**APPENDIX F**

# *QUESTIONNAIRE FORM INSTRUCTIONS*

### Questionnaire Instructions to Proposers

**\*\*\*DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING\*\*\***

* Provide an answer to each question even if the answer is “not applicable” or “unknown”. Please state why the Proposer’s response is “not applicable” or “unknown”. Incomplete questionnaires may be cause for disqualification.
* If your response to a question differs by the type of coverage you are proposing, provide a separate response for each coverage and clearly indicate to which coverage your response pertains.
* Answer the question as directly as possible.
	+ If the questions asks “How many…” provide a number
	+ If the question asks, “Do you…” indicate Yes or No **first**, followed by your additional narrative explanation.
* Responses should not exceed 200 words in length.
* Responses should not refer to an appendix/attachment for further information.
* Proposer will be held accountable for accuracy/validity of all answers.

### NOTE: Please make sure to include an electronic copy of your completed questionnaire in Word Format.

***QUESTIONNAIRE FORM***

**DO NOT ALTER THE QUESTIONS.**

**GENERAL RFP REQUIREMENTS**

### For this section of the questionnaire, answer the question/requirement with a simple “Yes” or “No” answer. If you answer “No” to any of the questions/requirements in this section, please explain the response at the end of the section. The explanation will be reviewed, however, failure to agree to all of the terms requested in this section may cause ACERA to deem your proposal non-responsive.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you agree that if this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, that any controversy arising over such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal? |  Yes |  | No |
| 2. Will you agree to be bound by the terms of your proposal until a final contract is executed? |  Yes |  | No |
| 3. Do you agree to all the terms and conditions in Section II of this RFP? |  Yes |  | No |
| 4. ACERA reserves the right to offer awards of contract to multiple Proposers for any, or all, plans of benefits contained in this RFP. ACERA also reserves the right to waive its right to award a contract for any plan of benefits contained in this RFP. Confirm your agreement with this provision. |  Yes |  | No |
| 5. You will be required to issue the Contract **within seven (7) calendar days** after being given a *Notice of Intent to Award* in time for contract execution by the Board in June 2021, unless waived by ACERA. Please confirm your acceptance of this requirement. |  Yes |  | No |
| 6. Confirm that your proposed premium rates are guaranteed for at least **36**months. |  Yes |  | No |
| 7. Confirm that your proposed rates exclude commissions. |  Yes |  | No |
| 8. Other than the quoted premium rates in the financial section of this RFP, there should not be any other charges or fees of any kind that will or could apply to ACERA such as start-up costs, booklets or printing. The fees quoted shall include all services and supplies that could reasonably be expected to be provided to ACERA during the course of your administration of the plans. Confirm your agreement to this requirement. |  Yes |  | No |
| 9. Please confirm that there will be no adjustments to the proposed fees and/or rates based on actual enrollment or subsequent shifts in enrollment. |  Yes |  | No |
| 10. ACERA requires that the contract include a right of ACERA to cancel the contract at any time during a contract term for any reason, upon 30 days’ advance notice. Please confirm your agreement to this requirement. |  Yes |  | No |
| 11. Will you transfer claim information, and other administrative records to any vendor that would replace you in the event of termination of this contract at no charge? |  Yes |  | No |
| 12. Do you agree to the provision that changes in premium rate may only occur on the anniversary date? |  Yes |  | No |
| 13. Do you agree to provide renewal rates by June 1st for the plan year beginning the following February 1st and will include this in your contract? |  Yes |  | No |
| 14. You must guarantee that all insureds, who would have continued to be covered on the plan effective date if there had been no change in vendors, will be covered under your policy on the plan effective date (i.e., no loss no gain provision). |  Yes |  | No |

|  |  |
| --- | --- |
| Please confirm your agreement to this requirement. |  |
| 15. Will you agree to accept any specified eligibility rule established by ACERA? |  Yes |  | No |
| 16. For each of the coverages being requested, you must agree to remove any and all pre-existing restrictions or any other provisions that might limit or eliminate benefits to current or future retirees. Please confirm your agreement. |  Yes |  | No |
| 17. Will you agree to include in your contract a hold harmless provision that indemnifies ACERA against liability that arises as the result of negligent acts, errors, omissions, fraud and other criminal acts committed by your network providers, officers, employees, and agents of the organization? |  Yes |  | No |
| 18. Is your network licensed in the state of California? |  Yes |  | No |
| 19. Do you agree to maintain compliance with HIPAA privacy and security for the duration of the contract with ACERA? |  Yes |  | No |
| 20. Confirm that your company is in compliance with all state and federal laws applicable to the programs you are proposing or the services you will provide. |  Yes |  | No |
| 21. Confirm applicable ACA fees are included in proposed premiums on a fully insured basis and future premiums will be reduced in the event applicable ACA fees are suspended. |  Yes |  | No |
| 1. Do you agree to provide monthly, quarterly, and annual reporting?
	* Enrollment: Monthly
	* Premium: Monthly
	* Claims: Monthly
	* Utilization: Quarterly, Semi-Annual and Annual
 |  Yes |  | No |

Explain any “No” answers provided in the requirements above:

## GENERAL ISSUES

|  |  |
| --- | --- |
|  | **PROPOSER RESPONSE** |
| 1. What are the most recent ratings for your company by the following: | **Rating** | **Date** |
| * Standard and Poor’s
 |  |  |
| * A.M. Best
 |  |  |
| * Moody’s
 |  |  |
| Has there been any downgrade in your ratings in the last two (2) years? |  |
| 2. If you are not rated by one or more of these organizations, please state so. |  |
| 3. Describe any current or pending litigation involving your organization. Please confirm if any current or pending litigation(s) will not disrupt future business arrangements and operations. |  |
| 4. Indicate if you expect any operational, systems or organizational changes with your company over the next twenty-four (24) months. Attach a high level project plan. |  |
| 5. Indicate what procedure your company requires when a subscriber elects coverage for his/her dependents after the period during which he/she was originally eligible. In other words, how are “late entrants” treated? |  |
| 6. What percentage of claims are paid at 100% of the frame allowance (where there is no copayment or out-of-pocket costs to the member) in your book of business? |  |
| 7. Please clarify the progressive lenses coverage in detail for all types of progressive lenses. Provide the cost to member copayment and the suggested retail cost. |  |
| 8. What is your referral process to an eye specialist, ophthalmologist or retina specialist? Please provide average time or these referrals. |  |
| 9. a) Does the contract (ASO or fully insured) provide ACERA the right to audit the performance of the plan and services provided? |  |
| b) Indicate what services, records and access will be made available to ACERA at no additional charge. |  |
| c) Indicate frequency and notice requirements that are part of the right to audit provision. |  |
| 10. Indicate if you expect any operational, systems or organizational changes with your company over the next twenty-four (24) months. Attach a high level project plan. |  |

|  |  |
| --- | --- |
| 11. a). What are the required data elements for eligibility feeds from ACERA? |  |
| b). What are your capabilities for loading and correcting data? |  |
| c). Do you have the capability to enter corrections to eligibility records in real time? |  |
| 12. Please provide your desired eligibility file format/layout. |  |
| 13. How do you handle retroactive enrollment and cancellations? What are your time limitations relative to processing retroactive eligibility adjustments? |  |
| 14. What are your termination requirements? |  |

15. Complete the following table for the claims processing system and location that will be used for ACERA.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Claim Turnaround Time (TAT) % processed in 15 calendar days** | **Claim TAT****% processed in 30 calendar days** | **Financial Payment Accuracy (Dollars)** | **Claim Processing Accuracy (% of Claims)** |
| **Payment Accuracy** | **Processing Accuracy** | **Overall Accuracy** |
| **Standard** |  |  |  |  |  |  |
| 2019 YTD |  |  |  |  |  |  |
| 2018 |  |  |  |  |  |  |
| 2017 |  |  |  |  |  |  |

## UNDERWRITING ISSUES

|  |  |
| --- | --- |
| Please provide the detailed rate development to support the rates in the proposal including claims cost, trend, retention, reserves, ACA fees, and all other components including the calculation of tiered rates. Indicate the factors used to set rates for the proposal, which should include Annual Trend Factor, Reserve Factor, and Margin as a percent of expected claims. |  |
| 2. Explain the methodology and data to be used for the renewal process. How will projected incurred claims and expenses be estimated for these plans? Please include a sample rate renewal development worksheet. |  |
| 3. Explain your methodology for establishing Incurred But Not Reported (IBNR) reserve. |  |

|  |  |
| --- | --- |
| 4. Explain any other required reserves other than for IBNR. Indicate amounts, reason for reserve, is interest credited and whether reserves are refunded to the client upon policy termination. |  |
| 5. What are your administrative requirements for the self-insured plans (provide in detail). |  |
| 6. Detail any underwriting provisions (rules), if any you will impose on ACERA. |  |

**ADMINISTRATION**

|  |  |
| --- | --- |
| 1. Name of Parent Company, if any: |  |
| 2. Identify service team: |  |
| a) Day to day contact |  |
| b) Underwriting |  |
| c) Billing |  |
| d) Overall account management |  |
| 3. Will you provide customized employee communication material at no additional cost? If not, what is the additional cost? |  |
| 4. What communication materials (i.e., I.D. cards) are provided to the employee to identify them as a member? Please provide a sample. |  |
| 5. a) Do you maintain a toll free telephone number for use by participants if they have questions or problems? |  |
| b) What days/hours is the number operating? |  |
| 6. a) What percentage of ophthalmologist/optometrist offices maintain the ability to dispense eyewear? |  |
| b) Indicate the types of services and supplies which will be provided at a discount to participants. |  |
| c) Are there circumstances in which a participant’s selection of discounted eyewear is limited to a portion of the total supply? Please elaborate. |  |
| 7. Is there a limit on the number of services or supplies which can be purchased at the discounted price? |  |
| 8. Please provide samples of monthly, quarterly, and annual reporting (i.e., premium, claims, and utilization). |  |

|  |  |
| --- | --- |
| 9. What on-line services/functions will be made available to ACERA via the Internet? *(Check all that apply)* | * Claims Summary
* Billing History
* Premium Rates
* Provider Directory
* Eligibility Summary
* Enrollment Counts
* Plan Details
* Health Topics/Medical Information
* Address Changes
* Other
 |
| 10. ACERA wishes to include a clause to the effect that, upon contract termination, the cost of any work required by a new administrator to bring records in unsatisfactory condition up to date shall be the obligation of your firm and such expenses shall be reimbursed by your firm. Do you agree to include these provisions in your contract? |  |
| 11. Under your ASO proposal, will you process run- out claims in the event the contract with the client is terminated? If so, what is your proposed fee for processing run-out claims? |  |
| 12. How is image scanning used in your claims adjudication system? |  |
| 13. Describer your preferred way of receiving, integrating and coordinating eligibility data. |  |
| 14. Confirm you accept electronic eligibility files. |  |
| 15. What percent of total claims are submitted to providers electronically? |  |
| 16. Briefly describe your process for administering claims. |  |
| 17. What is the percentage of claims processed? What percentage of claims process without manual processing or human intervention? |  |
| 18. Does your firm produce a newsletter specifically for public retirement plans or is the material produced for both public and private plans? |  |
| 19. Discuss any technological improvements your organization has planned for 2021 (e.g., Internet related services, online eligibility, etc.) and the impact on enrolled Members. |  |
| 20. Describe your capabilities and any restrictions related to the administration of COBRA for any plans you are awarded |  |

|  |  |
| --- | --- |
| 21. Do you agree to extend and allow COBRA Continuation and conversion privileges to all individuals ACERA deems eligible? |  |
| 22. Do you agree to allow Members who ACERA deems eligible to maintain coverage under COBRA for up to thirty-six (36) months? |  |

**RECRUITING/CREDENTIALING/TERMINATION**

|  |  |
| --- | --- |
| 1. How are providers recruited? |  |
| 2. What procedure must be followed if a participant or ACERA requests a provider to be included in your network? |  |
| 3. What is the annual turnover rate of the providers in your network? |  |
| 4. What percent of providers in Northern California are at full capacity and will no longer accept new patients? |  |
| 5. Indicate the reasons for which a participating provider can be terminated and the number of occurrences within the past year.**Reasons for Termination** | **Yes** | **No** | **Number of Occurrences** |
| Poor service |  |  |  |
| Poor utilization practices |  |  |  |
| Failed credentialing process |  |  |  |
| Contract violation |  |  |  |
| Provider moved/expired |  |  |  |
| Provider dissatisfaction |  |  |  |
| 6. Can a participant receive an eye exam at one provider and the glasses/lenses from a different provider? |  |
| 7. Are you able to provide special vision services such as Visual Display Terminal occupational coverage, safety lenses/eyewear, etc? |  |
| 8. Are there any special circumstances required for a participant to visit a network ophthalmologist? If so, please provide details and indicate whether preauthorization is required. |  |
| 9. a) At the end of a client’s contract, how is treatment in progress covered? |  |
| b) At the end of a participant’s eligibility, how is treatment in progress covered? |  |

**CUSTOMER SERVICE/QUALITY CONTROLS**

|  |  |
| --- | --- |
| 1. How will complaints regarding quality/timeliness of care from participants or the client be handled? |  |
| 2. How frequently do you perform patient satisfaction surveys? Please provide a copy of your most recent patient satisfaction survey results. |  |
| 3. Is cost efficiency/effectiveness of participating providers measured? Describe the process used. |  |
| 4. How is the quality of care, provided by each of your network providers, monitored? |  |
| 5. What systems checks are in place to prevent fraud? |  |
| 6. Indicate all services available to members through your website (include website address). |  |
| 7. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. *(Check all that apply)* | * No special accommodations
* Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired
* We accommodate non-English special enrollees by contracting with an independent translation company
* We maintain customer service staff with the ability to translate Spanish
* We maintain customer service staff with the ability to translate the following languages:

Please list all languages. |

**ASO BANKING/CLAIM REIMBURSEMENT ARRANGEMENTS**

|  |  |
| --- | --- |
| 1. Describe the way in which the banking arrangement works. Include explanations of the nature of the account from which claims are paid (e.g., in whose name it appears, where it will be, the timing of the call for funds [e.g., as checks are issued, as they are cashed]), any deposit amount required in the account, its term (weekly, monthly) how it is determined and any interest earned on the deposit, or on amounts held in the account until checks are cashed. In addition, please explain how excess deposits are handled during the term of the plan and when deposits are returned upon plan termination (including whether a deposit can be retained to pay for any deficit, etc.). If banking charges are not included in your ASO fee, please provide an estimate of |  |

|  |  |
| --- | --- |
| such charges and describe the basis on which they are made. |  |
| 2. If your plan does not require the use of a special bank account, but rather calls for funds on a single monthly bill, please explain the timing of such bill, when payment is due, the definition of claims due (checks issued or cashed) and what interest charges are made (or credits foregone) on such a program, relative to a conventionally insured plan. If your plan is not funded through a special bank account, but rather on a lump sum basis, please explain any interest charges. |  |
| 3. If your account is funded as needed, can the policyholder select a bank? Is there an added cost for such a bank? If so, how much? |  |
| 4. How often are check registers and reconciliations furnished? What is in these reports (please provide a sample)? |  |
| 5. Will you stock pile claims to a certain level before releasing them, so that the plan sponsor can fund claims less frequently? |  |
| 6. How quickly and often must the plan sponsor make reimbursements to you? |  |
| 7. What audits of reconciliations are done? |  |

**SERVICES**

|  |  |
| --- | --- |
| 1. Please answer Yes or No on what services are performed in your basic/routine eye exam: |  |
| Vision history |  |
| Visual acuity |  |
| General eye health |  |
| Glaucoma testing |  |
| Assess eye muscles |  |
| Refraction |  |
| Patient education |  |
| 2. a) Describe the coverage/selection for frames which is available to this client through your providers. (Discuss the quality of frames, variety of styles, ability to service all ages, consistency of frames between different provider offices) |  |
| b) What is the average size of inventory in your provider locations? |  |
| 3. Describe the coverage/selection of eyeglass lenses available to this client from your network. |  |

|  |  |
| --- | --- |
| Address single vision, bifocal, trifocal, glass, plastic, impact resistant, high refractive power lenses, high-index, blended bifocals, progressive bifocals, photochromic, tinted, antireflection, etc. |  |
| 4. Describe the coverage/selection of contact lenses available to this client from your network. Indicate the type and extent of coverage for daily wear soft lenses, hard contacts, extended wear and disposable. |  |
| 5. Would you offer a dedicated toll-free phone number? |  |
| 6. Please confirm whether your customer service personnel are U.S. based. If so, please confirm you will provide sufficient notification to ACERA should the customer service personnel ever be outsourced to another county. |  |
| 7. What are your hours of operation? |  |
| 8. What authority do customer service representatives have to resolve issues over the phone? Are customer service representatives authorized to make real-time claim payment adjustments? |  |
| 9. Do you record customer service calls? |  |
| 10. Can a Member leave a message at your member service line after working hours? If yes, what is the protocol for responding to that call? |  |
| 11. Please define your process for handling issues that are not resolved in the initial call. |  |

**HIPAA COMPLIANCE**

|  |  |
| --- | --- |
| 1. a) Do you have a formal HIPAA compliance plan in place? |  |
| b) Will you provide us with a sample copy upon request? |  |
| 2. a) Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions? |  |
| b) If ACERA wants a copy of your Companion Guide for HIPAA EDI transactions, where does this document reside? |  |
| 3. Will your organization be issuing Notices of Privacy Practices as required by HIPAA to each new plan enrollee? |  |

4. Do you agree to indemnify ACERA for any liabilities resulting from the improper disclosure of protected health information by you or any of your subcontractors?

 **NETWORK**

|  |  |
| --- | --- |
| 1. What is the name of your network(s)? |  |
| 2. How often are contracts renewed with Network Providers? |  |
| 3. Do you anticipate a significant change in the size or location of your network in the next year, which would impact this client’s population? |  |
| 4. a) How often are network directories updated? |  |
| b) How often will revised directories be made available to the client? |  |
| c) Is your provider directory available on the internet? If so, at what web address? |  |
| 5. a) State the number of member groups currently utilizing your network in Northern California. |  |
| b) How many members does this represent? |  |
| 6. Please provide average provider discounts of Usual, Customary and Reasonable (UCR) charges in California for General Providers and Vision Specialists. |  |
| 7. If a Provider drops/leaves your network, how are enrollees notified? |  |
| 8. What procedures are in place to prevent a member from being overbilled or balanced billed by a participating provider or specialist? |  |
| 9. Please provide National Network turnover for the last two (2) years. |  |

10. Indicate the total number of providers for specialties listed below in the state of California, by County.

|  |
| --- |
| **Number of Network Providers** |
| **Area** | **Opticians** | **Optometrists** | **Ophthalmologists** |
| **California** |  |  |  |
| Alameda County |  |  |  |
| Santa Clara County |  |  |  |
| Contra Costa County |  |  |  |
| Fresno County |  |  |  |
| Monterey County |  |  |  |
| Sacramento County |  |  |  |
| San Benito County |  |  |  |
| San Francisco County |  |  |  |
| San Mateo County |  |  |  |
| San Joaquin County |  |  |  |
| Santa Cruz County |  |  |  |
| All Other CA Counties |  |  |  |
| **Total California** |  |  |  |
| **Total Outside CA** |  |  |  |
| **Grand Total** |  |  |  |