**ATTACHMENT A**

REQUEST FOR PROPOSALS

FOR

CARE MANAGEMENT SERVICES

e-PIN 00215P0002

**CARE MANAGEMENT RFP QUESTIONNAIRE**

GENERAL INFORMATION AND EXPERIENCE

1. Briefly describe your organization’s approach and philosophy on care management and how it fits into your overall business strategy.

2. Please indicate your financial ratings from the following independent rating agencies:

a. AM Best

b. Standard & Poor

c. Moody’s

3. Has there been any downgrade to your ratings in the past two years? Yes or No?

4. Do you anticipate any major changes to your organization or structure in the next 12 – 24 months? If Yes, please explain.

5. Is your organization currently URAC and/or NCQA accredited for utilization management services?

6. Is your organization currently URAC and/or NCQA accredited for case management services?

7. What other accreditations does your organization hold?

8. Are there any outstanding legal actions against your organization? If Yes, please give a brief summary of outstanding legal actions.

9. Can you assure that any legal actions against your organization will not disrupt business operations?

10. Please certify that you are licensed to do business in the State of NY (Yes or No).

11. How long has your organization been performing care management services?

12. Does your organization subcontract for any portion of the services that are requested as part of the Scope of Work in this proposal, including physician review services?

13. Please indicate the days and hours of your operation.

14. If you are not available 24x7x365, what type of system is available for receipt of precertification calls before/after your normal working hours?

15. Considering the size and possible volume of incoming phone calls, please indicate your telephone system capabilities. Is the present system adequate or will it need to be expanded?

16. How does your organization determine appropriate staffing levels for utilization management and case management?

17. (a) Do you agree to maintain adherence to federal HIPAA Privacy and Security regulations as it relates to the personal health information you receive about plan participants during the proposal, implementation, contract and post-contract periods?

(b) Briefly describe your disaster recovery plan and protocols, including how participant data is housed and protected.

18. Will you be able to implement these services in full by January 1, 2016?

19. How long do you typically require for implementation? Briefly describe the implementation process and staff assigned to the process.

20. Will you need to hire additional staff to administer this program? If so, how many additional employees do you anticipate needing?

21. Do any of your precertification, concurrent review or case management staff work offsite/remotely? If so, how do you maintain HIPAA Privacy and Security in their offsite/remote location?

22. How does your organization stay up-to-date with medical advances? How does your organization communicate this information to clients?

23. Confirm that the City would have a dedicated toll free number for members and providers would use to call.

24. Do you have staff that can accommodate members who speak languages other than English? If so, please explain how and specify which languages.

25. Are you able to communicate electronically using the most current HIPAA EDI 278 transactions?

26. Do you subcontract with a clearinghouse to achieve EDI compliance?

27. Indicate the location(s) of the office(s) that will serve the plan.

28. Indicate what percent of your firm’s total revenue is from care management services.

29. Please indicate the average admissions per thousand lives and bed days per thousand lives for your book of business for employees in a PPO type plan.

30. Please indicate the average return on investment experienced by your clients for UM and CM services.

31. How do you calculate a client’s return on investment? Please provide details of your methodology to calculate savings.

32. Are there any specific reporting or administrative procedures you would require of the plan (including its carriers and vendors) prior to implementation of your program?

33. Please briefly describe any services provided by your organization not specifically requested in this RFP that could contribute to the City’s cost savings efforts. Examples could include wellness programs, health coaching, nurseline etc.

UTILIZATION MANAGEMENT SERVICES (UM)

34. Briefly describe your organization’s approach to each of the following services. Include any specifics that distinguish your program from similar programs.

a. Precertification review

b. Concurrent review

c. Discharge planning

d. Readmission Management

e. Catastrophic and complex case and disease management

f. Outpatient Procedure certification including surgical, medical, imaging, rehab services

g. Physician review

h. Steering/facilitation of care through in-network providers

i. First and second level of appeals for any adverse benefit determinations

j. Coordination with External Review

35. Please confirm that you can review all of the following under your precertification review program:

a. inpatient hospital/facility admissions for medical, surgery, and maternity (pediatrics and adults)

b. inpatient hospital/facility admissions for mental health and substance abuse (pediatrics and adults)

c. inpatient behavioral health residential admissions

d. inpatient rehabilitation admissions

e. inpatient skilled nursing facility admissions

f. outpatient surgical procedures

g. outpatient imaging

h. outpatient physical therapy

i. other outpatient services (specify)

36. What other services can be reviewed under your precertification review program that are not specifically requested in this RFP?

37. Indicate YES or NO. Precertification review includes an analysis and determination of which of the following? (Indicate YES or NO in the response grid for a – h below)

a. Appropriate level of care (e.g., inpatient versus outpatient)

b. Reasonable length of stay (LOS) for inpatient confinements

c. Medical necessity and appropriateness of the surgery or service being requested

d. Appropriate place of service for surgical procedure (i.e. inpatient hospital, outpatient hospital based ambulatory surgical center, freestanding surgical center, doctor’s office)

e. Necessity for the services of an assistant surgeon with each surgical procedure

f. Necessity for a proposed preoperative hospital day

g. Necessity for a proposed 24-hour observation stay following an outpatient surgery

h. Necessity for the specialty prescription drug being requested

i. Other: Explain

38. Indicate the primary clinical criteria utilized for determining the appropriate length of stay (LOS) for a hospital admission.

39. Please explain how you review hospital admissions that are paid using a DRG methodology.

40. What clinical criteria are utilized to determine the medical necessity for a surgical procedure?

41. a. With what frequency do you update your clinical criteria (e.g. never, annually, twice a year, etc.)?

b. Who is responsible to oversee the updating of your precertification screening criteria?

42. Within the past twelve months, in what percent of all precertification cases was a letter of non certification (denial) for medical necessity/appropriateness for the procedure/service issued? (Answer may require specific justification at a future date.) Please select one.

43. Do you have written screening criteria for:

a. behavioral health hospital admissions

b. residential treatment program admissions

c. partial day care

d. inpatient rehabilitation

44. If you do not have written screening criteria for a certain requested service, what are your instructions to your precertification staff with respect to determining the medical necessity of the requested service?

45. What level of staff takes initial phone calls from members and providers? At what point do callers speak with a registered nurse? Are determinations ever made by non-clinical staff

46. Indicate the category of staff that can make final disapproval for a precertification request. Please select all that apply.

a. Clerical

b. LPN/LVN

c. RN

d. Physician’s Assistant

e. Nurse Practitioner

f. Physician

47. Does your organization have the capability to accept information from providers electronically and issue an automatic determination electronically? If yes, in what percentage of cases are automatic determinations issued?

48. Indicate the qualifications of the staff that will pre-certify behavioral health cases.

49. a. Are there precertification cases that could be approved by your non-RN personnel?

b. If yes, describe the kinds of cases non-RNs review

50. What percentage of all precertification reviews require your physician advisor review for decision-making? What percent of precertification reviews are performed by physician advisors?

51. Can you direct or redirect precertification callers to an appropriate in-network provider when possible? Can you provide a report that explains how often your staff redirected a caller from a non-network provider to an appropriate in-network provider and/or the reasons the caller decided to proceed with a non-network provider.

52. When you issue a precertification approval or denial decision, do you provide a written copy of the decision to the member and provider in all situations? Please describe any situation where written copies are not sent.

53. How are precertification approval and denial letters transmitted to providers?

54. Can notification letters be customized to meet client requirements?

55. a. Is concurrent review performed telephonically in all cases?

b. Do staff members make onsite hospital visits during concurrent review?

c. If so, which staff, which locations, how often, and for what purpose?

56. Are the staff that perform concurrent review all registered nurses?

57. Indicate the average number of concurrent reviews a staff member performs each day.

58. What percent of your concurrent review cases need assistance/review by your physician advisors and/or medical director? What percent of these cases are reviewed by physician advisors?

59. What event(s) start your concurrent review process?

60. What event(s) terminate your concurrent review process?

61. When performing concurrent/continued stay review on cases in which a pre-certified length of stay was assigned, on what day does your staff perform the initial concurrent review:

a. on the day after precertified length of stay expires,

b. on the day the precertified length of stay expires,

c. on day before the precertified length of stay expires,

d. another day, or

e. some other option, describe:

62. After an initial length of stay is assigned, how do you determine what cases receive discharge planning services? When do discharge planning services typically begin and end? At what point does an appropriate case get transitioned to case management?

63. Describe the process you would implement for exchanging patient data with the plan’s carriers (GHI and Empire) on a real-time or near-time basis in order to effectively run the management programs required.

64. Indicate how many physicians are available for UM review and in what specialties? Are they internal staff or subcontracted? If physician review is subcontracted to another organization please identify the organization. Please indicate the name of your firm’s medical director(s) along with their subspecialty (e.g., internist, cardiology, etc.)

65. Do you currently perform the requested services for any clients that utilize GHI as their medical network? If yes, for how many clients do you support this arrangement? Describe any lessons learned.

66. Do you currently perform the requested services for clients that utilize Empire BCBS as their hospital network? If yes, for how many clients do you support this arrangement? Describe any lessons learned.

67. Describe your experience providing the requested services to “bifurcated plans”, where one vendor provides the medical/outpatient network and another provides the inpatient network.

68. Will you be able to implement these services in full by January 1, 2016? How long do you need for the implementation process? Briefly describe how you implement new clients.

69. Provide samples of your member and plan sponsor website content and capabilities (either as screen shots or via login).

70. Do you agree to follow the appeals process and timeframes required for plan sponsors that must comply with ERISA claims regulations including that your adverse decision letters must contain required ERISA claims appeal text?

71. Describe the method and frequency of notification from your firm to the plan about the cases that have received your precertification review, concurrent review and case management services.

72. How will your firm interface with the plan’s carriers (GHI and Empire) claims payment system for electronic import of the pre-certification details to the claims payment system for verification and timely payment of the claim? Please provide a description of any preferred/required file layout(s).

73. Describe examples of innovative cost savings utilization management programs that your organization has developed for its clients and how these programs generated savings.

CASE MANAGEMENT SERVICES (CM)

74. What are the qualifications of the staff that perform case management?

75. How do you identify cases for case management?

76. Do you use predictive modeling to identify appropriate cases for case and disease management? If yes, describe your capabilities.

77. On average, what percent of all the inpatient cases you review for a client actually receive case management services? What percent do not receive case management because they do not qualify? Which percent do not receive case management because the patient refuses the service?

78. What are the usual types of cases you identify for case management?

79. What percent of cases you identify for case management result in patients accepting case management services?

80. List the types of cases for which you have defined case management protocols. Do you manage both acute care and chronic high cost cases?

81. During case management do you agree to direct the patient and/or their health care providers to use in-network services (e.g., home health, DME, skilled nursing facility, etc.) to take advantage of the pre-negotiated discounts that save both the Fund and the patient money?

82. When network services are not available or were not utilized by a patient, can you negotiate with out of network providers to accept network rates or otherwise reduced rates? Describe your process for doing this including the level and training of staff that performs this service.

83. Indicate the average workload of open cases per day for each case manager?

84. Indicate the average number of hours per case your staff spends case managing.

85. Specific to case management, can your staff coordinate optimal treatment with patients’ providers? If so, please outline this process.

86. What event(s) start your case management process?

87. What event(s) terminate your case management process?

88. How long is an average case management case open?

89. What are the average number of hours billed on a case from start to finish?

90. Describe any case management services you offer that are not specifically mentioned in this RFP.

91. Describe examples of innovative cost savings case management programs that your organization has developed for its clients and how these programs generated savings.

REFERENCES

92. How many employer-sponsored plan clients do you have currently? What percent of your covered lives does this represent?

93. How many Public Sector entities do you have as clients currently?

94. List as references two (2) current Public Sector clients for which your organization currently provides UM services:

Contact Name

• Telephone

• E-mail

• Contract Start Date

• Size of group

95. How many Taft-Hartley Trust Funds do you have as clients currently?

96. List as references three (3) current Taft-Hartley clients for which your organization currently provides UM services, including at least one Taft-Hartley group and one uniform/civilian group:

Contact Name

• Client Name

• Telephone

• E-mail

• Contract Start Date

• Size of group

97. Provide two (2) recently terminated clients:

Contact Name

• Company Name

• Telephone

• E-mail

• Termination Date

• Reason for Termination

• Size of group

PERFORMANCE GUARANTEES

The City of New York will require the successful bidder to offer performance guarantees on service and return on investment that provide for significant financial risk on the part of the vendor.

Minimum requirements for performance will include the following:

• Guarantee a minimum level of ROI based on each of the programs in place and overall ROI.

• 90% of calls will be answered within 30 seconds

• A call abandonment rate of less than 3% is maintained during all business hours

• No call is placed on hold for more than 3 minutes

• 100% calls/emails placed during business hours by the plan to Account Service or clinical staff will be returned within 24 hours

• Research and reply to a plan inquiry/complaint within 3 business days

• Meet all timeliness requirements as specified by URAC and the DOL for all review and appeal requests

• Timely and accurate reporting of all agreed upon reports

• Maintain URAC accreditation during duration of contract

* Successful implementation

98 Please confirm that you agree to meet these requirements and propose an appropriate structure and measurements and the amount of financial risk the organization is willing to take on meeting these standards. If you are proposing any variation from these standards, please be specific.

99. In addition to the above minimum required performance guarantees, provide detail of any other performance guarantees you are offering to the City program, including a description of the guarantee, its measurement, and whether each is specific to the City or on a book-of-business or by-location level.

REPORTING

100. Can you provide quarterly UM reports with a YTD tally describing the utilization and effectiveness of your precertification services, concurrent review activity, case management activity, appeals outcome, specialty medication precertification.

101. a. Do you agree to provide prompt notification to the plan about the cases that have received your precertification review, concurrent review and case management services in sufficient detail so they can appropriately adjudicate claims?

b. How often do you transmit this information?

c. By what method do you transmit this information?

d. Indicate the information that would be included in your organization’s transmittals to the plan

102. Describe the types of situations that produce savings that your firm commonly can report as a result of the case management services you perform. Provide sample detailed methodology behind these savings calculations.

103. Indicate if your standard UM reports for the plan will include the following:

a. Procedure/service determined to be or NOT to be medically necessary

b. Appropriate level of care (e.g., outpatient, home)

c. Requested length of stay

d. Certified length of stay

e. Actual length of stay

f. Procedures where assistant surgeon was determined NOT to be medically necessary

g. Pre-op day(s) determined NOT to be medically necessary

h. Observation room determined NOT to be medically necessary

i. Total number admissions or discharges

j. Total number of bed days

k. Average length of stay

l. Admissions per thousand

m. Bed days per thousand

n. Admissions by service type or major diagnostic category or DRG

o. Admits by facility name

p. Number of Admits by employee, spouse, or child

q. Number of precertified cases by procedure name/type

r. Outcome of your review decisions on all precertified cases

s. Number of case management cases managed

t. Types of diagnoses for cases that have been case managed

u. Number of hours each case was managed

v. Effectiveness of your case management efforts

REQUIRED ATTACHMENTS

Please provide the following eight (8) attachments:

104. PRECERTIFICATION REVIEW

a. Attach a detailed description of your precertification review process.

b. Include a sample precertification confirmation/approval notice/letter to a provider.

c. Include a sample precertification denial/non-confirmation notice/letter to a provider.

105. APPEAL PROCESS

Attach a sample appeal closure letter indicating the service appealed is still denied.

106. CONCURRENT REVIEW (continued stay)

Provide a sample letter indicating that continued stay is no longer able to be certified/approved.

107. CASE MANAGEMENT

Include a sample case management summary report with detail regarding how the ROI savings projection is determined.

108. REPORTS

a. Include a sample standard report package the plan could expect to receive.

b. Include samples of your customized report capabilities the plan could select.