the top 5 physician groups (by claim volume) considered Tier 1, per each market, including TINs:

	Market name	Physician group name 1 and TIN	Physician group name 2 and TIN	Physician group name 3 and TIN	Physician group name 4 and TIN	Physician group name 5 and TIN
Market 1						
Market 2						
Market 3						
Market 4						
Market 5						

23.11 Explain how Tier 2 physicians (considered network in the PPO but not Tier 1 HPN providers) are reimbursed under the narrow network arrangement?

Response

23.12 Explain how you handle continuation of care of members whose HPN provider does not remain in the HPN.

Response

23.13 What was the turnover within your HPN over the last three years?

Response

23.14 How are claims paid in circumstances in which a participant receives services from a non-network provider at a network hospital facility?

	Automatically treated as network	Paid at network level via manual override	Paid at network level only upon appeal	Always treated as non-network	Other (please describe)
Hospital-based physicians	○	○	○	○	○
Hospital-based surgeons	○	○	○	○	○
Assistant surgeons	○	○	○	○	○
Anesthesiologists	○	○	○	○	○
Pathologists/Radiologists	○	○	○	○	○
Pneumatic Compression Devices	○	○	○	○	○

Physical Therapy	○	○	○	○	○

23.15 What percent of participating providers in the proposed HPN are currently closed to new patients? The term "closed" refers to an office that cannot currently accept new patients regardless of network affiliation (see definitions section). In other words, the doctor is not accepting new patients to his/her practice.

Primary care providers ____ %

Specialists ____ %

23.16 Using HEDIS' technical specifications, identify the percentage of contracted providers who are board certified in your HPN. If board certification is not tracked, enter 0.

	2018	2019
Primary care providers	%	%
Specialists	%	%

23.17 What is the source of your Usual, Customary and Reasonable (UCR) table used to determine non-network allowable amount levels? Select all that apply and describe your approach when used.

- ☐ Leased network contracted rate
- ☐ Medicare RBRVS or other Medicare-based schedule
- ☐ Fair Health
- ☐ Individual claim negotiation
- ☐ Billed charges
- ☐ Other (please describe)

23.18 Do you have a pre-determined dollar threshold and/or types of claims for which you will conduct negotiations for a discounted payment to non-network providers? If so, list the amount.

- ○ Yes (specify amount)
- ○ We conduct negotiations for non-network claims, but no formal policy or procedure exists to identify specific claims. Identify approximate percentage of non-network claims that are negotiated,
- ○ We do not typically conduct negotiations for non-network claims (please explain)

23.19 Complete the table below in regards to the negotiation of discount payments with non-network providers. In addition to listing any additional costs here, also include in Supplemental Pricing.

	Response	Impact, if any, to quoted ASO fee
What is the fee charged to MCHCP for negotiating discounted payments from non-network providers?		
How and when is it paid by MCHCP?		
Can MCHCP negotiate a different non-network provider discount savings program fee?		
Are you willing to cap the dollar amount of this fee for any one claimant? If yes, at what level?		
Can MCHCP opt out of the non-network shared savings program? If yes, indicate what impact, if any, there is to the quoted ASO fee.		

23.20 How are savings calculated in these non-network situations?

Response

23.21 Regarding services provided by a non-network provider where you are able to negotiate a discount on charges, what protection do members have against balance billing by the provider up to the original billed amount?

- ○ Provider agrees to refrain from balance billing
- ○ Other (please describe)

23.22 Confirm that the full provider discounts are passed onto plan sponsors and participating members for all eligible non-network shared savings claims. If a fee is applied, please note the percentage of savings retained by you or the vendor.

- ○ Confirmed
- ○ Not confirmed (please explain)

23.23 Complete the following table indicating your commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Procedure" means each incidence of the listed CPT code.

	Note which calendar year results are for (YYYY)	Procedures/1000 members	Average charge/procedure	Average allowed cost/procedure
CPT 29873: Knee arthroscopy/surgery				
CPT 33512: Coronary artery bypass				
CPT 36415: Drawing of blood				
CPT: 44950: Appendectomy				
CPT 45378: Diagnostic colonoscopy				
CPT 49505: Repair inguinal hernia				
CPT 55845: Extensive prostate surgery				
CPT 58150: Total hysterectomy				
CPT 59400: Obstetrical care				
CPT 59510: Cesarean delivery				
CPT 70460-26: CAT, head or brain, w contrast				
CPT 73610-26: X-Ray exam, ankle complete				
CPT 73721-26: MRI, any joint of lower extremity				

CPT 93000: Electrocardiogram, complete				
CPT 93015: Cardiovascular stress test				
CPT 98941: CMT; spinal, three to four regions				
CPT 99213: Office/outpatient visit				

Member Incentives

24.1 Do you have the ability to manage incentives to employees for selecting lower cost providers/higher quality providers including, but not limited to, cash rewards or waiver of cost-sharing?

- ○ Yes (please describe)
- ○ No (please explain)

24.2 Please describe your best practices approach for administering incentives to employees for selecting lower cost/higher quality providers, including, but not limited to, cash rewards, waiver of cost sharing, verifying the member's qualification for reward.

Response

24.3 What tools are used to provide this information - internally developed tools or external vendor/carrier tools?

- ☐ Internally developed tools (please describe)
- ☐ External vendor/carrier tools (please describe)

24.4 For what medical procedures/services do you provide cost data?

Response

24.5 Describe your methodology for determining the reference-based prices (e.g., average costs) for each procedure.

Response

24.6 Provide a description of how you evaluate and recommend a reward level (e.g., flat dollar, percentage of savings, waiver of deductible/coinsurance) for each procedure whether it is cash, waiver of cost sharing, or other modality.

Response

24.7 Does your incentive program apply to network providers only or do you include non-network providers?

- ○ Yes (please describe)
- ○ No (please explain)

24.8 Describe your approach to measurement. What activities and outcomes are tracked to demonstrate program impact?

Response

24.9 Confirm you have provided a set of sample program reports and specify the frequency with which various reports are provided. Upload the file to the Reference Files from Vendor section, and name the file "Q24.9 Incentive Program Reports".

- ○ Confirmed
- ○ Not confirmed (please explain)

24.10 Do you include a satisfaction survey as part of your program? If so, what are your most recent book of business results?

- ○ Yes (please describe results)
- ○ No (please explain)

24.11 What results (clinical, etc.) does your program typically achieve and what are the primary factors that are required to deliver a successful program?

Results achieved

Primary factors required for successful program

24.12 How do you measure ROI? Please provide the methodology used and any measurable results from actual client experience that can be tied to your ROI calculation. If necessary to provide a complete response, upload a file to the Reference Files from Vendor section, and name the file "Q24.12 Incentive Program ROI".

Response

24.13 Describe your quality control process. How do you ensure that projected prices are accurate? What records are kept of prior projections? What percent of your pricing data is within 10% of actual prices and what percent is 100% accurate?

Response

24.14 Do you provide quality measures for both individual providers and facilities?

- ☐ Individual providers (please describe)
- ☐ Facilities (please describe)

24.15 Explain how you measure provider quality and facility quality. Please list any metrics or methodologies used, along with their sources.

	Metrics or methodologies used	Source
Provider quality		
Facility quality		

24.16 Who do you partner with to provide quality data? Please include all sources of quality data, along with examples of the type of data provided by each source.

	Name of source	Examples of type of data provided
Source 1		
Source 2		
Source 3		
Source 4		
Source 5		

24.17 How frequently is your quality data updated?

Response

24.18 What quality data is incorporated in the consumer-facing portal? Please list sources and types of information (e.g., specify if you include hospital and provider data and the level of specificity for each).

	Name of source	Examples of type of data provided
Source 1		
Source 2		
Source 3		
Source 4		
Source 5		

24.19 Please describe your experience with increasing member participation in the reward programs you offer.

Response

24.20 Please describe your best practices for managing the tax implications of monetary incentive rewards to employees for selecting lower cost/higher quality providers, including how you track and issue necessary tax documents.

Response

24.21 How many clients do you administer member incentive rewards for?

No. of clients

24.22 What sizes are those clients by numbers of employees?

Response

24.23 Do you have any geographic limitations for your member incentive reward program?

- ○ Yes (please explain)
- ○ No (please describe)

Member Advocacy

25.1 Provide your definition of member advocacy and how it differs from traditional member services.

Response

25.2 Do you have a Member Advocacy product? If yes, provide an overview and answer the remaining questions in this section. If no, move to Section 26.

- ○ Yes (provide overview, and answer the remaining questions in this section)
- ○ No (please explain, and move to Section 26)

25.3 Confirm you have uploaded a brochure or process map that demonstrates the member experience under your advocacy program. Upload the file to the Reference Files from Vendor section, and name the file "Q25.3 Advocacy Process Map".

25.4 Is there an additional fee for this product? If yes, please provide detailed pricing.

○ Yes (please describe and list the additional cost in Supplemental Pricing)

○ No

○ Not applicable

25.5 How long has your organization been offering a member advocacy product? Provide the actual date the product became available.

Response (MM/YYYY)

25.6 Complete the following table in relation to your various base member advocacy product.

	Response
Name of product	
How many clients to you currently provide this product to?	
Is the advocacy product available as a buy-up for the care management models/programs in which it is not already included?	
What requirements does a client have to meet to have a dedicated advocacy team? (Examples - specific care management model/product, minimum enrollment threshold, etc.)	
Is your advocacy product included as a standard part of your care management model (if applicable)?	

25.7 Does the advocacy team closely collaborate with care management operations (if the two are operated separately) to provide a seamless member care model?

○ Yes (please describe)

○ No (please explain)

25.8 Provide the hours/days of operation of your member advocacy model.

Days of operation

Hours of operation

25.9 Does your member advocacy model include outbound calling/engagement efforts?

Yes (please describe)

No (please explain)

25.10 How do you measure the quality of interactions/feedback of members with your member advocacy model? Please provide your NPS score if tracked.

Response

25.11 Provide the after-hours access/coverage of your member advocacy model.

Response

25.12 Provide the qualifications and experience requirements for member-facing member advocacy representatives.

Response

25.13 Are any of the member advocacy representatives clinicians (i.e., registered nurses, social workers, or psychologists)?

○ Yes (please describe)

○ No (please explain)

25.14 Provide your advocacy staff to member ratio.

Response

25.15 When a member starts with an advocacy representative, do they continue with the same advocate throughout their experience?

- ○ Yes (please describe)
- ○ No (please explain)

Musculoskeletal Care Management (MCM) Program

26.1 Provide a description of your Musculoskeletal Care Management (MCM) program.

Response

26.2 Describe your company's overall experience in providing a MCM program and overall service capabilities.

Response

26.3 Describe your MCM problem identification process, intervention process, including methods and success rates.

Response

26.4 Describe your medical management staffing model for MCM including physician oversight.

Response

26.5 Is the MCM program able to accept and integrate data from MCHCP's contracted PBM or other vendors?

- ○ Yes, at no additional cost (please describe)
- ○ Yes, at an additional cost (please describe, and list additional cost in Supplemental Pricing)
- ○ No (please explain)

26.6 What are the criteria for discharging a member from the MCM program?

Response

26.7 Provide a description of the frequency and types of interactions you have with the member's primary care provider/treating provider once they have been enrolled in the MCM program.

Describe types of interactions

Describe frequency of interactions

26.8 Provide a description of the frequency and types of interactions you have with a member once they have been enrolled in the MCM program.

Describe types of interactions

Describe frequency of interactions

26.9 Confirm you have uploaded copies of standard quarterly MCM reporting that would be made available to MCHCP at no additional cost. Standard reports must include program participation data, demographic information, and outreach rates. Upload the file to the Reference Files from Vendor section, and name the file "Q26.9 MCM Quarterly Reporting".

○ Confirmed
○ Not confirmed (please explain)

26.10 Confirm you have uploaded copies of the standard member communications regarding the MCM program that would be provided to MCHCP's members at no additional charge. Upload the file to the Reference Files from Vendor section, and name the file "Q26.10 MCM Member Communications".

○ Confirmed
○ Not confirmed (please explain)

26.11 What is the average caseload (open cases) for MCM nurses?

Response

26.12 How many years and in what geographic regions has your MCM program been in place?

Response

26.13 What is the length of term of your longest tenured client in which you provide the MCM program contemplated in this RFP?

Response

26.14 What is your total number of clients that use your MCM program?

Response

26.15 How many new clients have you added in the last two years to your MCM program?

Response

26.16 What MCM program experience do you have in the State of Missouri?

Response

26.17 For CY2018, what was your MCM program's average approval, redirection, denial and appeal rate?

Approval rate %
Redirection rate %
Denial rate %
Appeal rate %

26.18 Provide your most recent provider and member satisfaction metrics. If necessary to provide a complete response, upload a file to the Reference Files from Vendor section, and name the file "Q26.18 Musculoskeletal Program Satisfaction Metrics".

Response

26.19 Confirm you have provided your individual program operational metrics (e.g., phone statistics, claims processing, credentialing, etc.) for the last three years broken out by line of business and separately for Missouri members. Upload the file to the Reference Files from Vendor Section, and name the file "Q26.19 Musculoskeletal Program Operational Statistics".

○ Confirmed
○ Not confirmed (please explain)

Disease Management

27.1 Describe your approach to managing chronic disease.

Response

27.2 Can the DM program offered to MCHCP be an optional program at MCHCP's discretion to elect each year?

- ○ Yes, at no additional cost (please describe)
- ○ Yes, at an additional cost (please describe and specify cost on Supplemental Pricing)
- ○ No (please explain)

27.3 What does your Disease Management (DM) program include? Include whether it is an opt in or opt out program, dedicated team to MCHCP and what physician oversight is performed.

Response

27.4 Describe your DM identification process and intervention process, including methods and success rates.

Response

27.5 Describe your medical management staffing model for DM.

Response

27.6 Is the DM program able to accept and integrate data from MCHCP's contracted PBM or other vendors?

- ○ Yes, at no additional cost (please describe)
- ○ Yes, at an additional cost (please describe, and list additional cost in Supplemental Pricing)
- ○ No (please explain)

27.7 What is the average caseload (open cases) for DM staffing?

Response

27.8 What are the criteria for discharging a member from the DM program?

Response

27.9 Provide a description of the frequency and types of interactions you have with the member's primary care provider once they have been enrolled in the DM program.

Describe types of interactions

Describe frequency of interactions

27.10 Provide a description of the frequency and types of interactions you have with members once they have been enrolled in the DM program.

Describe types of interactions

Describe frequency of interactions

27.11 If a member has more than one DM diagnosis, are they managed and counted in only one program?

○ Yes
○ No (please explain)

27.12 Confirm you have uploaded copies of standard quarterly disease management reporting that would be made available to MCHCP at no additional cost. Standard reports must include program participation data, demographic information, and outreach rates. Upload the file to the Reference Files from Vendor section, and name the file "Q27.12 DM Quarterly Reporting".

○ Confirmed
○ Not confirmed (please explain)

27.13 Confirm you have uploaded copies of the standard member communications regarding the disease management program that would be provided to MCHCP members at no additional charge. Upload the file to the Reference Files from Vendor section, and name the file " Q27.13 DM Member Communications".

○ Confirmed
○ Not confirmed (please explain)

27.14 Complete the following table, indicating which DM programs have received accreditation and from whom (NCQA, JCAHO, URAC).

	Program name	Accrediting organization
Program 1		
Program 2		
Program 3		
Program 4		
Program 5		
Program 6		
Program 7		
Program 8		
Program 9		
Program 10		

MBE-WBE Participation Committment

If the bidder is committing to participation by or if the bidder is a qualified MBE/WBE, the bidder must provide the required information in the appropriate table(s) below for the organization proposed and must submit the completed Exhibit A-9 with the bidder's proposal. For Minority Business Enterprise (MBE) and/or Woman Business Enterprise (WBE) Participation, if proposing an entity certified as both MBE and WBE, the bidder must either (1) enter the participation percentage under MBE or WBE, or must (2) divide the participation between both MBE and WBE. If dividing the participation, do not state the total participation on both the MBE and WBE Participation Commitment tables below. Instead, divide the total participation as proportionately appropriate between the tables below.

28.1 MBE Participation Committment Table

	Name of Qualified Minority Business Enterprise (MBE) Proposed	Committed Percentage of Participation for MBE	Description of Products/Services to be Provided by MBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total MBE Percentage		%	

28.2 WBE Participation Committment Table

	Name of Qualified Women Business Enterprise (WBE) Proposed	Committed Percentage of Participation for WBE	Description of Products/Services to be Provided by WBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total WBE Percentage		%	

Scope of Work

29.1 Confirm you will meet all Administrative Services requirements stated in Exhibit B, Section B1.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.2 Confirm you will meet all Coordination with MCHCP Business Associates requirements stated in Exhibit B, Section B2.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.3 Confirm you will meet all Account Management requirements as stated in Exhibit B, Section B3.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.4 Confirm you will meet all Network requirements as stated in Exhibit B, Section B4.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.5 Confirm you will meet all Member Service requirements as stated in Exhibit B, Section B5.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.6 Confirm you will meet all Implementation requirements as stated in Exhibit B, Section B6.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.7 Confirm you will meet all Reporting Requirements stated in Exhibit B, Section B7.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.8 Confirm you will meet all Eligibility requirements as stated in Exhibit B, Section B8.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.9 Confirm you will meet all Website requirements as stated in Exhibit B, Section B9.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.10 Confirm you will meet all Appeals requirements as stated in Exhibit B, Section B10.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.11 Confirm you will meet all Clinical Management requirements as stated in Exhibit B, Section B11.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.12 Confirm you will agree to all Claim Payment requirements as stated in Exhibit B, Section B12.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.13 Confirm you will meet all Banking requirements as stated in Exhibit B, Section B13.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.14 Confirm you will meet all Performance Standard requirements as stated in Exhibit B, Section B14.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.15 Confirm you will meet all Optional Administrative Services requirements as stated in Exhibit B, Section B15.

- ○ Confirmed
- ○ Not confirmed (please explain)

29.16 Confirm you will meet all Funding requirements as stated in Exhibit B, Section B16.

- ○ Confirmed
- ○ Not confirmed (please explain)

Attachment Checklist

30.1 Confirm the following have been provided with your proposal. A check mark below indicates they have been uploaded to the Reference Files from Vendor section of the RFP.

- ☐ Q2.10 E&O Insurance
- ☐ Q2.12 Economic Impact
- ☐ Q2.13 Audited Financial Statements
- ☐ Q2.16 State of Missouri License
- ☐ Q3.3 Organizational Chart
- ☐ Q3.4 Implementation Plan
- ☐ Q4.11 Satisfaction Survey Results
- ☐ Q4.13 Member Communications

- [ ] Q5.12 Reliability Metrics
- [ ] Q5.14 Disaster Recovery Plan
- [ ] Q5.15 Disaster Recovery Plan Testing
- [ ] Q6.3 Customer Service Reports
- [ ] Q6.4 Sample Reporting Package
- [ ] Q7.7 Sample EOB
- [ ] Q9.2 Preferred Banking Arrangement
- [ ] Q9.10 Banking Reports
- [ ] Q10.11 Medical Procedures/Services
- [ ] Q12.6 UM Quarterly Reporting
- [ ] Q12.7 UM Member Communications
- [ ] Q13.13 CM Quarterly Reporting
- [ ] Q13.14 CM Member Communications
- [ ] Q14.5 Provider Network - Broad
- [ ] Q14.6 Hospital Network - Broad
- [ ] Q15.1 ACO Strategy
- [ ] Q15.3 PCMH Strategy
- [ ] Q20.1 Internal Appeal Process
- [ ] Q21.28 Additional Performance Guarantees
- [ ] Q21.29 Member Incentive Performance Guarantees
- [ ] Q22.2 Trend Guarantee
- [ ] Q22.5 Business Partners
- [ ] Q23.4 Provider Network(s) - High Performance
- [ ] Q23.5 Hospital Network(s) - High Performance
- [ ] Q24.9 Incentive Program Reports
- [ ] Q24.12 Incentive Program ROI
- [ ] Q25.3 Advocacy Process Map
- [ ] Q26.9 MCM Quarterly Reporting
- [ ] Q26.10 MCM Member Communications
- [ ] Q26.18 Musculoskeletal Program Satisfaction Metrics
- [ ] Q26.19 Musculoskeletal Program Operational Statistics
- [ ] Q27.12 DM Quarterly Reporting
- [ ] Q27.13 DM Member Communications

Mandatory Contract Provisions Questionnaire

Mandatory Contract Provisions

Bidders are expected to closely read the Mandatory Contract Provisions. Rejection of these provisions may be cause for rejection of a bidder's proposal. MCHCP requires that you provide concise responses to questions requiring explanation. Please note, there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of this questionnaire.

1.1 Term of Contract: The term of this Contract is for a period of one (1) year from January 1, 2020 through December 31, 2020. This Contract may be renewed for four (4) additional one-year periods at the sole option of the MCHCP Board of Trustees. The submitted pricing arrangement for the first year (January 1 - December 31, 2020) is a firm, fixed price. The submitted prices for the subsequent (2nd - 5th) years of the contract period (January 1 - December 31, 2021, January 1 - December 31, 2022, January 1 - December 31, 2023, and January 1 - December 31, 2024 respectively) are guaranteed not-to-exceed maximum prices and are subject to negotiation. Pricing for the one-year renewal periods are due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.2 Contract Documents: The following documents will be hereby incorporated by reference as if fully set forth within the Contract entered into by MCHCP and the Contractor: (1) Written and duly executed Contract (form of which will be provided and negotiated if necessary prior to award); (2) amendments to the executed Contract; (3) The Report and Data provisions set forth in the Exhibits of this RFP (subject to change in format, as needed and as mutually agreed upon by both parties); (4) The completed and uploaded Exhibits set forth in this RFP; and (5) This Request for Proposal.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.3 Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of Contractor involving any and all transactions related to the performance of this Contract. Contractor shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review. MCHCP and Contractor shall agree to reasonable times for Contractor to make such records available for audit. Audits must be conducted by a firm selected by MCHCP.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.4 Breach and Waiver: Waiver or any breach of any contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties thereto. If any contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the contract terms and conditions are severable.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.5 Confidentiality: Contractor will have access to private and/or confidential data maintained by MCHCP to the extent necessary to carry out its responsibilities under this Contract. No private or confidential data received, collected, maintained, transmitted, or used in the course of performance of this Contract shall be disseminated by Contractor except as authorized by MCHCP, either during the period of this Contract or thereafter. Contractor must agree to return any or all data furnished by MCHCP promptly at the request of MCHCP in whatever form it is maintained by Contractor. On the termination or expiration of this Contract, Contractor will not use any of such data or any material

derived from the data for any purpose and, where so instructed by MCHCP, will destroy or render it unreadable.

○ Confirmed
○ Not confirmed (please explain)

1.6 Electronic Transmission Protocols: Contractor and all subcontractors will maintain encryption standards of 1024 bit encryption or higher for the encryption of confidential information for transmission via non secure methods including File Transfer Protocol or other use of the Internet.

○ Confirmed
○ Not confirmed (please explain)

1.7 Eligibility: All determinations for coverage eligibility will be made by MCHCP. Effective and termination dates of plan participants will be determined by MCHCP. Contractor will be notified of enrollment changes through the carrier enrollment eligibility file, by telephone or by written notification from MCHCP.

○ Confirmed
○ Not confirmed (please explain)

1.8 Force Majeure: Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by Contractor's or its subcontractor's employees.

○ Confirmed
○ Not confirmed (please explain)

1.9 Governing Law: This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

○ Confirmed
○ Not confirmed (please explain)

1.10 Jurisdiction: All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

○ Confirmed
○ Not confirmed (please explain)

1.11 Independent Contractor: Contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, Contractor shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. Contractor assumes sole and full responsibility for its acts and the acts of its personnel.

○ Confirmed
○ Not confirmed (please explain)

1.12 Injunctions: Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, Contractor shall not be entitled to make or assess claim for damage by reason of said delay.

○ Confirmed
○ Not confirmed (please explain)

1.13 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

○ Confirmed
○ Not confirmed (please explain)

1.14 Modification of the Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

○ Confirmed
○ Not confirmed (please explain)

1.15 Notices: All notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the course of this contract shall be in writing and shall be made by personal delivery or by overnight delivery, prepaid, to the other party at a designated address or to any other persons or addresses as may be designated by notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355.

○ Confirmed
○ Not confirmed (please explain)

1.16 Ownership: All data developed or accumulated by Contractor under this Contract shall be owned by MCHCP. Contractor may not release any data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.17 Payment: Upon implementation of the undertaking of this Contract and acceptance by MCHCP, Contractor shall be paid as stated in this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.18 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require Contractor to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

○ Confirmed
○ Not confirmed (please explain)

1.19 Solicitation of Members: Contractor shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.20 Statutes: Each and every provision of law and clause required by law to be inserted or applicable to the services provided in the Contract shall be deemed to be inserted herein and the Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.21 Termination Right: Notwithstanding any other provision, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days notice.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.22 Off-shore Services: All services under this Contract shall be performed within the United States. Contractor shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in the Contractor being in breach of this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.23 Compliance with Laws: Contractor shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.24 Non-discrimination, Sexual Harassment and Workplace Safety: Contractor agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. Contractor shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. Contractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.25 Americans with Disabilities Act (ADA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA), Contractor understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, Contractor agrees to comply with all regulations promulgated under ADA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.26 Patient Protection and Affordable Care Act (PPACA): If applicable, Contractor shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations promulgated under PPACA, which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

○ Confirmed
○ Not confirmed (please explain)

1.27 Health Insurance Portability and Accountability Act of 1996 (HIPAA): Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

○ Confirmed
○ Not confirmed (please explain)

1.28 Genetic Information Nondiscrimination Act of 2008: Contractor shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

○ Confirmed
○ Not confirmed (please explain)

1.29 Contractor shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of Contractor's, or any associate's or subcontractor's of Contractor, failure to comply with paragraphs 1.24, 1.25, 1.26, 1.27, and 1.28 above.

○ Confirmed
○ Not confirmed (please explain)

1.30 Prohibition of Gratuities: Neither Contractor nor any person, firm or corporation employed by Contractor in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

○ Confirmed
○ Not confirmed (please explain)

1.31 Subcontracting; Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. Contractor shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of MCHCP. Contractor may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of MCHCP. Contractor agrees that any and all subcontracts entered into by Contractor for the purpose of meeting the requirements of this Contract are the responsibility of Contractor. MCHCP will hold Contractor responsible for assuring that subcontractors meet all the requirements of this Contract and all amendments thereto. Contractor must provide complete information regarding each subcontractor used by Contractor to meet the requirements of this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.32 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

○ Confirmed
○ Not confirmed (please explain)

1.33 Hold Harmless: Contractor shall hold MCHCP harmless from and indemnify against any and all claims for injury to or death of any persons; for loss or damage to any property; and for infringement of any copyright or patent to the extent caused by Contractor or Contractor's employee or its subcontractor. MCHCP shall not be precluded from receiving the benefits of any insurance Contractor may carry which provides for indemnification for any loss or damage to property in Contractor's custody and control, where such loss or destruction is to MCHCP's property. Contractor shall do nothing to prejudice MCHCP's right to recover against third parties for any loss, destruction or damage to MCHCP's property.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.34 Insurance and Liability: Contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement. Contractor shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. Contractor shall bear the risk of any loss or damage to any personal property in which Contractor holds title.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.35 Financial Record Audit and Retention: Contractor agrees to maintain, and require its subcontractors to maintain, supporting financial information and documents that are adequate to ensure the accuracy and validity of Contractor invoices. Such documents will be maintained and retained by Contractor or its subcontractors for a period of seven (7) years after the date of submission of the final billing or until the resolution of all audit questions, whichever is longer. Contractor agrees to timely repay any undisputed audit exceptions taken by MCHCP in any audit of this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.36 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, Contractor agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. Contractor agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the seven (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.37 Access to Records: Upon reasonable notice, Contractor must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. Contractor agrees to provide the access described wherever Contractor maintains such books, records, and supporting documentation. Further, Contractor agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. Contractor shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by

MCHCP, to audit the books, documents and records of Contractor to the extent that the books, documents and records relate to costs or pricing data for this Contract. Contractor agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. To the extent described herein, Contractor shall give full and free access to all records to MCHCP and/or their authorized representatives.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.38 Response/Compliance with Audit or Inspection Findings: Contractor must take action to ensure its or its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include Contractor's delivery to MCHCP, for MCHCP's approval, a corrective action plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

- ○ Confirmed
- ○ Not confirmed (please explain)

1.39 Inspections: Upon notice from MCHCP, Contractor will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to Contractor service locations, facilities, or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. Contractor must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.40 Acceptance: No contract provision or use of items by MCHCP shall constitute acceptance or relieve Contractor of liability in respect to any expressed or implied warranties.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.41 Termination for Cause: MCHCP may terminate this contract, or any part of this contract, for cause under any one of the following circumstances: 1) Contractor fails to make delivery of goods or services as specified in this Contract; 2) Contractor fails to satisfactorily perform the work specified in this Contract; 3) Contractor fails to make progress so as to endanger performance of this Contract in accordance with its terms; 4) Contractor breaches any provision of this Contract; 5) Contractor assigns this Contract without MCHCP's approval; or 6) Insolvency or bankruptcy of the Contractor. MCHCP shall have the right to terminate this Contract, in whole or in part, if MCHCP determines, at its sole discretion, that one of the above listed circumstances exists. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP, subject to any offset by MCHCP for actual damages including loss of any federal matching funds. Contractor shall be liable to MCHCP for any reasonable excess costs for such similar or identical services included within the terminated part of this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.42 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

○ Confirmed
○ Not confirmed (please explain)

1.43 Assignment: Contractor shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by Contractor made without prior written consent of MCHCP. Notwithstanding the foregoing, Contractor may, without the consent of MCHCP, assign its rights to payment to be received under this Contract, provided that Contractor provides written notice of such assignment to MCHCP together with a written acknowledgment from the assignee that any such payments are subject to all of the terms and conditions of this Contract. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Contractor provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by Contractor and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by Contractor, following which Contractor's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. Contractor shall give MCHCP written notice of any such change of name.

○ Confirmed
○ Not confirmed (please explain)

1.44 Compensation/Expenses: Contractor shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. Contractor shall be compensated only for work performed to the satisfaction of MCHCP. Contractor shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.45 Contractor Expenses: Contractor will pay and will be solely responsible for Contractor's travel expenses and out-of-pocket expenses incurred in connection with providing the services. Contractor will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

○ Confirmed
○ Not confirmed (please explain)

1.46 Conflicts of Interest: Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP.

○ Confirmed
○ Not confirmed (please explain)

1.47 Patent, Copyright, and Trademark Indemnity: Contractor warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. Contractor shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall

provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at the Contractor's written request, it shall be at Contractor's expense, but the responsibility for such expense shall be only that within Contractor's written authorization. Contractor shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that the Contractor or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by Contractor in such suit or proceeding are held to constitute infringement and the use is enjoined, Contractor shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If Contractor is unable to do any of the preceding, Contractor agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of Contractor under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of Contractor without its written consent.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.48 Tax Payments: Contractor shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on Contractor.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.49 Disclosure of Material Events: TPA agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies: (*) Any material adverse change to the financial status or condition of TPA; (*) Any merger, sale or other material change of ownership of TPA; (*) Any conflict of interest or potential conflict of interest between TPA's engagement with MCHCP and the work, services or products that TPA is providing or proposes to provide to any current or prospective customer; and (1) Any material investigation of TPA by a federal or state agency or self-regulatory organization; (2) Any material complaint against TPA filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming TPA before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming TPA as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against TPA by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against TPA as a result of any material criminal or civil action in which TPA was a party; or (7) Any other matter material to the services rendered by TPA pursuant to this Contract. 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 Contract. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, TPA is obligated to make its best faith efforts to disclose only those relevant matters which to the attention of or should have been known by TPA's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of TPA designated by TPA to monitor and report such matters. Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

- ○ Confirmed

○ Not confirmed (please explain)

1.50 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require TPA to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination.

○ Confirmed
○ Not confirmed (please explain)

1.51 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

○ Confirmed
○ Not confirmed (please explain)

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2020 Health Plan RFP
April 16, 2019

These responses are provided by MCHCP to questions received from potential bidders for the 2020 Health Plan RFP.

	General	Response
1	When will we receive an employee/retiree census in Excel?	A census file is available after receipt of the completed and signed Exhibit A-2, Limited Data Use Agreement, available as a Response Document within the DirectPath system.
2	Please confirm no hard-copy binders are required.	Confirmed.
3	Please confirm that a non-officer individual with the authority to bind a contract is sufficient to sign all applicable signature documents required for this RFP submission.	MCHCP requires the person that signs has the "requisite authority to execute this agreement on behalf of the vendor and to bind such respective party to the terms and conditions set forth herein."
4	Please confirm detail on the costs MCHCP pays via the claim wire? Are there any administrative fees billed via the claim wire for network access or care management?	MCHCP pays via ACH all administrative fees to the third party administrator on the 10th of the month following the coverage month. Claims payments are paid via ACH or check draft as specified by the provider. Access to United Healthcare Choice Plus and Transplant Centers of Excellence networks are included in the base fee and are not separately paid. The care management services provided to MCHCP are also included in the base fee and are not separately paid. The fees for the cost reduction and savings program are not included in the base fee and are paid via check draft through the monthly claims register.
5	Can you provide a detail sample of your claim wire (report)?	MCHCP has provided an additional reference file, Attachment 9, that provides the requested information.
6	Please provide paid claim data by plan option and employee count by month.	MCHCP has provided an additional reference file, Attachment 7, that provides the requested information.
7	The Introductions and Instructions document indicates "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." Please clarify if covered lives includes all members or refers only to employee lives.	Covered lives refers to all members.
8	Please confirm how many employees are included in this bid process.	This RFP covers MCHCP's non-Medicare population, approximately 41,400 subscribers and 79,700 members.
9	Is there any flexibility in plan design? For example language regarding some benefits, like allergy benefits, may cause a substantial decrease in adjudication for those benefits. Simplified language could greatly increase adjudication.	MCHCP is looking for a vendor that can implement plan design as described and as specified in state regulation.
10	What vendor provides disease management services for MCHCP's members currently? What is the cost (PEPM) for these disease management services? What specific programs are included in the disease management package?	MCHCP does not currently include disease management services in its plan.

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11	Does MCHCP use UMR's teledoc program or an outside vendor? What is the cost for teledoc?	MCHCP utilizes Teladoc for general medicine through its current TPA contractors - UMR and Aetna. UMR charges $0.80 PEPM and a $45 visit fee for general medical services. Aetna charges $0.95 PEPM and $40 visit fee for general medicine services.
12	Are any 'concierge' services purchased from UMR for member services? Please describe these services, hours of operation, etc.	Concierge services are not purchased from UMR for member services.
13	What vendor provides maternity management for MCHCP's members? Please describe these services. What is the cost for the current maternity management program (PEPM)?	UMR provides maternity management for MCHCP members enrolled in a UMR managed plan. The cost is included as part of the overall PEPM and not separately detailed.
14	Does MCHCP contract with an outside vendor for claim fiduciary services? What is the fee for this service?	MCHCP does not contract with an outside vendor for claim fiduciary services. As a non-federal governmental health plan, MCHCP has opted to use MAXIMUS Federal for external appeals provided at no charge through the US Department of Health and Human Services.
15	Does MCHCP have a musculoskeletal program today? What is the cost (PEPM) and who is the vendor? What services are covered under this program?	MCHCP does not have a musculoskeletal program today.
16	What is the volume for the top 25 inpatient facilities?	MCHCP has provided an additional reference file, Attachment 8, that provides the requested information.
17	What are the bed days/1,000 for med/surg and for behavioral health? Please exclude maternity.	For claims paid in 2018 for non-Medicare members: Medical: 92.93 Surgical: 85.28 Behavioral health/Substance Use: 43.31
18	What are the top five conditions for MCHCP's members?	The top five clinical conditions for calendar year 2018 paid claims are, in descending order, as follows: 1) Prevent/Adm Hlth Encounters 2) Signs/Symptoms/Oth Cond, NEC 3) Osteoarthritis 4) Arthropathies/Joint Disord NEC 5) Spinal/Back Disord, Low Back
19	What are the programs purchased through UMR and what are the programs' respective PEPM costs?	In addition to administrative claims and banking services, UMR provides Care Management services (CMS includes case management and ER support) and Group Population Support services (includes maternity management, HealtheNotes Reminders, Treatment decision Support, Readmission Prevent, and nurseline), quarterly preventive care management member communication, and member satisfaction survey services. All of these programs are included in the base PEPM and are not separately priced. UMR provides Subrogation and Overpayment services with UMR retaining 25% or 33% (if handled by outside legal counsel) of the recovery amount. UMR provides A Cost Reduction and Savings Program for non-network claims with UMR charging 30% of savings.

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20	Does MCHCP contract for services, related to health care, that are not provided by UMR?	MCHCP contracts with Aetna for services in the Southwest South Central Region. MCHCP has contracts for dental with MetLife and for vision with NVA. MCHCP has a contract with Cerner to manage MCHCP's onsite health center. MCHCP has a contract with NS412, LLC for an electronic based weight management services. MCHCP has a contract with ComPsych for EAP services.
21	Can you provide us an enrollment report providing total enrolled employees and members?	MCHCP has provided an additional reference file, Attachment 7, that provides the requested information.
22	Can you provide us 24 months of monthly claims/enrollment?	MCHCP has provided an additional reference file, Attachment 7, that provides the requested information.
23	We have reviewed the provider file layout, and we are unable to provide all of the data elements requested (among other items, we are unable to provide TINs, as those may include individual provider SSNs). Can you provide us a provider file for us to disrupt?	MCHCP will not supply a provider file to conduct a disruption analysis. MCHCP can accept a provider file that does not include the TIN.
24	Will the claims repricing/ network discounts that are submitted by each carrier to Willis Towers Watson be based on using UDS fields of data?	Yes, they should be based on using UDS fields of data.
25	Can you please send MCHCP's plan design for review?	The current plan designs are included as part of the Pricing Model. Additional information regarding benefits can be found on MCHCP's website at www.mchcp.org.
26	Can you please clarify what network reports (if any) are being requested (i.e. GeoAccess, Disruption, Repricing, etc.)?	MCHCP has requested provider files (Questions 14.5, 14.6, 23.4 and 23.5 of the Health Plan RFP Questionnaire). A disruption analysis is not required at this time. MCHCP's contracted actuary/consultant, Willis Towers Watson (WTW), will analyze provider discounts utilizing the information required in Exhibits A-3, A-4 and A-5. Information on submitting these exhibits to WTW can be found in the Introduction/Instructions document.
27	Would MCHCP consider stand-alone bids for services like Advocacy and Musculoskeletal services?	No.

Mandatory Contract Provisions Questionnaire		**Response**
1	Regarding Q1.22 (Mandatory Contract Provisions), will MCHCP allow the selected carrier to offshore non-member facing services?	As stated in Section 2.5 of the Exhibit A-10 Sample Contract, "Off-Shore Services: All services under this Contract shall be performed within the United States. TPA shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in TPA being in breach of this Contract."

MBE-WBE		**Response**
1	Is the use of Minority Business Enterprise/Women Business Enterprises required as part of this bid?	MBE/WBE requirements are detailed in the reference documents, beginning on pages 11 and 12 of the Introduction. Questions regarding MBE/WBE are found in Section 28 of the Questionnaire.

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2	Per the Instructions document: 'The bidder should secure participation of certified MBEs and WBEs in provider products/services required in the RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.' Is the 15% based on the total dollar value of the MCHCP contract or individual contracts specific to products and services?	Total value of the MCHCP contract.

	Questionnaire	**Response**
1	Question 6.3 says: Confirm you have uploaded copies of the standard customer service reports that will be made available to satisfy the requirements stated in Exhibit B, Section 5.3 to the References Files from Vendor. Section 5.3 doesn't reference reports. Should this question refer to Section B7 instead?	The correct section reference in Exhibit B is Section 7.2.

Attachment 7 - Member counts and Net Pay by Plan by Month

Plan	Paid Month	Subscribers	Members	Net Pay Med
PPO 300 Plans	Jan 2017	17,762.0	28,214	$11,967,676.72
	Feb 2017	17,866.0	28,362	$9,984,252.13
	Mar 2017	17,904.0	28,413	$9,818,049.04
	Apr 2017	17,906.0	28,417	$9,925,299.60
	May 2017	17,925.0	28,473	$10,362,007.37
	Jun 2017	17,975.0	28,577	$8,853,134.76
	Jul 2017	17,991.0	28,619	$9,437,308.52
	Aug 2017	18,026.0	28,666	$12,663,126.12
	Sep 2017	18,058.0	28,700	$9,337,518.94
	Oct 2017	18,091.0	28,741	$11,024,766.05
	Nov 2017	18,106.0	28,768	$10,704,657.82
	Dec 2017	18,126.0	28,796	$9,042,010.81
	Jan 2018	17,173.0	27,308	$14,415,847.51
	Feb 2018	17,213.0	27,384	$9,359,944.28
	Mar 2018	17,254.0	27,428	$9,962,996.51
	Apr 2018	17,286.0	27,495	$11,182,004.06
	May 2018	17,323.0	27,552	$10,357,234.94
	Jun 2018	17,307.0	27,554	$9,172,734.72
	Jul 2018	17,331.0	27,610	$9,985,861.45
	Aug 2018	17,321.0	27,606	$10,663,735.75
	Sep 2018	17,316.0	27,568	$11,168,957.89
	Oct 2018	17,314.0	27,536	$10,819,969.47
	Nov 2018	17,353.0	27,618	$10,049,164.62
	Dec 2018	17,324.0	27,577	$9,764,031.55
	Jan 2019			$10,553,170.12
	Feb 2019			$4,638,717.38
PPO 600 Plans	Jan 2017	32,308.0	59,644	$25,240,008.07
	Feb 2017	32,187.0	59,482	$19,689,347.79
	Mar 2017	32,099.0	59,358	$21,265,570.50
	Apr 2017	31,986.0	59,195	$21,546,546.35
	May 2017	31,943.0	59,095	$23,360,459.17
	Jun 2017	31,881.0	59,002	$22,848,549.40
	Jul 2017	31,789.0	58,892	$21,332,341.48
	Aug 2017	31,711.0	58,763	$31,411,069.79
	Sep 2017	31,644.0	58,655	$21,465,799.74
	Oct 2017	31,561.0	58,519	$23,746,456.09
	Nov 2017	31,512.0	58,425	$24,925,881.48
	Dec 2017	31,473.0	58,348	$22,017,943.34
	Jan 2018	32,632.0	60,405	$34,209,458.96
	Feb 2018	32,552.0	60,240	$23,494,332.49
	Mar 2018	32,439.0	60,042	$23,968,900.16
	Apr 2018	32,382.0	59,954	$24,030,292.05
	May 2018	32,302.0	59,847	$23,469,135.27
	Jun 2018	32,152.0	59,578	$22,201,013.21
	Jul 2018	32,020.0	59,302	$25,715,330.82
	Aug 2018	31,849.0	59,008	$27,015,954.50
	Sep 2018	31,718.0	58,771	$24,257,362.22
	Oct 2018	31,596.0	58,544	$27,624,326.09
	Nov 2018	31,513.0	58,323	$26,100,830.29
	Dec 2018	31,400.0	58,065	$23,560,693.32
	Jan 2019			$24,847,902.38
	Feb 2019			$9,694,320.25
HSA Plans	Jan 2017	3,668.0	8,267	$1,399,786.80
	Feb 2017	3,701.0	8,320	$1,271,054.07

Plan	Paid Month	Subscribers	Members	Net Pay Med
	Mar 2017	3,705.0	8,332	$1,067,315.09
	Apr 2017	3,708.0	8,327	$1,459,590.63
	May 2017	3,688.0	8,292	$1,136,398.80
	Jun 2017	3,692.0	8,309	$1,348,989.72
	Jul 2017	3,698.0	8,303	$1,260,660.95
	Aug 2017	3,702.0	8,318	$1,932,630.73
	Sep 2017	3,713.0	8,317	$1,442,681.12
	Oct 2017	3,712.0	8,304	$2,002,226.43
	Nov 2017	3,739.0	8,318	$1,886,357.71
	Dec 2017	3,746.0	8,318	$1,875,976.95
	Jan 2018	3,874.0	8,621	$2,891,000.15
	Feb 2018	3,891.0	8,636	$1,532,744.50
	Mar 2018	3,895.0	8,651	$1,409,682.36
	Apr 2018	3,900.0	8,646	$1,421,784.89
	May 2018	3,904.0	8,642	$1,263,071.15
	Jun 2018	3,897.0	8,608	$1,582,066.72
	Jul 2018	3,904.0	8,599	$1,570,282.56
	Aug 2018	3,910.0	8,611	$2,109,906.15
	Sep 2018	3,896.0	8,567	$1,819,412.04
	Oct 2018	3,918.0	8,583	$1,645,959.77
	Nov 2018	3,951.0	8,616	$1,822,505.26
	Dec 2018	3,977.0	8,646	$1,739,646.26
	Jan 2019	5,537.0	11,963	$2,333,663.17
	Feb 2019	5,598.0	12,079	$1,421,001.36
PPO 1000	Jan 2017	440.0	554	$185,725.06
	Feb 2017	445.0	559	$78,350.82
	Mar 2017	442.0	555	$96,399.00
	Apr 2017	445.0	560	$208,139.50
	May 2017	448.0	562	$323,959.78
	Jun 2017	451.0	565	$162,649.85
	Jul 2017	452.0	569	$204,897.19
	Aug 2017	453.0	571	$298,571.33
	Sep 2017	450.0	569	$188,319.57
	Oct 2017	447.0	566	$155,454.78
	Nov 2017	451.0	570	$203,917.65
	Dec 2017	453.0	576	$171,465.45
	Jan 2018	451.0	573	$313,201.48
	Feb 2018	454.0	574	$106,050.36
	Mar 2018	456.0	581	$111,541.22
	Apr 2018	453.0	581	$145,378.08
	May 2018	453.0	580	$152,696.35
	Jun 2018	461.0	587	$177,720.88
	Jul 2018	465.0	597	$178,506.88
	Aug 2018	467.0	599	$250,746.16
	Sep 2018	468.0	602	$289,854.01
	Oct 2018	463.0	592	$277,932.97
	Nov 2018	464.0	589	$237,643.01
	Dec 2018	466.0	593	$124,712.48
	Jan 2019			$160,437.26
	Feb 2019			$38,089.35
PPO 750 Plans	Jan 2019	12,143.0	23,023	$291,892.57
	Feb 2019	12,219.0	23,167	$6,549,141.26
PPO 1250 Plans	Jan 2019	24,046.0	45,183	$251,195.49
	Feb 2019	23,976.0	45,046	$8,199,921.37

Attachment 8
Top 25 Hospital Profile
Non Medicare Members
Jan 2018 - Dec 2018 (Paid)

Facility Name	Allowed Amount Admit Acute	Admits Acute	Days LOS Admit Acute
University Hospital	$18,988,759.09	618	4.22
Barnes-Jewish Hospital	$14,947,906.07	260	5.75
Boone Hospital Center	$7,189,480.96	320	3.40
SSM Health St Marys Hospital - Jefferson City	$6,193,967.04	511	2.65
Saint Lukes Hospital of Kansas City	$5,191,086.22	112	5.05
Mercy Hospital St Louis	$4,978,700.61	216	4.48
University of Kansas Health	$4,926,309.27	99	6.31
Mercy Hospital Springfield	$4,917,837.78	207	3.45
Mosaic Life Care at St Joseph - Medical Center	$4,378,035.18	192	2.80
SSM Health Good Samaritan Hospital - Mt Vernon	$4,242,541.97	309	3.27
Capital Region Medical Center	$4,146,777.75	334	2.71
Saint Francis Medical Center	$3,684,357.94	89	3.63
St Louis Childrens Hospital	$3,333,800.92	69	4.81
Childrens Mercy Hospital - Adele Hall Campus	$2,593,395.72	60	3.88
Cox Medical Center South	$2,441,775.80	162	3.36
Missouri Baptist Medical Center	$2,164,990.77	104	4.05
Mercy Hospital Jefferson	$1,647,785.02	134	2.25
Southeast Hospital	$1,508,307.10	85	3.58
Saint Lukes East Hospital	$1,407,402.60	64	2.84
St Anthonys Medical Center	$1,374,495.17	94	4.88
Poplar Bluff Regional Medical Center - Oak Grove	$1,368,044.99	53	2.40
North Kansas City Hospital	$1,365,375.97	72	2.74
Phelps County Regional Medical Center	$1,285,288.00	51	3.08
Hannibal Regional Hospital	$1,193,362.73	41	2.29
SSM Cardinal Glennon Childrens Medical Center	$1,102,159.89	26	5.73

Central Bank EPS Daily Reporting

Payment Recon Report

EPS Payment Instruction Reconciliation Report

Processing Date: 04/12/19

Settlement Date: 04/16/19

Discrepancy Amount **#VALUE!**

NACHA File Total	**XX.XX**
Total ACHs	**1,897**
Checks Total	**$0.00**
Total Checks	**0**
Total Non-Transactions	**0**
Grand Total 835s	**1,897**

Funding Notifications

Payer	Payer Funded	Total	
State of MO	XX.XX	$0.00	Discrepancy
	Funding Total	**$0.00**	**#VALUE!**

EPS NACHA by Payer

UMR State of MO

Payment Instruction Reconciliation

PayerID	Payer Name	Payer Funding Amount	Total ACH Payment	Total ACHs	Total CHK Payment	Total CHKs	Total NON Payments
UMR01	UMR	XX.XX	XX.XX	1897	0	0	0
	Totals	XX.XX	XX.XX	1897	0	0	0

Subpayer ID	Subpayer Name	Payer Funding Amount	Total ACH Payment	Total ACHs	Total CHK Payment	Total CHKs	Total NON Payments
431652936	UMR MISSOURI CONSOLIDATED HEALTH CARE PLAN	0	XX.XX	1793	0	0	0
999999001	UMR MISSOURI CONSOLIDATED HEALTH CARE PLAN	0	XX.XX	104	0	0	0
	Totals	0	XX.XX				

835 Reconciliation

PayerID	Payer Name	Payer Funding Amount	Total Payment From Consolidated 835s
UMR01	UMR	XX.XX	XX.XX
	Totals	XX.XX	XX.XX

Payment Instruction Recon Grand Totals	**XX.XX**	**XX.XX**	**1,897**	**$0.00**	**0**	**0**

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Summary of All Wirelines

Funds Summary Report (FSR) Totals

Prepared: 4/5/2019
Activity Period: 03/01/2019 to 03/31/2019
Policyholder #: 737379
Policyholder: MO CONSOLIDATED HEALTH CARE PLAN
Wireline: SUMMARY
Wireline Name: SUMMARY
Renewal Date: 1/1/2020

Total Summary for Wireline

	Current Reporting Period	Renewal Year to Date
Total Policyholder Claims Recorded	XX.XX	XX.XX
Prior Year Renewal Adjustment (+)	0.00	0.00
Total Adjusted Funded Claims (-)	XX.XX	XX.XX
Total Funds Received	XX.XX	XX.XX
Total Adjusted Funded Claims (-)	XX.XX	XX.XX
Difference	0.00	0.00

IF THERE IS A DIFFERENCE PLEASE REFER TO THE FUNDS REQUEST RECEIPT REPORT (FRRR) FOR AN EXPLANATION

All CSA Summary for Wireline

	Current Reporting Period				Renewal Year to Date			
Type	Policyholder	Aetna Funded	Over Limit	Totals	Policyholder	Aetna Funded	Over Limit	
RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX

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Funds Request / Receipt and Funds Summary Report

Prepared: 4/5/2019
Activity Period: 03/01/2019 to 03/31/2019
Policyholder #: 737379
Policyholder: MO CONSOLIDATED HEALTH CARE PLAN
Wireline: 48897
Wireline Name: MCHCP
Renewal Date: 1/1/2020

Funds Request and Receipt Report (FRRR)

Wireline Summary

	Amount
Total Funds Requested	XX.XX
Total of All Other Adjustments (-)	0.00
Total Amount of Funded Claims	XX.XX
Total Funds Receipt	XX.XX
Total Amount of Funded Claims (-)	XX.XX
Difference	0.00

Wireline Detail

Date of Request	Amount of Funded Claims	All Other Adjustments (See Notes)	Funds Requested	Date of Funds Receipt	Funds Receipt	Notes
3/4/2019	XX.XX	0.00	XX.XX	3/4/2019	XX.XX	
3/5/2019	XX.XX	0.00	XX.XX	3/5/2019	XX.XX	
3/6/2019	XX.XX	0.00	XX.XX	3/6/2019	XX.XX	
3/12/2019	XX.XX	0.00	XX.XX	3/12/2019	XX.XX	
3/14/2019	XX.XX	0.00	XX.XX	3/14/2019	XX.XX	
3/15/2019	XX.XX	0.00	XX.XX	3/15/2019	XX.XX	
3/18/2019	XX.XX	0.00	XX.XX	3/18/2019	XX.XX	
3/19/2019	XX.XX	0.00	XX.XX	3/19/2019	XX.XX	
3/20/2019	XX.XX	0.00	XX.XX	3/20/2019	XX.XX	
3/22/2019	XX.XX	0.00	XX.XX	3/22/2019	XX.XX	
3/25/2019	XX.XX	0.00	XX.XX	3/25/2019	XX.XX	
3/26/2019	XX.XX	0.00	XX.XX	3/26/2019	XX.XX	
3/27/2019	XX.XX	0.00	XX.XX	3/27/2019	XX.XX	
3/29/2019	XX.XX	0.00	XX.XX	3/29/2019	XX.XX	
4/1/2019	XX.XX	0.00	XX.XX	4/1/2019	XX.XX	

Funds Summary Report (FSR)

Total Summary for Wireline

	Current Reporting Period	Renewal Year to Date
Total Policyholder Claims Recorded	XX.XX	XX.XX
Prior Year Renewal Adjustment (+)	0.00	0.00
Total Adjusted Funded Claims (-)	XX.XX	XX.XX
Total Funds Received	XX.XX	XX.XX
Total Adjusted Funded Claims (-)	XX.XX	XX.XX
Difference	0.00	0.00

IF THERE IS A DIFFERENCE PLEASE REFER TO THE FUNDS REQUEST RECEIPT REPORT (FRRR) FOR AN EXPLANATION

All CSA Summary for Wireline

		Current Reporting Period			Renewal Year to Date		
Type	Policyholder	Aetna Funded	Over Limit	Totals	Policyholder	Aetna Funded	Over Limit	
RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX

CSA Breakdown for Wireline

			Current Reporting Period				Renewal Year to Date			
CSA	Account Name	Type	Policyholder	Aetna Funded	Over Limit	Totals	Policyholder	Aetna Funded	Over Limit	Totals
737379-10-1	$1250 ACTIVE PP	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-3	$1250 RETIREE U	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-7	$1250 LTD PPO N	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-8	$1250 SERVIVING	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-9	$1250 VESTED PP	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-103	$1250 RETIREE U	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-105	$1250 RETIREE A	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-107	$1250 LTD PPO M	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-108	$1250 SERVIVING	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX

737379-10-203	MDCR DEPS OF NO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-10-305	NON-MDCR DEP OF	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-1	$750 ACTIVE PPO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-3	$750 RETIREE UN	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-7	$750 LTD PPO NO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-8	$750 SURVIVING	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-9	$750 VESTED PPO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-103	$750 RETIREE UN	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-105	$750 RETIREE AG	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-108	$750 ACTIVE SUR	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-203	MDCR DEPS OF NO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-303	NON-MDCR DEP OF	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-11-305	NON-MDCR DEP OF	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-12-1	HDHP ACTIVE PPO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-12-3	HDHP RETIREE UN	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
737379-12-7	HDHP VESTED PPO	RCD CLAIMS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX
		TOTALS	XX.XX	0.00	0.00	XX.XX	XX.XX	0.00	0.00	XX.XX

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2020 Health Plan RFP
April 18, 2019

These responses are provided by MCHCP to additional questions received from potential bidders for the 2020 Health Plan RFP.
The

	General	Response
1	Regarding the response to Question 4 in the Q&As from vendors, please define 'cost reduction and savings program'.	The cost reduction and savings program is UMR's solution to assist MCHCP in managing the cost of non-network claims.
2	Since the Medicare retirees movved of the plan effective 1-1-19, would you be able to add a column for claims for the retirees and for the actives since the retirees are no longer in scope?	MCHCP has provided an additional reference file, Attachment 10, that provides the requested information.

Attachment 10 - Non-Medicare Member counts and Net Pay by Plan by Month

Subsets		Non Medicare Member		
Plan	**Time Period: Paid Month**	Employees Avg Med	Members Med	Net Pay Med
PPO 300 Plans	Jan 2017	10,247.0	18,642	$10,447,755.93
	Feb 2017	10,352.0	18,795	$8,861,214.45
	Mar 2017	10,397.0	18,856	$8,838,819.92
	Apr 2017	10,402.0	18,858	$8,772,296.50
	May 2017	10,418.0	18,909	$9,084,194.42
	Jun 2017	10,458.0	19,004	$7,798,763.16
	Jul 2017	10,471.0	19,041	$8,431,142.44
	Aug 2017	10,491.0	19,066	$11,101,486.65
	Sep 2017	10,508.0	19,085	$8,260,656.50
	Oct 2017	10,536.0	19,120	$9,832,876.61
	Nov 2017	10,554.0	19,148	$9,244,524.92
	Dec 2017	10,568.0	19,170	$8,070,860.35
	Jan 2018	9,601.0	17,655	$12,528,281.32
	Feb 2018	9,655.0	17,749	$8,331,866.64
	Mar 2018	9,702.0	17,808	$8,836,154.95
	Apr 2018	9,727.0	17,866	$10,029,599.91
	May 2018	9,768.0	17,927	$9,130,927.01
	Jun 2018	9,759.0	17,935	$7,943,860.74
	Jul 2018	9,774.0	17,992	$8,633,973.25
	Aug 2018	9,759.0	17,981	$9,233,468.38
	Sep 2018	9,756.0	17,947	$10,101,910.79
	Oct 2018	9,749.0	17,912	$9,181,614.21
	Nov 2018	9,796.0	18,001	$8,773,877.58
	Dec 2018	9,768.0	17,959	$8,498,708.41
	Jan 2019			$8,603,366.43
	Feb 2019			$4,084,289.13
PPO 600 Plans	Jan 2017	28,595.0	54,775	$24,514,306.25
	Feb 2017	28,447.0	54,568	$19,175,666.15
	Mar 2017	28,328.0	54,398	$20,866,143.39
	Apr 2017	28,176.0	54,188	$21,022,491.06
	May 2017	28,112.0	54,052	$22,771,204.28
	Jun 2017	27,996.0	53,894	$22,408,814.92
	Jul 2017	27,873.0	53,726	$20,925,406.93
	Aug 2017	27,758.0	53,542	$30,685,359.05
	Sep 2017	27,664.0	53,389	$21,014,446.76
	Oct 2017	27,550.0	53,206	$23,174,395.32
	Nov 2017	27,482.0	53,084	$24,280,982.82
	Dec 2017	27,416.0	52,969	$21,517,873.87
	Jan 2018	28,589.0	55,047	$33,331,904.97
	Feb 2018	28,484.0	54,840	$23,079,555.51
	Mar 2018	28,345.0	54,604	$23,411,855.93
	Apr 2018	28,270.0	54,485	$23,431,605.06
	May 2018	28,152.0	54,332	$22,940,263.33
	Jun 2018	27,966.0	54,012	$21,629,614.42
	Jul 2018	27,796.0	53,681	$25,062,590.37
	Aug 2018	27,568.0	53,314	$26,302,586.77
	Sep 2018	27,403.0	53,026	$23,703,298.90
	Oct 2018	27,236.0	52,737	$26,879,973.11
	Nov 2018	27,127.0	52,476	$25,428,821.95
	Dec 2018	26,990.0	52,185	$22,889,038.88
	Jan 2019			$23,963,737.91
	Feb 2019			$9,407,553.56
HSA Plans	Jan 2017	3,668.0	8,267	$1,399,786.80
	Feb 2017	3,701.0	8,320	$1,271,054.07
	Mar 2017	3,705.0	8,332	$1,067,315.09

	Apr 2017	3,708.0	8,327	$1,459,590.63
	May 2017	3,688.0	8,292	$1,136,398.80
	Jun 2017	3,692.0	8,309	$1,348,989.72
	Jul 2017	3,698.0	8,303	$1,260,660.95
	Aug 2017	3,702.0	8,318	$1,932,630.73
	Sep 2017	3,713.0	8,317	$1,442,681.12
	Oct 2017	3,712.0	8,304	$2,002,226.43
	Nov 2017	3,739.0	8,318	$1,886,357.71
	Dec 2017	3,746.0	8,318	$1,875,976.95
	Jan 2018	3,874.0	8,621	$2,891,000.15
	Feb 2018	3,891.0	8,636	$1,532,744.50
	Mar 2018	3,895.0	8,651	$1,409,682.36
	Apr 2018	3,900.0	8,646	$1,421,784.89
	May 2018	3,904.0	8,642	$1,263,071.15
	Jun 2018	3,897.0	8,608	$1,582,066.72
	Jul 2018	3,904.0	8,599	$1,570,282.56
	Aug 2018	3,910.0	8,611	$2,109,906.15
	Sep 2018	3,896.0	8,567	$1,819,412.04
	Oct 2018	3,918.0	8,583	$1,645,959.77
	Nov 2018	3,951.0	8,616	$1,822,505.26
	Dec 2018	3,977.0	8,646	$1,739,646.26
	Jan 2019	5,525.0	11,927	$2,333,663.17
	Feb 2019	5,584.0	12,038	$1,421,001.36
PPO 1000	Jan 2017	438.0	551	$185,676.60
	Feb 2017	443.0	556	$78,291.88
	Mar 2017	440.0	552	$96,388.68
	Apr 2017	443.0	557	$208,113.66
	May 2017	446.0	559	$323,920.34
	Jun 2017	449.0	562	$162,649.85
	Jul 2017	450.0	566	$204,896.68
	Aug 2017	451.0	568	$298,546.00
	Sep 2017	448.0	566	$188,297.71
	Oct 2017	445.0	563	$155,292.18
	Nov 2017	449.0	567	$203,876.68
	Dec 2017	451.0	573	$170,847.24
	Jan 2018	450.0	571	$313,182.75
	Feb 2018	453.0	572	$106,028.96
	Mar 2018	455.0	579	$111,541.22
	Apr 2018	452.0	579	$145,141.75
	May 2018	452.0	578	$152,659.14
	Jun 2018	460.0	585	$177,373.81
	Jul 2018	464.0	595	$178,421.30
	Aug 2018	466.0	597	$250,734.25
	Sep 2018	467.0	600	$289,838.42
	Oct 2018	462.0	590	$277,926.73
	Nov 2018	463.0	587	$237,326.59
	Dec 2018	465.0	591	$124,712.48
	Jan 2019			$160,425.19
	Feb 2019			$38,089.35
PPO 750 Plans	Jan 2019	11,962.0	22,684	$291,068.69
	Feb 2019	12,042.0	22,835	$6,546,942.41
PPO 1250 Plans	Jan 2019	23,650.0	44,486	$248,498.60
	Feb 2019	23,592.0	44,358	$8,199,843.77

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2020 Health Plan RFP
April 23, 2019

These responses are provided by MCHCP to additional questions received from potential bidders for the 2020 Health Plan RFP.

	Questionnaire	Response
1	How is MCHCP defining "markets" referenced in Q23.9 and Q23.10? Do markets refer to the regions on the map provided as Attachment 2?	Please assume the term “markets” refers to Metropolitan Statistical Areas (MSAs) determined by 3-digit zip code.

	Attachment 8	Response
1	Regarding Attachment 8, what membership is included in those numbers? Is that total population (96,000 members) or base population only (non-GRS 80,000 members)?	Attachment 8 includes admissions for non-Medicare members only, approximately 80,000 members.
2	Regarding Attachment 8, do the admissions include all admissions? Specifically, does it include nursing facility admissions, maternity, well baby, NICU, behavior health, medical, surgical?	Attachment 8 includes all acute admissions for non-Medicare members including inpatient hospitals, birthing centers, inpatient psychiatric facilities and residential substance use treatment facilities. It does not include services provided in a long-term care setting such as a skilled nursing or custodial care facilities.

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2020 Health Plan RFP
April 26, 2019

These responses are provided by MCHCP to additional questions received from potential bidders for the 2020 Health Plan RFP.

	Questionnaire	Response
1	We understood from WTW that we are to submit the provider files to them and not through DirectPath. Questions 23.4, 23.5, 14.5 and 14.6 imply that we are to upload those provider files to DirectPath. Can you confirm which is correct?	Responses to Questions 14.5, 14.6, 23.4 and 23.5 should be submitted through DirectPath. Exhibits A-3, A-4, and A-5 must be submitted to Willis Towers Watson and should not be uploaded to DirectPath.

	Pricing	Response
1	Would you please advise how we should show pricing for services that are billed at a percentage of savings? The grid requires a PEPM dollar amount. Is it okay to show $0.00 in pricing and put percentage in the description?	In the Supplemental Pricing worksheet, you may put $0.00 in the Fees field and provide a description in the Basis for Payment column. All amounts in the ASO Fee worksheet should be on a PEPM basis.