# Medicare Advantage Technical Questionnaire

As part of the Expression of Interest, respondent shall include responses to the questions set forth in the Medicare Advantage Technical Questionnaire.

Instructions for completing the Medicare Advantage Technical Questionnaire:

Every question and subpart below must be answered even if the answer is not applicable.

In order to complete the Medicare Advantage Technical Questionnaire, respondent will need the following document:

• New York City Health Benefits Program Census File (Secure File)

Please see instructions in Notice of Intent for access to the Census File.

# SECTION A.

Introductory Questions

| **#** |  |
| --- | --- |
| **C.1.** | Carrier agrees to negotiate in good faith if the City requests changes to those portions of the insurance contract which are available for negotiation as determined by applicable law and regulations. |
| Carrier comment: |
| **C.2.** | The final schedules of benefits for the MA plan(s) must be complete by March 1, 2021. Final insurance contract and certificates of coverage should be complete by May 1, 2021. |
| Carrier comment: |
| **C.3.** | Carrier agrees that its customer service operation will be prepared to receive telephone calls from plan participants beginning March 1, 2021 (based on retiree meetings and enrollment process beginning April 1, 2021). |
| Carrier comment: |
| **C.4.** | Carrier agrees that initial ID cards will be received by plan participants no later than June 15, 2021, based on receipt of eligibility enrollment files. |
| Carrier comment: |
| **C.5.** | Carrier agrees to provide expanded telephone customer service hours beginning June 1, 2021 as required by CMS. |
| Carrier comment: |
| **C.6.** | Carrier agrees that ID cards will be issued on an on-going basis within ten (10) days of CMS’ acceptance and verification of the enrollment. |
| Carrier comment: |
| **C.7.** | Carrier agrees to hold retiree meetings at up to ten retiree locations/meetings within New York City and the immediate area, and up to three other locations with retiree concentrations with personnel, presentations and materials approved by the City. |
| Carrier comment: |
| **C.8.** | Carrier agrees to return subsequent drafts of the contract (after the initial draft) within 3 business days of receiving revision requests. Resolution of issues should be completed within one week. |
| Carrier comment: |
| **C.9.** | Carrier agrees to provide a SOC 2 report for the most recent year. The report must be provided upon contract execution and each year thereafter throughout the term of the agreement, with quarterly updates from Carrier on any outstanding issues. |
| Carrier comment: |
| **C.10.** | Carrier agrees to provide certification of HITECH compliance; if currently not compliant, carrier agrees to provide a project plan for future compliance and regular updates to the City. |
| Carrier comment: |
| **C.11.** | Carrier agrees to provide benefits as detailed in Section C in this Questionnaire. |
| Carrier comment: |
| **C.12.** | Carrier agrees to perform a final reconciliation of annual premium payments by February 28th of the succeeding plan year. |
| Carrier comment: |
| **C.13.** | Carrier agrees that all services, including performance guarantees, provided to the City and to Plan participants are subject to audit by an independent auditor determined by the City. Any third party auditor used by the City shall sign a confidentiality agreement that is satisfactory to the Carrier and the City. Carrier agrees to fund $75,000 toward post-implementation audit. |
| Carrier comment: |
| **C.14.** | The City reserves the right to request replacement of the designated Account Manager and/or other members of the designated team. |
| Carrier comment: |
| **C.15.** | Carrier agrees that there will be no change in account management without 30 days written notice and the City’s approval of replacement. |
| Carrier comment: |
| **C.16.** | Account management team shall provide timely responses to all inquiries from the City. A timely response shall be by the next business day. |
| Carrier comment: |
| **C.17.** | Carrier agrees to accept Medicare Advantage enrollment and disenrollment in an electronic format, from the eligibility administrators. Carrier agrees to load enrollment and disenrollment information within two (2) business days of confirmation by CMS that the participant is Medicare-eligible. |
| Carrier comment: |
| **C.18.** | Carrier agrees that any retiree data provided by the City to the Carrier remains the property of the City. |
| Carrier comment: |
| **C.19.** | Carrier agrees that no external communications material that mentions the City, the Municipal Labor Committee (MLC), or their benefit plans may be circulated without prior written approval from the City and the MLC. |
| Carrier comment: |
| **C.20.** | Carrier agrees to disclose all services provided by its subcontractors (those services provided by individuals or organizations that are not bona fide employees). Carrier shall assume all liability for any subcontracts it enters into and the work or services performed thereunder and shall be responsible for services provided by subcontractors. |
| Carrier comment: |
| **C.21.** | Carrier’s relationship to the City shall be that of an independent contractor. No personnel employed by or contracted with by Carrier for use in Carrier’s performing its obligations shall be considered an employee or agent of the City. |
| Carrier comment: |
| **C. 22.** | Carrier will implement and maintain appropriate technical and organizational measures to safeguard individually identifiable participant information, including: administrative, technical and physical safeguards in place, the encryption of electronic files and secure communication protocol, restricted servers and secure storage of paper files. |
| Carrier comment: |
| **C.23.** | Carrier will promptly report to the City any breaches of protection of participant information (of which Carrier becomes aware) and the parties will cooperate in investigating any such breaches. The City acknowledges that the Carrier, as the Covered Entity, will provide such information to the City in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as amended). The City may require Carrier to inform the Department of Health and Human Services. |
| Carrier comment: |
| **C.24.** | Carrier agrees to establish and maintain a disaster recovery plan consistent with industry standards for MA plan data and participant services that ensure the continuation of services if an event, act or omission threatens to impair or disrupt Carrier’s delivery of services. The disaster recovery plan will be tested by Carrier at least annually. Carrier agrees to execute recovery of essential operations within forty eight (48) hours of a disaster. Upon request, Carrier will provide the City with a summary of its disaster recovery plan and recent test results. |
| Carrier comment: |
| **C.25.** | Carrier shall maintain complete and accurate records with respect to eligibility and premium payments for ten (10) years after the end of the calendar year in which the transaction occurred, unless any longer period is required by applicable law. Carrier agrees to maintain off-site storage of back-up copies of all computer files relating to the MA plan. |
| Carrier comment: |
| **C.26.** | Carrier shall provide to the City, upon request, all information necessary for the City to satisfy its reporting and disclosure obligations under applicable federal and state laws. |
| Carrier comment: |
| **C.27.** | In providing services to the City and to participants in the MA plan drug rider and pre-Medicare rider, if applicable, Carrier shall comply with all applicable state and federal and local laws, ordinances, regulations and codes including procurement of required permits and certificates, licenses and insurance. |
| Carrier comment: |
| **C.28.** | Carrier hereby agrees to indemnify and hold harmless the City and its agents, directors, officers and employees (acting in the course of their employment), successors and assigns from and against any losses, claims, fines and penalties, damages, suits, liabilities, judgments or expenses (including reasonable attorneys' fees) that arise directly or indirectly out of or result from Carrier's acts or omissions relating to the insurance contract and/or the side agreement. |
| Carrier comment: |
| **C.29.** | Carrier will carry enough liability insurance sufficient to meet the requirements of its obligations to indemnify the City and its agents, directors, officers and employees of at least ten million dollars ($10,000,000) per claim and at least ten million dollars ($10,000,000) in the aggregate. |
| Carrier comment: |
| **C.30.** | The City may terminate the contract with or without cause by giving Carrier thirty (30) days prior written notice. The City may terminate the MA plan at any time if Carrier materially breaches the terms of the insurance contract, but only after the City has given Carrier thirty (30) days prior written notice during which time Carrier may attempt to cure the breach to the City’s satisfaction. |
| Carrier comment: |
| **C.31.** | Carrier shall only have the right to modify the contract during its term if a state or federal law or regulation requires a modification. Carrier shall notify the City of such modification at least ninety (90) days prior to the effective date, unless otherwise dictated by the law or regulation. |
| Carrier comment: |
| **C.32.** | Carrier agrees that costs associated with implementation of the plans will be borne by the Carrier and not charged back to the City. |
| Carrier comment: |
| **C.33.** | To ensure that bidders responding to this RFP have extensive and proven experience working with the Medicare Advantage program, it is a minimum requirement that in order for a bid to be eligible, the bidding organization must currently serve a) at least 250,000 Medicare Advantage members; b) at least one employer Medicare Advantage Custom with 50,000 members; c) at least five group Medicare Advantage customers with 10,000 or more members each; and d) at least five public sector employers/unions. Please confirm that your organization meets these minimum requirements. List the customer over 50,000 members, the five customers over 10,000 members, as well as the five public sector customers, and the 2019 and 2020 enrolled membership for each group. |
| Carrier comment: |
| **C.34.** | Carrier agrees to provide the CMS Monthly Membership Report (MMR) to the City on a monthly basis. |
| Carrier comment: |
| **C.35.** | Carrier will fully fund (up to $60,000) a pre-implementation audit focusing on its phone and claims system, and will have any issues identified during the audit resolved prior to July 1, 2021. |
| Carrier comment: |
| **C.36.** | Carrier agrees to provide the City with detailed claim information for the Medicare Advantage plans, including submitted, allowed, paid claims, administrative expenses, CMS revenue and other detail as requested by the City. |
| Carrier comment: |

# SECTION B. PLAN INFORMATION

Please complete the grid with your company information and provide a brief explanation, where applicable.

|  |  |
| --- | --- |
| **GENERAL PLAN INFORMATION** | |
| Please indicate the primary and secondary carrier contact, should there be any questions concerning submitted responses. | |
| **Primary Contact** |  |
| Name |  |
| Title |  |
| Address |  |
| City |  |
| State |  |
| Zip |  |
| Phone Number |  |
| Fax Number |  |
| E-mail Address |  |
| **Secondary Contact** |  |
| Name |  |
| Title |  |
| Address |  |
| City |  |
| State |  |
| Zip |  |
| Phone Number |  |
| Fax Number |  |
| E-mail Address |  |

|  |  |
| --- | --- |
| **GENERAL PLAN INFORMATION** | |
| Carrier product type (if other than a National PPO): |  |
| Indicate any states for which you cannot provide coverage through an Extended Service Area network. |  |
| Carrier product description(s): |  |
| The number of years your organization has offered MA products: |  |
| Does anyone in your firm have any connection (business or personal) to any City employee? |  |
| Does your firm, or any of its employees, have any clients or associations that could present a conflict of interest should you be chosen to represent the City? If so, please explain in detail. |  |

|  |  |  |
| --- | --- | --- |
| **NETWORK CREDENTIALING** | **CREDENTIALING** | |
| Indicate if the following credentialing activities are performed in-house or subcontracted:  A) Network credentialing  B) Provider credentialing |  | |
| The health plan will disclose the following:   1. NCQA accreditation status scores by category 2. Recommendations for corrective action 3. Date of next scheduled NCQA survey. |  | |
| Indicate whether participating physician quality of care and member satisfaction information is shared with, and in what format it is shared:   1. Purchasers 2. Members 3. Physicians |  | |
| Describe the defined program and process used to evaluate participating PCPs for:   1. Cost 2. Utilization 3. Clinical service delivery 4. Member satisfaction 5. Member disenrollment | |  | |
| Please confirm PCPs, OB/GYNs, and high volume specialists are re-credentialed every two years. | |  | |

|  |  |
| --- | --- |
| **NETWORK SIZE AND COMPOSITION** |  |
| Please indicate in which of the 50 states your organization is NOT licensed to offer employer-sponsored, network-based Medicare Advantage solutions. |  |
| The City is expecting to use an Extended Service Area network, but would be interested in understanding your passive PPO network options. In order to provide an MA solution for the City, what is your plan to optimize your current products? |  |
| Describe your organization’s MA network growth and development plans. |  |
| Describe your organization’s approach for selecting and recruiting providers to participate in your MA networks. |  |
| Describe your process for collaborating with purchasers and key providers to address provider acceptance issues that may surface over time. |  |
| What is the annual turnover of providers in your network area for the past 3 years? |  |
| Are you proposing to administer a custom service area for the City plan that does not match your standard service area? |  |
| Describe how you handle Medicare Advantage coverage for individuals who travel outside the home plan service area. |  |
| Indicate any areas where your network access does not meet the CMS-standard access requirements. |  |

|  |  |
| --- | --- |
| **PLAN INFORMATION** | |
| Please complete the following chart based on your national, ESA offering. *If there are additional, passive PPO network offerings that would be proposed, please list information for each*. | |
| National ESA Network | CMS Contract Number(s):  PBP:  Star Rating:  Star Rating Bonus in 2020: (Indicate Yes or No):  If Yes, how will bonus funds be used? |
| Alternative: | CMS Contract Number(s):  PBP:  Star Rating:  Star Rating Bonus in 2020: (Indicate Yes or No):  If Yes, how will bonus funds be used? |

|  |  |
| --- | --- |
| **MEDICARE ADVANTAGE EXPERIENCE** | |
| Describe your organization’s experience participating in Medicare as a private plan option. Include the number of years that your organization has participated in Medicare and a brief history of your group Medicare offering. |  |
| Provide your organization’s year-end Medicare membership for each year that you have participated in the Medicare program. |  |
| Provide recent examples of your organization’s success in providing employer-sponsored Medicare Advantage solutions for large groups. Include a profile describing the customer, number of Medicare-eligible retirees enrolled, location of retirees, product solution(s) purchased, plan design, funding arrangement and any other key factors. |  |
| How many new group Medicare Advantage members did your organization add effective January 1, 2018, January 1, 2019 and January 1, 2020? |  |
| What percentage of your 2019 total group Medicare Advantage membership renewed for the 2020 plan year? |  |
| Have you been sanctioned by CMS in the past 5 years? If so, please explain. |  |

|  |  |
| --- | --- |
| **MEDICARE ADVANTAGE SUSTAINABILITY STRATEGY** | |
| Describe your organization’s strategy and key initiatives to assure that Medicare Advantage will offer the City a long term, financially prudent solution. Provide specific examples of each initiative and current results by initiative. |  |
| How do you see the current presidential election impacting your strategic initiatives? What if any concerns do you have for 2021 and later? |  |
| Illustrate your business case for providing effective MA products. Include the following:   * Financial impact of your medical management program * Financial impact of your network strategy * Financial impact of your regional/product contracting strategy |  |
| Describe what your organization has done thus far to maximize its CMS Star rating. |  |
| Describe your plans and processes for maximizing your CMS Star rating. |  |
| Describe your infrastructure supporting group Medicare Advantage administration. |  |
| What is the current Medical Loss Ratio for your Medicare Advantage business? |  |

|  |  |
| --- | --- |
| **MEDICARE RISK ADJUSTMENT (MRA)** | |
| **Medicare Risk Adjustment Process** | |
| Describe your risk adjustment transition plan for the Medicare-eligible retiree population. Indicate the activities that will take place before, during, and after the effective date. |  |
| How does your organization track Medicare member risk scores? |  |
| How would your organization manage data to maximize risk scores for individuals aging into Medicare and your Medicare Advantage products? |  |
| The City currently does not provide prescription drug benefits to its retirees. Describe your strategy to gather prescription drug data from retirees, and to manage the MA benefit effectively for those who may not have coverage elsewhere? |  |
| What controls does your organization have in place to ensure all required data is sent to the Centers for Medicare and Medicaid Services (CMS) for each data collection period? |  |
| What process is in place to ensure that pended claims/encounters are worked for timely submission of MRA data to CMS? |  |
| What metrics are in place to evaluate the risk score trends? |  |
| What kind of data analysis does your organization perform to identify risk adjustment trends? |  |
| What processes do you use to identify incomplete coding at the member level to ensure that all diagnoses are captured? |  |
| What processes do you use to ensure that the most specific ICD-10-CM diagnosis codes are used? |  |
| Do you do risk modeling to detect possible conditions that are not being coded? Please describe. If such a condition is identified, how do you proceed? |  |
| Do you have procedures to identify members who might be eligible for Medicaid? Please describe. |  |
| Do you have procedures to identify members who might be eligible for ESRD? Please describe. |  |
| What tests are used to evaluate completeness of risk data on provider claims? |  |
| Describe any processes you have to identify providers with suspect coding patterns. |  |
| What controls are in place to communicate results of medical record reviews with providers? |  |
| Does your organization provide any incentives to providers to submit complete and accurate data for risk adjustment? Please describe. |  |
| Does your organization require providers to submit HEDIS data? |  |
| What other efforts does your organization take to identify and collect complete and accurate risk adjustment data for submission to CMS? |  |
| The plan design, plus what other factors, contribute to the development of the MRA? |  |
| Describe what clinical programs you have in place and are offering the City that will improve the members’ risk scores. |  |

|  |  |
| --- | --- |
| **Data Submission to CMS** | |
| What controls are in place to ensure that claims data that is submitted to CMS only includes valid risk adjustment codes? |  |
| What controls are in place to ensure that data sent to CMS is from a valid provider type? |  |
| What controls are in place to identify duplicate transactions that are ineligible from a CMS perspective? |  |
| What are the financial implications for submitting incomplete or inaccurate risk adjustment data to CMS? |  |
| What process is in place to assess and/or monitor the potential financial impact for instances of noncompliance (particularly as it relates to the submission of duplicate transactions)? |  |
| **Data Integrity** | |
| What steps are taken to ensure that all risk adjustment codes on claims that are reviewed by Plan coders, are supported by medical record documentation? |  |
| What process is in place to review and collect missing data to ensure that codes that are not supported in the medical record documentation are being submitted for deletions? |  |
| Does your organization have Medicare Risk Adjustment ethics training? If so, please provide details. |  |
| **CMS Reconciliation** | |
| What process is in place to reconcile your organization’s member risk scores with the risk scores on file for the member at CMS? |  |
| How frequently do you reconcile your organization’s member risk scores with the risk scores on file for the member at CMS? |  |
| What process is in place to ensure that the correct CMS capitated premium was paid based on the most accurate risk score? |  |
| **CMS Compliance with Medicare Risk Adjustment Submission** | |
| What have been your audit findings on your MRA submission process with CMS? |  |
| How are potential penalties for noncompliance assessed? |  |
| How is your organization’s Medicare Risk Adjustment staff notified of changes to the CMS requirements? How is the MRA staff educated on new CMS requirements? |  |
| **Financial Impact of Medicare Risk Score** | |
| What process is used to track the financial impact of risk adjusted data? |  |
| How is risk adjustment data used by your organization’s actuaries? |  |
| How is risk-adjusted data used by your organization’s finance staff? |  |

|  |  |
| --- | --- |
| **Clinical Components of Medicare Risk Adjustment (MRA)** | |
| Does your organization’s MRA effort include a clinical analysis component? |  |
| Does your organization’s MRA group work with disease management, case management, etc.? |  |

| **PLAN DESIGN** |  |
| --- | --- |
| The plan designs outlined below and in Section F are reflective of the 2020 City of New York Senior Care benefit plan design.  Please confirm for each benefit listed in Section F that you can administer the exact benefits as requested. If you are unable to administer the exact benefits as requested, please include specific details on all deviations within the scope of this section or by attaching a separate document. If you answer “Yes,” the City will assume that you can match the plan design exactly as requested. | |
| Please indicate the services that accrue towards the primary annual out-of-pocket maximum (for coinsurance-based services). |  |
| Please indicate the services to which the coinsurance percentage applies (if applicable). |  |
| Please indicate the services that accrue to the secondary annual out-of-pocket maximum (for copayment-based services, as required by CMS). |  |
| Are there any CMS filing limitations that would impact benefit coverage levels for any benefit design elements? If yes, please explain. |  |
| Are non-emergent out-of-area services covered for:   1. Participants 2. Dependents |  |
| Please specify if your plan covers emergency services incurred outside of the United States. |  |
| Please explain the process for submitting non-US emergency claims. |  |
| Please confirm if the entire hospitalization charge is covered under your plan where a member terminates coverage and is hospitalized prior to the termination date and remains hospitalized subsequent to the coverage termination date. |  |
| Please provide a description of skilled nursing facility services coverage. |  |
| Please describe your radiology benefit management program, including details any services that are subcontracted |  |
| Please provide a description of any advanced illness or end-of-life programs available to City members. Please include:   * How members are identified for the program * How they are engaged * How your program addresses   + Patient physical and emotional pain   + Provider communications   + Advanced directives   + Hospice   + End-of-life counseling – for both member and family |  |
| Please explain how your organization maintains connectivity between a member’s pre-Medicare plan and the MA plan. Please include:   * How your plan will collect data from pre-Medicare plans and how that data will be used to:   + Estimate an individual’s Medicare Risk Score   + Engage a member in medical management programs * How a member will be educated about transition of care assistance |  |
| How does your organization administer “never events” from a design perspective? |  |

|  |  |  |
| --- | --- | --- |
| **IMPLEMENTATION** | |  |
| Please provide a detailed implementation timeline for a 7/1/2021 effective date. | | |
| Assuming a July 1, 2021 implementation date, what are the options for managing a mid-year transition with respect to deductibles, out of pocket expenditures and other cost sharing operated on a calendar year basis? |  | |

|  |  |
| --- | --- |
| **GENERAL FINANCIAL INFORMATION** | |
| Provide your company’s most recent rating or filing (identify date) from each of the following: | |
| **A.M. Best** |  |
| Rating |  |
| Date |  |
| **Moody’s** |  |
| Rating |  |
| Date |  |
| **Standard & Poor’s** |  |
| Rating |  |
| Date |  |
| **Fitch** |  |
| Rating |  |
| Date |  |
| If your rating has changed within the past 12 months for any of the rating agencies, discuss changes. |  |
| Please list any known upcoming capital expenditures or mergers. |  |
| Please provide a copy of your most recent audited financial statements (preferably as of 12/31/2019)  Please provide additional comments regarding financial stability, if necessary. |  |

# SECTION C. PLAN DESIGN

**Healthcare Plan Design:** (*Current 2020 Senior Care Benefits*)

The requested plan design is displayed in the chart below.

|  |  |  |
| --- | --- | --- |
|  | **Copayment/Coinsurance** | **Plan is Able to Administer Benefit Y/N\*** |
| **Deductible** | $248 (2020 Part B Deductible + $50) per participant except as follows or otherwise noted below:   * No deductible for services covered under Part A * $25 deductible for ambulance, DME, and private duty nursing after Part B deductible has been reached |  |
| **Primary Out of Pocket Limit**  (Includes the deductible) | Maximum allowed under law or statute. |  |

**Except as noted, all services covered at 100%**

|  |  |  |
| --- | --- | --- |
| **Benefit** | **In-Network**  **Copayment/Coinsurance** | **Plan is Able to Administer Benefit Y/N\*** |
| **Inpatient Hospital Care**  1st through 60th day | $300 Copay per admission ($750 maximum per calendar year), not subject to the deductible |  |
| **Inpatient Hospital Care**  61st through 90th day | Not Covered |  |
| **Inpatient Hospital Care**  91st through 201st day | 50% covered |  |
| **Inpatient Hospital Care**  202nd through 365th day | Not Covered |  |
| **Inpatient Mental Health** | Same as inpatient hospital |  |
| **Inpatient Substance Abuse** | Same as inpatient hospital |  |
| **Skilled Nursing Facility**  120 day max per confinement | Covered 100% through 100th day (no deductible) |  |
| **Blood Transfusions** | Covered for first three pints (no deductible) |  |
| **Emergency Room Care** | 100% coverage after $50 copay (no deductible) |  |
| **Outpatient surgery** | 100% coverage after $198 of deductible has been met |  |
| **Hospital Care when outside**  **the U.S.A.** | Covered in full from 1st through 60th day except the Medicare deductible amount, and from the 61st through 90th day, except for the Medicare coinsurance amount. |  |

**Note: If you marked “No”** for any benefit listed in Section F and cannot match the exact benefits as requested, please include specific details on all deviations within the scope of this section or by attaching a separate document. **If you answer “Yes**,**”** the City will assume that you can match the plan designs exactly as requested.

**Prescription Drug Optional Rider:** (*Current 2020 Medicare Design*)

|  |  |  |
| --- | --- | --- |
|  | **Generic** | **Brand Name** |
| Deductible | $0 | $0 |
| Expenses up to $3,700 (max $925) | 25% | 25% |
| Expenses $3,700 to Catastrophic (True out of pocket of $4,950) | 51% | 40% |
| Catastrophic | 50% with minimum charge of $40 or actual cost if less | $60 |
| Formulary | Open | Open |
| Care Management | Prior Authorization, Step Therapy and Quantity Limits may apply | Prior Authorization, Step Therapy and Quantity Limits may apply |

**Pre-Medicare Healthcare Plan Design:** (*Current 2020 CBP Non-Medicare Plan Design*)

The requested plan design is displayed in the chart below.

|  |  |  |
| --- | --- | --- |
|  | **In-Network** | **Out-of-Network** |
| Deductible | $0 | $200/$500[[1]](#footnote-1) |
| Out-of-Pocket Maximum | $7,150/$14,3001 | None |
| Preventive Care | $0 | 0% after deductible |
| PCP (Preferred/non-Preferred) | $0 / $10 | 0% after deductible |
| Specialist (Preferred/non-Preferred) | $0 / $30 | 0% after deductible |
| Diagnostic test (x-ray, blood work) | $20 / visit | 0% after deductible |
| Imaging (CT/PET scans, MRIs) | $50 copay | 0% after deductible |
| Emergency Room | $150 waived if admitted | $150 waived if admitted |
| Urgent Care | $50 | 0% after deductible |
| Inpatient Care | $300 / admit; $750 max per year | $500 / admit; $1,250 max per year + 20% of allowed amount and balance billing |
| Outpatient Surgery | 20% up to $200 max per year | $500 deductible + 20% after deductible and balance billing |
| Home Health Care | $0 | $50 deductible + 20% after deductible and balance billing |
| Durable Medical Equipment | $100 deductible | $100 deductible + 50% of U&C |
| Prescription Drugs | Not Covered | Not Covered |

**Prescription Drug Optional Rider:** (*Current 2020 CBP Non-Medicare Design*)

|  |  |  |
| --- | --- | --- |
|  | **Retail** | **Mail Order** |
| Deductible | $150 / $450 | $0 |
| Generic | 20% with minimum charge of $5 or actual cost if less | $10 |
| Preferred Brand | 40% with minimum charge of $25 or actual cost if less | $40 |
| Non-preferred Brand | 50% with minimum charge of $40 or actual cost if less | $60 |
| Specialty | Coverage based on above categories | Must be dispensed by specialty pharmacy manufacturer |
| Days Supply/Max fills | 30 days / 2x | 60 days / mandatory after 2 fills |

# SECTION D. MEDICAL MANAGEMENT

The City of New York seeks vendor partners with proven effective, patient-oriented medical management services for a retiree-only population. The City is especially interested in Medicare Advantage plans that can:

* Contribute to improved quality of care and quality of life for our retiree population
* Educate our retiree population about the programs and assistance available
* Maximize program engagement in case management and disease management programs with our retiree population.
* Encourage our retirees to complete the program, not just enroll
* Sustain program results through follow-up communication and ongoing education
* Addresses treatment of co-morbidities associated with specific disease states

**Pre-Certification**

1. Please describe the pre-certification process.
2. What services are subject to pre-certification?
3. What are the major reasons for hospitalization subject to hospital pre-admission review?
4. List the requirements for radiology pre-certification and the name of vendor partners used to conduct the reviews.
5. If pre-certification is required for durable medical equipment, list the services and the name of vendor partners used to conduct the reviews.
6. If pre-certification for a service is denied, is the provider or member liable for services? Please describe the sanctioning process, if applicable.

**Concurrent Review**

1. Explain the process and frequency of concurrent review for inpatient hospital admissions.

**Case Management**

1. Describe your clinical transition plan for the City’s Medicare-eligible retiree population. Indicate the activities that will take plan before, during and after the effective date.
2. Describe how you identify, engage, and assist the members in need of case management services.
3. If you offer more intensive management of members with complex medical needs, describe the services and the targeted population.
4. Indicate the targeted staffing ratio of Case Managers per 1,000 members for the City’s case management program (do not include support/ancillary staff, managers, quality personnel, etc. that do not provide case management services directly to members).
5. Will case managers assigned to this account be "dedicated" (manage this account only) or "designated" (manage this account and a defined number of other accounts)?
6. Describe the method to identify members with home safety issues or environmental concerns and the process for assessing members in their home environment.
7. What percentage of Medicare Advantage members experienced a home assessment in 2019? How did you approach the home assessment in 2020?
8. How does your organization identify the frail (possibly home-bound) elderly?
9. What programs are in place for the frail elderly and those that have complex illness and multiple co-morbidities?
10. Briefly describe transitional care policies and procedures for members moving from home to acute to chronic care and back to home.

**Condition management**

1. For which of the following conditions do you provide condition management interventions?

Included in base premium rate (Y/N)

* 1. Asthma ( )
  2. CAD ( )
  3. CHF ( )
  4. COPD ( )
  5. Diabetes ( )
  6. Low Back Pain/Musculoskeletal ( )
  7. Depression ( )
  8. Cancer ( )
  9. Other Disease State(s) - please list ( )

1. Briefly describe any “high-touch” condition management efforts that have demonstrated effectiveness with a senior population.
2. How are members with both medical and behavioral concerns identified? How many times do you call someone to enroll in the program if you are unable to reach them?
3. What is the maximum number of letters sent out if you are unable to make phone contact with the member?
4. Please list languages (other than English) available for enrollment outreach.
5. Who makes the enrollment calls?
   1. Automated caller system - can members enroll electronically?
   2. Enrollment coordinator (not a clinician)
   3. Clinical staff
   4. Other (please explain)
6. If the member’s phone number is not correct, describe the process for acquiring updated phone numbers including use of external agencies to find phone numbers (include name search tool/company used).
7. Do you graduate participants from Chronic Condition Management Programs? How do you define "graduation" from this type of program?
8. If you have special processes for managing members who have dual eligibility (Medicare/Medicaid), describe them briefly.
9. What is your staffing ratio of nurses to members for very high/high acuity chronic care cases?
10. What is your staffing ratio of nurses to members for moderate acuity cases?
11. What are your hours of operation and days of operation for member outreach and in-bound calls (be sure to specify time zones).
12. For the Medicare Advantage book of business age 65+ disease management population in 2019, provide the following participation statistics for each disease state program: (Note: The total % of the high, moderate and low segments for each disease state should equal 100%).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **High** | **Moderate** | **Low** | **Total** |
| Asthma |  |  |  |  |
| CAD |  |  |  |  |
| CHF |  |  |  |  |
| COPD |  |  |  |  |
| Diabetes |  |  |  |  |
| Low Back Pain/Musculoskeletal |  |  |  |  |
| Depression |  |  |  |  |
| Cancer |  |  |  |  |

1. Explain the interventions for high, moderate and low risk chronically ill members, e.g., telephonic outreach involving X number of calls or condition education materials mails to member’s home. Please indicate if the cost for these interventions is included in the base premium rate.
2. Will your organization distribute the following equipment at no cost to active disease management program participants?
   1. Glucose meters for diabetics
   2. Peak flow meters for asthmatics
   3. Home blood pressure monitors for hypertensives
   4. Other – please indicate what additional equipment is available at no cost through your disease management programs

**References**

1. Provide three client references with significant retiree populations whose experience with your Medicare Advantage products’ medical management program has achieved cost savings objectives and improved the quality of life for its retirees.

**Special Care Management Programs**

**Advanced Illness (End of Life)**

1. Describe briefly your organization's Advanced Illness Management program philosophy. List Advanced Illness program goals and objectives. Please indicate if the cost for this program is included in the base premium rate.
2. Describe how your organization engages and manages members participating in the Advanced Illness Management program.
3. If any of the Advanced Illness services are subcontracted, list the outsourced service(s), the name of the corresponding outsourced partner, and the length of time your organization has partnered with the outsourced service provider.
4. What percentage of all Medicare Advantage members in each state for which you propose to serve members were enrolled in the Advanced Illness program during 2019? 2020?
5. Describe how the program engages and involves the attending physician.
6. What support is offered to Advanced Illness patient’s family members or friends?
7. How are community resources incorporated into the member’s treatment plan?
8. Are all Advanced Illness case managers certified in Death, Dying and Bereavement (Thanatology) by the Association for Death Education and Counseling?
9. What are the skill sets of individual nurses / case managers that administer the program?

**Behavioral Health Management**

1. Are Behavioral Health issues managed internally or by a third party?
2. Describe how behavioral health issues will be considered when working with City members for case management and condition management programs.
3. Are members in case management, chronic condition management and advanced illness programs routinely assessed for depression?
4. How often are members in these programs assessment for depression?
   1. Case management
   2. Chronic condition management
   3. Advanced Illness

**ER Utilization Management**

1. What approaches are used to assist members to avoid abusive use of the emergency room?

**Gaps in Care**

1. Is there a “Gaps in Care” patient safety program? Please describe
2. For medical gaps?
3. For preventive screenings?
4. Member messaging
5. Physician messaging?
6. When did your “Gaps in Care” Program begin? How have you improved the program over the years?
7. Your Gaps in Care program may also identify pharmacy gaps. Given the City does not provide coverage for prescription drug benefits, how would you propose to handle those findings?

**Readmission Avoidance**

1. If you have special campaigns to avoid hospital readmissions, list the name of the program and a brief description.
2. What is the 30-day readmission rate for all Medical Advantage members in each state for which you propose to serve City members?
3. What is the 60-day readmission rate for all Medical Advantage members in each state for which you propose to serve City members?

**Lifestyle Behavioral Change Program**

**Health Risk Questionnaire (HRQ)**

1. Provide the name and a copy of the HRQ you propose to use.
2. How long has your organization been providing this HRQ?
3. Are "readiness to change" and "productivity" questions included in the HRQ?
4. Describe how your proposed HRQ instrument is offered (e.g., telephone interviews of all new members, online, hard copy, or all three)?
5. How long on average does it take for a participant to complete the HRQ process?
6. Provide the percentage of members who complete the HRQ.
7. Describe one or two key features that differentiate your HRQ from your competitors.
8. Please indicate if the cost for this program is included in the base premium rate.

**Programs Content and Delivery**

1. Indicate for each program offered below if content is delivered via paper/mail based, telephonic coaching, and/or online.
2. Diabetes Prevention
3. Fractures/Fall Prevention
4. Hypertension prevention
5. Nutrition Management
6. Physical Activity
7. Stress Management
8. Tobacco Cessation
9. Weight Management
10. Exercise Management
11. Other Programs - specify
12. How are these programs tailored to a Medicare retiree only population?
13. Will you provide a primary health coach model? The same coach works with participants throughout the duration of the program.
14. Indicate program content delivery methods available:
15. Do you routinely “push” individually tailored information to those individuals identified with high risk behaviors in the HRQ (e.g., if HRQ results demonstrate an individual doesn't exercise can you push out a physical activity module to that person automatically)?
16. Please indicate if the cost for these programs is included in the base premium rate.

**Engagement**

1. Do health coaches accept in-bound calls and place out-bound calls to at risk members?
2. What are your hours of operation and days of operation for member outreach and in-bound calls?
3. How many times do you attempt to call someone to enroll in the program if you are unable to reach them?
4. How many attempts are made to contact the member? Please describe the method(s) for contact.
5. If a member’s phone number is not correct, describe the process for acquiring updated phone numbers including use of external agencies to find phone numbers (include name search tool/company used).
6. Will you agree to routinely provide corrected phone numbers to the City administrators?
7. What is your rate of obtaining correct phone numbers for those whose number is not correct?

**Member Health Portal and Communications**

1. Does your organization provide direct links from the member portal to the CMS cost and quality transparency tools for seniors?
2. If your organization provide slinks to any other third-party tools specifically targeted to cost and quality for seniors list the names.
3. Is a log on and password required for access to web-based tools?
4. Indicate which of the following resources are available to Medicare members:
5. Physician locator
6. Health Libraries
7. Hospital Comparison Tool
8. Nurse Line with 24/7 staffing
9. Preventive screening reminders (personalized)
10. Online Personal Health Record
11. Self-care guides
12. Multimedia health topics (e.g., streaming video)
13. Local community health resources
14. Guidance on Medicaid and Partial Medicaid Entitlements
15. Describe how you increase senior use of the health portal and how you keep participants engaged in web-based programs.
16. If an online Personal Health Record is available on the portal, how often is the individual’s claim information updated?
17. Describe any plans to expand web-based information technology that will be effective within the next 12 months.
18. Please provide information such as user ID and password needed to access your web site (sufficient to experience the web site).

**Network Programs**

**Accountable Care / Hospital-Physician Collaboration**

1. Provide the names of operational ACOs or special care management collaborations with medical providers in each state for which may serve City members. Give brief overview of each arrangement in these states, and include a description of how they are paid for their services.

**Centers of Excellence**

1. Provide a listing of all COE facilities that members will have access to under your plan offering, and include the location and services (for which it is the COE) that are provided at each.

**Patient-Centered Medical Home**

1. Describe briefly the role you expect PCMH may play in each State which may serve City members.

**Quality Improvement**

1. List the top three quality of care initiatives for 2020-2021 focused on the retiree population.
2. Indicate which of the following QI programs is offered in the plan in which you plan to serve City members:
3. Geriatric-medication safety (polypharmacy issues)
4. Risk for falls
5. Depression
6. Memory changes
7. Home safety
8. Alcohol abuse screening,
9. ADL (activities of daily living) functioning.
10. Indicate which of the following accreditation levels have been achieved for the Medicare Advantage program:
11. NCQA Disease Management Accreditation
12. NCQA Disease Management Program Certification
13. JCAHO Disease Specific Chronic Care Certification Status
14. URAC: Disease Management Accreditation
15. Date NCQA Status Expires
16. Date JCAHO Status Expires
17. Date URAC Status Expires
18. Please provide at least the last three years of Medicare Star Ratings for each Health Plans in the plan in which you plan to serve City members.

**Measurement**

**Engagement Measures and Reporting**

1. How is your organization leveraging data and technology to engage physicians in better compliance with evidence-based medicine and getting a broader view of their patients’ health status and healthcare experiences?
2. Does your organization use predictive scoring to identify high risk, high need retirees that require outreach or more aggressive case management?
3. Attach one sample of all standard reports that would be provided to the City. For each report included in the sample reporting package provided, indicate the name of the report, describe the information reported and the frequency of the issuance of the report.

Standard Report #1: Report Name, Description, Frequency and Format/File Type

Standard Report #2: Report Name, Description, Frequency and Format/File Type

Standard Report #3: Report Name, Description, Frequency and Format/File Type

Standard Report #4: Report Name, Description, Frequency and Format/File Type

Standard Report #5: Report Name, Description, Frequency and Format/File Type

1. In reports dealing with cost, outcomes and quality of care, will the City’s specific results be compared to:
2. National averages
3. Your book of business
4. Will you offer the City the option to receive customized or ad hoc reports?
5. If there is a charge for ad hoc reports, explain charge structure.
6. Explain the charge structure for customized reports.

**Integration with the City’s Health Vendor Partners**

1. Describe how your organization collaborates to provide integrated delivery of the programs (e.g., data sharing, coordination of care procedures, warm transfers) with the City’s other health care initiatives or existing vendors.
2. The City offers an Employee Assistance Plan to its retirees. Briefly describe how you would propose working with the program to coordinate care?
3. Have you accepted/sent secure electronic data feeds from/to the following health vendor partners: Emblem Heath and Empire Blue Cross Blue Shield.

**SECTION E. CUSTOMER SERVICE**

1. Please provide details of the proposed customer service function that will serve the City retirees. Include the following:
2. Overview of customer service objectives
3. Staffing levels
4. Organization chart
5. Staff selection criteria
6. Required training, with emphasis on any retiree-sensitivity training
7. Any additional customer service differentiators
8. How the customer service department interacts with the Account Management team assigned to the City
9. Please complete the grid with your company’s responses to the customer service questions listed below and provide a brief explanation, where applicable. We encourage you to explain any “No” responses.

|  |  |
| --- | --- |
| **MEMBER SATISFACTION AND ADMINISTRATION** | |
| Does your organization provide a member and customer service infrastructure that is totally dedicated to serving its Medicare Advantage members and customers? If so, provide a detailed description of the dedicated services and the number of employees dedicated to providing these services. |  |
| What services does your organization provide for new member orientation to a MA plan? |  |
| What concierge-type services and member advocacy services are provided to the members under the proposed plans? |  |
| Will customized City of New York customer satisfaction surveys be conducted annually? |  |
| Are customer satisfaction surveys administered by a third party or by your organization? |  |
| There will be a single toll-free dedicated, customer service telephone number for addressing claims payment, member services and any appeals.   * Will calls be re-routed based on question type-i.e. claims, network utilization? |  |
| Do you provide warm transfers for members from customer service centers to medical providers? To the City for eligibility questions? |  |
| Do you provide a dedicated individual or staff responsible for resolving claim disputes or other issues? |  |
| During the 2019 plan year, what was the member services telephone abandonment rate? |  |
| During the 2019 plan year, what percentage of your calls to member services provided first call resolution to the issue? |  |
| What are the location, size and operating hours of the customer service center(s) that will service the City’s account? |  |
| What are the ratios for the following?   * Customer service supervisors : staff * Customer service staff : retired member |  |
| What is the process that you use for auditing member service representative performance? |  |
| What services are available for hearing impaired members? |  |
| Do you have a dedicated telephone number for members who are calling from outside of the United States? |  |
| Can members access clinical resources 24 hours a day, 7 days a week via a national toll-free nurse line? |  |
| Please explain your current patient grievance procedure that members must follow. |  |

|  |  |
| --- | --- |
| **PROVIDER DIRECTORIES** | |
| Will you provide a toll-free number for continuous updates and updated provider directories? |  |
| Are provider directories available in print form? |  |

|  |  |
| --- | --- |
| **SENIOR FOCUSED TRANSPARENCY** | |
| Does your organization provide direct links to the CMS cost and quality transparency tools for seniors? Do you provide links to any other third-party tools specifically designed for seniors? |  |
| Do your senior-focused transparency tools contain any of the following features: |  |
| The ability for seniors to complete a patient survey about their experience with a physician that includes ratings and an opportunity to leave comments? If so, is this survey endorsed by the ABMS (American Board of Medical Specialties)? |  |
| The ability for seniors to specify the most important traits they desire in a physician and then display the best matching physicians in order of how well they meet their criteria (i.e., by displaying the % match score for easy identification of the best match)? |  |
| The ability to display photos of physicians? |  |
| The ability to provide medical concierge services? |  |
| The ability to provide member advocacy services? |  |
| The ability to guide seniors to the appropriate physician / specialist by allowing them to visually select a body part and symptom? |  |
| The ability to perform a side-by-side comparison of physicians? |  |
| The ability to display US News & World Report rankings on the medical schools attended by each physician? |  |
| The ability to display US News & World Report rankings on the attending and training hospitals (i.e., residency and fellowship training) for each physician? |  |
| The ability to display professional appointments received by each physician? |  |
| The ability to display awards and national professional recognitions for each physician? |  |
| The ability to display research studies and publications completed by each physician? |  |
| The ability for each physician to leave a personal note about their practice and interests in order to allow seniors to better match with a physician who is in tune with their specific needs and lifestyle preferences? |  |
| A visual map that notes the relative location of each physician office so that seniors can easily find the most convenient location for them? |  |

|  |  |
| --- | --- |
| **INTERNET CAPABILITIES** | |
| **Please indicate whether or not members can currently access the following information via your website and/or smartphone app:** | |
| Provider locator |  |
| Does locator include the ability to generate a map? |  |
| Plan information (e.g., plan design and cost share information) |  |
| Individual claims history |  |
| Family claims history |  |
| Downloadable Explanation of Benefits (EOB) |  |
| Downloadable forms (Vendors or the City’s) |  |
| Temporary ID card |  |
| Treatment cost information |  |
| Other (please specify) |  |
| Is all information available online also made available in hard-copy by individuals calling the customer service line? |  |
| Does your website allow for single-sign on capabilities when linked from other locations such as those from the City’s administrators? |  |

|  |  |
| --- | --- |
| **OTHER SERVICES** | |
| Please describe your process and capabilities on the following services. Please identify if there are additional fees related to the services. |  |
| Appeals process |  |
| Coordination of benefits |  |
| Subrogation |  |
| Escheat process |  |
| ID Cards |  |
| Booklets |  |
| Certificates |  |
| SPDs |  |
| EOCS |  |
| Low Income Subsidy (LIS)  Please include both a program description and the standard processes for routing LIS funds back to the City. |  |
| Special Needs Plan  Please indicate if you offer a Medicare Advantage Special Needs Plan and provide a brief description of the plan, including differences from a traditional Medicare Advantage plan |  |

# SECTION F: GEO ACCESS, NETWORK DISRUPTION AND COMMUNICATION

**GEO ACCESS**

Please utilize the census files provided to complete a geo access report for the ESA program included in the bid.

1. Please provide geo access results for medical and pharmacy separately
2. Please include a “key” indicating the description of the information provided
3. Please use estimated driving distance/As-the-crow-flies distance for calculating distances

Please ensure a working format is provided (not just pdf files).

If you provide a passive PPO alternative bid, please provide the geo access report separately (and clearly labelled)

**NETWORK DISRUPTION**

* + 1. Provide a list of all hospitals in each applicable state indicating if the hospital is in or out of the plan network.
    2. The City of New York may request you analyze a list of “top hospitals” utilized by members (based on claims utilization) to identify if those hospitals are in or out of the plan network.
    3. The City of New York may request you analyze a list of “top providers” utilized by members (based on claims utilization) to identify if those hospitals are in or out of the plan network.
    4. Provide an analysis that demonstrates changes in network over the past 3 years. How many providers/hospitals were added? How many providers/hospitals were removed due to quality or service issues? How many providers/hospitals left the network?

**NETWORK COMMUNICATION**

The City of New York may request samples of communications used to identify network provider/facility status, or pre-enrollment materials.

1. Single/Family [↑](#footnote-ref-1)