# SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Department seeks through this RFP process to award a contract to a qualified Offeror to provide Vision Plan Services. The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Offeror by the Department and to obtain required submissions concerning those duties and responsibilities. The Offeror's Proposal must contain responses to all of the required submissions from Offerors in the format requested. Each Offeror may submit only one Technical Proposal. Offerors' Technical Proposals will be evaluated based on each Offeror's responses to the required submissions contained in this section.

**Note:** Numbers, data or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

**The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.**

**Please note that Offerors must not include any cost information in the Technical Proposal including exhibits or attachments. Proposed Performance Guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.**

## A. Plan Administration

### 1. Executive Summary

#### a. Required Submission

The Offeror must submit an Executive Summary outlining its overall program and its capacity to administer the NYS Vision Plan. The Executive Summary must include:

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

(2) A description of the Offeror's understanding of the requirements presented in the RFP and how the Offeror can assist the Department in accomplishing its objectives;

(3) A statement explaining the Offeror's previous experience managing the vision plans of other state or local government employers or any other organizations with over 100,000 covered lives. Detail how this experience qualifies the Offeror to undertake the functions and activities required by this RFP;

(4) A detailed description of how the following functions will be allocated between the Offeror and any Key Subcontractor, if applicable (i.e., Will the role of the Offeror be limited to supervision of the Key Subcontractor, or will the Offeror perform any administrative functions?).

(a) Account Management
(b) Customer service
(c) Member and Provider Communications
(d) Enrollment Management
(e) Reporting
(f) Consulting
(g) Network Management
(h) Claims Processing
(i) Frame & Lens selection
(j) Contact Lens Selection
(k) Occupational Vision Program
(l) Medical Exception Program
(m) Upgrade Program

## 2. General Qualifications

The NYS Vision Plan covers 269,000 lives and incurs a cost of approximately $20 million for 2010. The Offeror must have the experience, reliability and integrity to ensure that each Plan Member's vision care needs are addressed in a clinically appropriate and cost effective manner.

**a. Required Submission**

The Offeror must demonstrate its acceptance of the program duties and responsibilities set forth in this RFP and ensure full compliance with the Program's benefit design. The Offeror must demonstrate that it has the financial and operational wherewithal to administer the Plan as required by this RFP. Offerors should provide detailed responses to the following:

(1) What experience does the Offeror have in managing a vision plan similar to the Plan described in this RFP?

(2) Explain how the Offeror's account team will be prepared to administer the operational and clinical aspects of the Plan?

(3) What financial actions would be taken to provide for ongoing operations if timely payments could not be made timely to the Contractors?

## B. Program Services

The Offeror must demonstrate its capacity to provide the required Program Services described in this Section of the RFP.

### 1. Account Team

The Department expects the successful Offeror to have in place a proactive, experienced leader and an experienced team who have the authority to coordinate the appropriate resources to implement and administer the Plan.

**a. Duties and Responsibilities**

(1) The Offeror must maintain, for the entire term of the Agreement, an organization of sufficient size with the skills and experience necessary to administer, manage, and oversee all aspects of the Plan during implementation and operation.

(a) The Offeror's account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who will ensure that the

operational, clinical and financial resources are in place to operate the Program in an efficient manner;

(b) The Offeror must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all Program requirements and to address any issues that may arise during the performance of the Agreement.

(2) The Offeror's assigned account team shall be experienced, accessible and sufficiently staffed to provide timely responses (no longer than 1 to 2 Business Days) to administrative concerns and inquiries posed by the Department or other staff on behalf of the Council on Employee Health Insurance for the duration of the Agreement to the satisfaction of the Department.

**(3)** The Offeror's assigned account team must immediately notify the Department of actual or anticipated events impacting Plan costs and/or delivery of services to Plan Enrollees.

**(4)** The Offeror's assigned account team must ensure that the Program is in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Department must be notified immediately.

**b. <u>Required Submission</u>**

(1) Provide an organizational chart and narrative description illustrating how the Offeror proposes to administer, manage, and oversee all aspects of the Plan. Include the names, qualifications, and job descriptions of the key individuals proposed to comprise the operational, clinical and management team for the Offeror and its Key Subcontractor(s) (if applicable). Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account management team. Where key individuals are not named, include qualifications of the individuals that you would seek to fill the positions. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other business units of the Offeror such as the call center(s), quality assurance, reporting and network management within the Offeror's organization. Describe how the account management team interfaces with senior management and ultimate decision makers within the Offeror's organization;

(2) Confirm that the account team will be readily accessible to the Program. Describe where the account team will be based.

(a) Describe how the Offeror proposes to ensure that timely responses (1 to 2 Business Days) are provided to administrative concerns and inquiries.

(b) Describe the protocols that will be put into place to ensure the Department will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Program Enrollees. Provide a representative scenario.

(3) Describe the corporate resources that will be available to the account team to ensure compliance with all legislative and statutory requirements. Confirm the Offeror's commitment to notify the Department immediately if the Offeror were to be unable to comply with any legislative or statutory requirements and to work with the Department to take the appropriate remedial action to come into compliance as soon as practicable.

## 2. Plan Implementation

The Offeror must have a strong implementation plan to ensure that the Plan will be fully functioning on January 1, 2012. The Offeror's implementation plan must be detailed and comprehensive and exhibit a firm commitment by the Offeror to complete all Plan implementation activities by December 31, 2011.

### a. Duties and Responsibilities

(1) The Offeror must undertake and complete all start-up and implementation activities no later than December 31, 2011, so that the Plan as described in this RFP, including

but not limited to those specific activities set forth below, is fully operational on January 1, 2012.

(2) ***Implementation and Start-Up Service Level Standard:*** The Offeror must complete all Implementation and Start-Up activities no later than December 31, 2011, so that, effective January 1, 2012, the Offeror can assume full operational responsibility for the Plan. For the purpose of this Service Level Standard, the Offeror must, on January 1, 2012, have in place and operational:

(a) Its contracted Participating Provider Network that meets the access standard set forth in Section IV.B.9.a.(1) of the RFP;

(b) Its contracted Laser Vision Correction Participating Provider Network that provides reasonable access as defined by the Offeror in Section IV.B.10.b.(2) of the RFP;

(c) A fully operational call center providing all aspects of customer service as set forth in Section IV.B.3.a. of this RFP;

(d) A fully operational claims processing system that accurately reimburses claims in accordance with Plan provisions as set forth in Section IV.B.10.a of the RFP; utilizes accurate enrollment and eligibility data provided by the Department to accurately pay claims for eligible Enrollees/Dependents consistent with the Plan benefit design;

(e) A fully functioning customized Plan website with a secure dedicated link from the Department's access to the specific website requirements as set forth in Section IV.B.3.a.(5)of this RFP.

**b. <u>Required Submission</u>**

(1) Provide an implementation plan (narrative diagram and timeline) upon contract approval, on or about October 1, 2011 that results in the implementation of all Plan services by the required date of January 1, 2012, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as

Member and Provider communications, training customer service staff, report generation, eligibility feeds and claims testing.

(2) ***Implementation and Start-Up Performance Guarantee.*** The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in "2.a through 2.e" will be in place on or before December 31, 2011. The Offeror shall propose the forfeiture of a percentage of its Monthly Administrative Fees (prorated on a daily basis) for each day that all Implementation and Start-Up Guarantees are not met.

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*The Standard Credit Amount for each day that all Implementation and Start-Up requirements are not met is fifty percent (50%) of the Monthly Administrative Fees (prorated on a daily basis*). *However, Offerors may propose higher percentages.*

The Offeror must propose its Implementation and Start-Up Performance Guarantee in the format set forth below:

The Offeror's quoted percent to be credited for each day that all Implementation and Start-Up requirements are not met is _____ percent ( %) of the Monthly Administrative Fees (prorated on a daily basis).

## 3. Customer Service

The Plan requires that the Offeror provide quality customer service to Plan Members. The Offeror must maintain a nationwide toll-free telephone number to service Plan Members and Providers. Through this toll-free telephone number Members and Providers must have access to representatives who respond to questions and inquiries regarding Plan benefits, the Participating Provider Network, the Laser Vision Correction Participating Provider Network, eligibility and claims status, and complaints. Accordingly, the Plan's required Program Services include customer service Service Level Standards that reflect strong commitments to quality customer service.

### a. Duties and Responsibilities

The Offeror shall be responsible for all customer support and services including, but not limited to:

(1) Providing Members and Providers 24-hour access, except for regularly scheduled maintenance, to information on vision benefits and eligibility related to the NYS Vision Plan through a nationwide toll-free number.

(2) Maintaining a call center located in the United States employing an adequate staff of fully trained customer service representatives, and supervisors available between the hours of 8:00 a.m. and 8:00 p.m. ET, Monday through Friday, and between the hours of 9:00 a.m. and 4:00 p.m. ET on Saturday, except for legal holidays observed by the State. These hours may be adjusted based on actual call volume by mutual agreement between the Department and the Offeror. Customer service representatives must be able to timely respond to questions, complaints and inquiries, including but not limited to, Plan benefits, Participating Provider and Laser Vision Correction Participating Provider locations, eligibility and claims status.

(3) Customer service staff must use an integrated system to log and track all Member calls. The system must create a record of the Member contacting the call center, the call type and all customer service actions and resolutions.

(4) Maintaining a back-up telephone system to be utilized in the event the primary telephone system fails or is unavailable.

(5) Developing and maintaining a secure online customized website for Enrollees, 24 hours a day, 7 days a week, except for regularly scheduled maintenance throughout the term of the Agreement, which will provide access to information including, but not limited to: Plan benefits; Participating Provider locations; laser vision benefits and Laser Vision Correction Participating Provider locations; eligibility and claim status. The Offeror must establish a dedicated link to the website for the Plan from the Department's website and content is subject to the approval of the Department. Information from the link must be limited to information that pertains to the NYS Vision Plan. Any links should bring a viewer back to the Department website. No other links are permitted without the prior written approval of the Department. Any costs associated with customizing the website or establishing a dedicated link for the Plan shall be borne by the Offeror.

(6) ***Call Center Telephone Service Level Standard:*** The Offeror must meet the following four (4) measures of service on the toll-free customer service number:

(a) ***Call Center Availability*****:** The Plan's Service Level Standard requires that the Offeror's telephone line will be operational and available to Members and Providers at least ninety-nine and five-tenths percent *(*99.5%) of the Offeror's proposed customer service telephone line availability (minimum scheduled time between the hours of 8:00 a.m. and 8:00 p.m. ET, Monday through Friday; and between the hours of 9:00 a.m. and 4:00 p.m. ET on Saturday, except for legal holidays observed by the State), calculated on an annual calendar year basis. The Offeror shall measure telephone system availability monthly and report the results to the Department quarterly;

(b) ***Call Center Telephone Response Time:*** The Plan's Service Level Standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative. The telephone response time shall be measured monthly and reported to the Department quarterly;

(c) ***Telephone Abandonment Rate:*** The Plan's Service Level Standard requires that the percentage of incoming calls in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be measured monthly and reported to the Department quarterly; and

(d) ***Telephone Blockage Rate*****:** The Plan's Service Level Standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be measured monthly and reported to the Department quarterly.

**b. Required Submission**

(1) Confirm that the Offeror will maintain a call center located in the United States employing a staff of fully trained customer service representatives and supervisors available, at a minimum, between the hours of 8 a.m. and 8 p.m. ET, Monday through Friday and between the hours of 9 a.m. and 4 p.m. ET on Saturday, except for legal holidays observed by the State. If additional hours are proposed please state.

(2) Describe the training that will be provided to customer service representatives before they go "live" on the phone with Members/Providers. Include:

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Members/Providers;

(b) The first call resolution rate for the proposed call center;

(c) The call center location, average staff and turnover rate for call center employees;

(d) Ratio of management and supervisory staff to customer service representatives and;

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

(3) Describe the information, resources and capabilities that will be available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed;

(b) A sample of the IVR script and a description of customizable options, if any, the Offeror is proposing for the Plan;

(c) A description of the management reports and information that will be available from the system including any key statistics the Offeror is proposing to report;

(d) A description of the capabilities of the phone system to track call types, reasons and resolutions.

(4) Describe the Offeror's proposed back-up systems for its proposed primary telephone system which would be used in the event the primary telephone system fails or is unavailable. Indicate the number of times the back-up system has been utilized over the past two (2) years.

(5) Describe the information and capabilities the Offeror's proposed website will provide to Members/Providers. Does the Offeror currently have customized websites for its clients? If so, describe the process utilized by the Offeror to establish customized websites for its clients.

(6) ***Call Center Telephone Performance Guarantees*:** For each of the four (4) Call Center Telephone Service Level Standards above, the Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee, for failure to meet the Offeror's proposed Performance Guarantee.

**(a) *Call Center Availability Performance Guarantee*:**

*The Standard Credit Amount for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone line is not operational and available to Members and Providers during the Offeror's Call Center Hours as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Call Center Availability Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed standard of____%) that the Offeror's telephone line is not operational and available to Members and Providers during the Offeror's Call Center Hours as calculated on a calendar year basis, is $_____."

**(b)** ***Call Center Telephone Response Time Performance Guarantee*****:**

*The Standard Credit Amount for each .01 to 1.0% below the standard of ninety percent (90%) of incoming calls to the Offeror's customer service toll-free telephone line that are not answered by a customer service representative within sixty (60) seconds, as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Call Center Telephone Response Time Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed standard of ___%) that incoming calls to the Offeror's customer service toll-free line that are not answered by a customer service representative within sixty (60) seconds, as calculated on a calendar year basis, is $_____."

**(c)** ***Telephone Abandonment Rate Performance Guarantee*****:**

*The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%), as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Telephone Abandonment Rate Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed standard of ___%), as calculated on a calendar year basis, is $_____."

**(d)** ***Telephone Blockage Rate Performance Guarantee*:**

*The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of three percent (3%), as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Telephone Blockage Rate Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of three percent (3%) (or the Offeror's proposed standard of ___%), as calculated on a Calendar Year basis, is $_____."

## 4. Member Communication Support

The Offeror shall be required to create Plan materials that enhance a Member's understanding of Plan benefits. All Member communications are subject to the review and approval of the Department.

### a. Duties and Responsibilities

The Offeror shall be responsible for providing Member communication support and services including but not limited to:

(1) Designing and producing all necessary claim forms, benefit booklets, Participating Provider directories, and other printed materials in sufficient quantities to promote and operate the Plan. All such materials are subject to the Department's review and approval.

(2) Developing, printing and mailing to Enrollees' homes within 90 days of the Contractor's implementation date a directory of Participating Providers (or customized listing of such providers) and a Vision Plan Summary of Benefits booklet which states the Plan benefits applicable to each Member and summarizes Plan provisions, including eligibility criteria. Vision Plan Summary of Benefit booklets are not required for Enrollees represented by SEHP;

(3) Distributing to the Health Benefits Administrators (HBAs) of each State Agency and Participating Employer, a sufficient quantity of Vision Plan Summary of Benefits booklets for the Plan to provide a copy to each newly eligible employee throughout the term of the Agreement. The initial shipment of Vision Plan Summary of Benefit Booklets will equal 5% of the Agency's Enrollee count by bargaining unit as of January 1, 2012. The Enrollee count by State agency by bargaining unit is included as Exhibit II.F for informational purposes.

(4) Developing an order entry process for HBAs to order replacement copies of Plan materials and fulfilling and shipping such orders to HBAs in an expeditious manner.

(5) Developing, printing and mailing to Enrollees' homes notification of benefit modifications and any other communications materials that may be required by the Department during the term of the Agreement, in cooperation with and subject to the approval of the Department and in accordance with Article VIII; Paragraph 8.3.0 of the Agreement.

(6) Accounting and paying for all development, production and mailing costs incurred to disseminate Plan communications materials to Enrollees and HBAs.

(7) The Department shall:

(a) Retain editorial control over all aspects of the Plan material, including final determination on the content and tone. The Department will provide expeditious final approval of all print and/or other materials developed for the Plan;

(b) Make available, if possible, any records or information which the Offeror clearly needs to design and implement effective communication strategies; and

(c) Assist the Offeror as necessary in communicating with Enrollees and Providers but at no additional expense to the State, except as provided in Article IX, Paragraph 8.3.0 of the Agreement.

(8) The Offeror shall retain no proprietary or literary rights with respect to communication material developed solely for the Plan and shall execute any assignment found necessary to release proprietary rights.

(9) Attending health benefit fairs, conferences, and benefit design information sessions, located in New York State, at the request of the Department.

(10) ***Website Maintenance Service Level Standard:*** The Offeror must accurately update the Plan's customized website within thirty (30) days of notification by the Department.

**b. <u>Required Submission</u>**

(1) Provide an outline of the communications campaign the Offeror is proposing for the Plan's first year; including the timeline for developing, printing and mailing Enrollee and Provider Plan materials.

(2) Does the Offeror have staff within its organization or a Key Subcontractor that specializes in enrollee communications? What is their capacity to provide the communication support described above?

(3) Confirm that upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror shall provide staff to attend health benefit fairs, conferences, and benefit design information sessions. **The Offeror agrees that the costs associated with these services are included in the Offeror's Monthly Administrative Fee.** Describe the experience and qualifications of the staff who will be assigned to attend such events when so requested by the Department.

(4) State the Offeror's agreement to work with the Department to develop appropriate customized forms and letters for the Program, including but not limited to Enrollee claim forms, disruption letters, etc., and that all such communications must be approved by the Department.

**(5)** ***Website Maintenance Performance Guarantee*****:**

The Plan's Service Level Standard requires that all Plan benefit changes be accurately updated by the Offeror to the Plan's customized website within thirty (30) days of notification by the Department.

*The Standard Credit Amount for each calendar day beyond thirty (30) days notification by the Department that all Plan benefit changes are not accurately updated to the Plan's customized website is $500. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Website Maintenance Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each calendar day in excess of the thirty (30) day standard that Plan benefit changes are not accurately updated to the Plan's customized website, is $_____."

## 5. Enrollment Management

The Plan requires the Offeror to ensure timely addition of enrollment data as well as cancellation of benefits in accordance with Plan eligibility rules. EBD utilizes a web-based enrollment system for the administration of employee benefits. The system is referred to as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all NYS Vision Plan Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A and II.B.

**Note:** The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

### a. Duties and Responsibilities

The Offeror shall be responsible for the maintenance of an accurate, complete and up-to-date enrollment file based on information provided by the Department. This enrollment file shall be used by the Offeror to process claims, provide customer service,

and produce management reports. The Offeror is required to provide enrollment management services including, but not limited to:

**(1)** ***Initial testing***

(a) Performing an initial enrollment load to commence upon receipt of a test file from the Department during Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)) or a custom file format. The determination will be made by the Department;

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

**(2)** Providing an enrollment system capable of receiving secure enrollment transactions and having all transactions fully loaded to the claims processing system within forty-eight (48) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within forty eight (48) hours of their release, as required. The Offeror must have a process in place to correct any records that cannot be loaded programmatically in a timely manner. The Department will transmit enrollment transactions changes to the Offeror in an electronic format weekly. The format of these transactions will be in EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department (see Exhibit II.G for a detailed record layout). The Offeror must also have the capability to receive any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required; and

**(3)** Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. The Offeror shall store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the QMCSO;

**(4)** Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. The Offeror must have an Information Security Plan (ISP) acceptable to the Department in place on the effective date of the Agreement, which states all of the security policies and procedures for the protection of data, equipment and facilities, including receipt of and transmission of data in accordance with Department standards, policies and procedures. The ISP must, at a minimum conform to the requirements of the Department of Civil Service Information Security Policy (**Exhibit I.X**); and agree to the policies, terms and conditions stated in this RFP, the Agreement and Appendices A, B and C. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process;

**(5)** Cooperating fully with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

**(6)** Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's staff with access to current Program enrollment information. Offeror's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of State holidays;

**(7)** Providing a back-up system in the event that the primary enrollment system fails or cannot be accessed so that there is no interruption of service to Members.

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**(8)** Verifying dependent child full-time student status for all employee groups (except for those covered by SEHP) for Dependents age nineteen through twenty-five, prior to authorization of Vision Plan services. Student status is not maintained in NYBEAS. Dependent children of Employees who are in SEHP are covered up to age twenty-six regardless of student status.

**(9)** ***Enrollment Management Service Level Standard*:** The Program's Service Level Standard requires that one hundred percent (100%) of all Plan enrollment records that meet the quality standards for loading must be loaded into the Offeror's enrollment system within forty-eight (48) hours of release by the Department.

**b. Required Submission**

(1) Describe the Offeror's proposed testing plan to ensure that the initial enrollment load is accurately updated to the Offeror's system and that the Offeror's enrollment system interfaces correctly with the Offeror's claims system.

(a) Describe what quality controls will be performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system.

(b) Describe how the Offeror's system will identify transactions that will not load into the Offeror's enrollment system. What exceptions will cause enrollment transactions to fail to load into the enrollment system? What steps will be taken to resolve the exceptions, and what is the proposed turnaround time for the exception records to be added to the enrollment file?

**(2)** Describe the Offeror's system capabilities for retrieving and maintaining enrollment information within forty-eight (48) hours of its release by the Department as well as:

(a) How the Offeror's system will maintain a history of enrollment transactions and how long enrollment history will be kept online. Indicate whether or not there will be a limit as to the quantity of historic transactions that can be kept online.

(b) How the Offeror's system will handle retroactive changes and corrections to enrollment data.

(c) Confirm that the Offeror's enrollment and claims processing system has and will have the capability to administer a social security number and Employee identification number. Indicate whether or not the system has any special requirements to accommodate these Enrollee identification numbers? Explain how Dependents will be linked to the Enrollee in the enrollment and claims processing systems.

**(3)** Describe the Offeror's ability to meet the administrative requirements for national Medical Support Orders and Dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in the Offeror's system so that information about the Dependent is only released to the individual named in the QMCSO.

**(4)** Describe the process the Offeror will utilize to verify a dependent child's full time student status prior to authorization of Vision Plan services. Confirm whether this process is utilized for other customers.

**(5)** Describe how the Offeror's enrollment system data transfer and procedure for handling data are HIPAA compliant.

**(6)** Confirm that the Offeror will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be able available to access enrollment information through NYBEAS during the required hours.

**(7)** Describe the Offeror's backup system, process or policy that will be used in the event that enrollment information is not immediately available.

**(8)** ***Enrollment Management Performance Guarantee*****:** The Program's Service Level Standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading be loaded into the Offeror's enrollment system within forty-eight (48) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee for failure to meet this level of standard.

*The Standard Credit Amount for each twenty- four (24) hour period beyond forty-eight (48) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $500. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Enrollment Maintenance Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each twenty- four (24) hour period beyond forty-eight (48) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $____."

## 6. Reporting

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Participating Providers and Laser Vision Correction Participating Providers and the terms of the Agreement. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames. The Program requires that the Offeror provide accurate claims data information on a monthly basis as well as specific summary reports concerning the Plan and its administration.

### a. Duties and Responsibilities

The selected Offeror will be responsible for reporting services including, but not limited to:

**(1)** Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, and analysis of the Plan. These reports must tie to the amounts billed to the Plan. The final format of reports is subject to the Department review and approval;

(2) Providing Ad Hoc reports and other data analysis at no additional cost to the State. The exact format, frequency and due dates for such reports shall be specified by the

Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis

(b) Benefit design Modeling

(c) Reports to meet clinical program review needs

**(3)** Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Semi-Annual, Quarterly and Monthly Reports below and include the time frames for each report's submittal to the Department:

**Semi-Annual Reports**

***Utilization Reports:*** The Offeror must submit reports that detail utilization by type of service and employee group for both network(s) and non-network claims, including services provided under the Occupational Vision Program and the Medical Exception Program as well as the Laser Vision Correction Program. Additionally, for the Medical Exception Program, the Offeror must report the number of authorized services, by medical condition and employee group. The reports are due on a semi-annual basis, thirty (30) days after the end of the reporting period.

***Enrollee Satisfaction Survey Summary Report:*** The Offeror must submit a semi-annual report which summarizes, by employee group, the results of Enrollee satisfaction surveys designed to evaluate the level of Enrollee satisfaction with the Plan. The survey should seek Enrollee satisfaction with:

(i) Quality of Professional care provided, including eye examinations, contact lens fittings and eyewear dispensing;

(ii) Quality of frames and lenses;

(iii) Technical competency, familiarity with Plan benefit design, and customer service skills of the Participating Provider staff; and

(iv) Adequacy of Provider access, including ease of making an appointment and convenience of office hours.

The format of the report is subject to Department input and approval and must include free form reporting of all Enrollee comments and an accounting and resolution of any Enrollee issues. This report is due on a semi-annual basis, ninety (90) Days after the end of the reporting period.

**Quarterly Reports**

***Quarterly Performance Guarantee Report:*** The Offeror must submit quarterly the Plan's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's Performance Guarantees. The report shall include, at a minimum, the areas of Plan implementation, customer service (telephone availability, response time, blockage rate, abandonment rate), eyewear turnaround time, enrollment management reports, and Participating Provider access. Documentation of compliance/non-compliance is to be included with this report. The report is due thirty (30) Days after the end of the quarter.

**Monthly Reports**

***Monthly Payment Summary:*** The Offeror is required to submit a monthly report that provides summarized claims processed, issued and paid on behalf of the NYS Vision Plan during the reporting period. Such report shall separately identify claims for State employees from those of Participating Employers (PE) and include a summarized breakout by service type. This report will be used for PE billings, thus should include sufficient claims detail for a PE to verify that it was correctly billed. The report must identify separately paid claims on behalf of direct pay Enrollees (i.e. COBRA) of PEs. This report shall serve as the billing to the NYS Vision Plan, and is due ten (10) Days after the end of the month. The exact format will be specified by the Department but should include, at a minimum, the data elements outlined in Exhibit II.E.

***Monthly Claims File:*** The Offeror shall provide a Microsoft Access database file containing the claims payment information for the month, in accordance with the specifications presented in Exhibit II.E. The monthly file is due fifteen (15) Days after the end of the month.

**(4)** ***Management Reports and Claim File Service Level Standard:*** The Plan's Service Level Standard requires that accurate management reports and claim files, as specified in Section IV.B.6.a.(3) of this RFP, be delivered to the Department no later than their respective due dates, inclusive of the date of receipt.

**b. <u>Required Submission</u>**

**(1)** The Offeror must submit examples of the financial, utilization and Enrollee satisfaction survey reports that have been listed without a specified format in the reporting requirements above, as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the NYS Vision Plan. Provide an overview of the Offeror's reporting capabilities and the value the Offeror believes it will bring to the Plan.

**(2)** Confirm that the Offeror will provide reports in the specified format (paper and or electronic- Microsoft Access, Excel, Word) as determined by the Department.

(3) Confirm that the Offeror will provide direct, secure access to its claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement the Offeror proposes, if any, for Department staff to execute in order to obtain system access.

(4) Confirm the Offeror's ability and willingness to provide Ad Hoc reports and other data analysis. Provide examples of Ad Hoc reporting that the Offeror has performed for other clients.

**(5)** ***Management Reports and Claims File Performance Guarantee*****:** The Plan's Service Level Standard requires that, for the management reports and claim files listed in Section IV.B.6.a.(3) of this RFP, accurate management reports and claims files will be delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Monthly Administrative Fee.

*The Standard Credit Amount for each management report or claim file that is not received by its respective due dates is $500 per report per each Business Day. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Management Reports and Claims File Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee for each management report or claim file listed in Section IV.B.6.a.(3) that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt."

## 7. Consulting

The Department expects the Offeror to be an expert in the vision services industry. Thus, the State may request the advice and recommendations of the selected Offeror to provide the State with up-to-date developments in the vision services field. The State expects the selected Offeror to proactively provide advice and recommendations that are related to the clinical quality and cost management of the Plan. Such recommendations must include preliminary analysis of financial and enrollee impact of proposed and contemplated benefit design changes.

### a. Duties and Responsibilities

The selected Offeror will be responsible for providing advice and recommendations regarding the Plan. Such responsibility shall include, but not be limited to:

(1) Informing the State in a timely manner concerning such matters as innovative cost containment strategies, new products, technological improvements, and State/Federal legislation that may affect the Plan. The Offeror must also make available to the State one or more members of the account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

(2) Assisting the State with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate Plan modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed Plan modifications and contemplated benefit design changes on Enrollees.

(3) If a significant change in benefits occurs during the term of the Agreement which, determined by the Department in its sole discretion, materially impacts the Contractor's Level of effort/cost, the State reserves the right to and at its sole discretion may renegotiate the unit rates contained in the Participating Provider and Laser Vision Surgery Fee Schedules and/or the Monthly Administrative Fees.

**b. Required Submission**

(1) What resources will the Offeror utilize to ensure the Plan is kept abreast of the latest developments in the vision services field? How does the Offeror propose to communicate trends, pending legislation and industry information to the Department?

## 8. Transition and Termination of Contract

The Offeror shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Members with uninterrupted access to their vision benefits and associated customer services through final termination of the Agreement. This includes, but is not limited to: ensuring that Members can continue to receive services from network(s) providers as necessary, processing all network(s) and non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreement. It is also imperative that the Plan continue to have dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Plan after the effective end date of the Agreement. In addition, the Offeror and the selected successor shall fully cooperate with the Department to create and establish a transition plan in a timely manner.

**a. Duties and Responsibilities**

(1) The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Plan.

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(2) The Offeror must, within ninety (90) days of the end of the Agreement resulting from this RFP, or within forty-five (45) Days of notification of termination, if the Agreement resulting from this RFP is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

(a) Electronic transition of Plan data including, but not limited to, the most recent date of service for Enrollees and Dependents and unique information required for a smooth transition to a successor contractor including providing a test file to the successor contractor in advance of the implementation date; and

(b) Completion of all such Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement.

(3) Within fifteen (15) business days from receipt of the Transition Plan, the Department shall either approve the Transition Plan or notify the Offeror, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department.

(4) Within fifteen (15) business days from the Offeror's receipt of the required changes, the Offeror shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department for approval.

(5) The selected Offeror shall be responsible for transitioning the Plan in accordance with the approved Transition Plan.

(6) To ensure that the transition to a successor organization provides Enrollees with uninterrupted access to their Vision benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Offeror is required

to provide the following Contractor related obligations to the Program through the final financial settlement of the Agreement which includes but is not limited to:

(a) Providing an electronic file of the most recent date of service for Enrollees and covered Dependents, including Laser Vision Correction Surgery Services in a format to be specified by the Department, no later than thirty (30) days prior to termination of the Agreement. A lag file must be provided fifteen (15) days after termination and monthly thereafter until the 90-day benefit period has elapsed;

(b) Providing all Contractor provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims and, manual submit claims, and retaining NYBEAS access.

(c) Completing all required reports in the reporting section of this RFP;

(d) Providing the Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

(e) Agreeing to fully cooperate with all the Department or Office of the NYS Comptroller (OSC) audits consistent with the requirements of Appendices A and B;

(f) Performing timely reviews and responses to audit findings submitted by the Department and the OSC's audit unit in accordance with the requirements set forth in Article XV "Audit Authority," Section VII, Contract Provisions; and

(g) Remitting reimbursement due the Program in a timely manner upon final audit determination consistent with the process specified in Article XV "Audit Authority" of Section VII, Contract Provisions and Appendix B.

(7) The selected Offeror is required to reach agreement with the Department on receiving and applying enrollment updates, keeping phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjusting phone scripts, and transferring calls to a successor contractor's lines.

(8) If the selected Offeror does not meet all of the Transition Plan requirements, the selected Offeror **will permanently forfeit 100%** of all Monthly Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

**b. Required Submission**

(1) Provide an outline of the key elements and tasks that the Offeror proposed would be included in its Transition Plan to ensure that all the required duties and responsibilities are completed if the Offeror were to be the incumbent contractor. Include a brief explanation on how the Offeror would accomplish this with the successor contractor.

(2) Detail the level of customer service that the Offeror would provide after the termination date of the Agreement.

(3) Confirm the Offeror's agreement to ***permanently*** **forfeit 100%** of all Monthly Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

## 9. Network Management

Vision Plan Enrollees and Dependents reside primarily in New York State and contiguous states. For this reason, the selected Offeror must have a comprehensive Participating Provider Network in place to allow adequate access for Plan Members. The Plan establishes minimum standards for Participating Provider Network access. Although the access standards only apply to New York State, Offerors are encouraged to propose a nationwide network that would provide access to Members residing or traveling in areas outside of New York.

**Participating Provider Network**

The current Plan includes a regional Participating Provider Network. The selected Offeror must have a credentialed Participating Provider Network in place January 1, 2012, that meets the

Plan's minimum access standards. The selected Offeror must also illustrate and attest that it has the capability and contractual right to effectively audit its Participating Provider Network.

**a. <u>Duties and Responsibilities</u>**

(1) The Offeror must maintain a credentialed and contracted Participating Provider Network that meets or exceeds the Program's minimum access standards throughout the term of the Agreement.

(2) ***Participating Provider Network Service Level Standard***: The selected Offeror must have a Participating Provider Network that throughout the term of the Agreement, meets or exceeds the Department's minimum access standards within New York State as follows:

(a) Ninety-five (95%) of Enrollees in urban areas of New York State will have access to at least one (1) Participating Provider within five (5) miles;

(b) Ninety-five (95%) of Enrollees in suburban areas of New York State will have access to at least one (1) Participating Provider within fifteen (15) miles, and

(c) Ninety-five (95%) of Enrollees in rural areas of New York State will have access to at least one (1) Participating Provider within thirty (30) miles;

**Note:** In calculating whether the Offeror meets the minimum access standards, all Enrollees residing in New York State must be counted; no Enrollee may be excluded even if a provider is not located within the minimum access area. Offerors should propose a Performance Guarantee for each of the three (3) measurements and areas (urban, suburban and rural).

These standards are based on the distance, in miles, from an Enrollee's home zip code to the nearest Participating Provider location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may propose Performance Guarantees with better access than the minimums, but the access proposed must follow the same

structure as the above minimum (i.e., access for each of the three (3) areas based on the NYS Vision Plan population in New York State).

**b. Required Submission**

(1) Propose access standards for the Plan's Participating Provider Network that meet or exceed the minimum access standard set forth below. The access standard must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access standards stipulated below.

| **NYS Enrollee Location** | **Access Standard – At least 1 Provider within** |
|---|---|
| | |
| Urban | 5 miles |
| Suburban | 15 miles |
| Rural | 30 miles |

(2) Confirm that if selected, the Offeror shall provide an updated Exhibit I.Y on December 1, 2011 confirming that the proposed Participating Provider Network will be implemented as required on January 1, 2012.

(3) Describe the approach(es) the Offeror would use to solicit additional providers to enhance its proposed Participating Provider Network or to fulfill a request to add a Participating Provider.

(4) If a national network of Participating Providers is proposed, explain whether Members traveling or residing outside of New York State will have access to the same level of benefits as those offered by Participating Providers located in New York State.

(5) ***Participating Provider Access Performance Guarantees*:** The Offeror must guarantee that throughout the term of the Agreement, Enrollees living in urban, suburban and rural areas of New York State will have access to a Participating Provider. The Offeror must propose an access standard that meets or exceeds the minimum access standards set forth in the "Participating Provider Network" Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee for failure to meet these guarantees.

(a) *The Standard Credit Amount for each .01% to 1.0% below the ninety-five percent (95%) minimum access standard in which the Participating Provider Access for Urban Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Urban Areas of New York State Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's standard of __%) for any Calendar Year in which the Participating Provider Access for Urban Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror."

(b) *The Standard Credit Amount for each .01% to 10% below the ninety-five percent (95%) minimum access standard in which the Participating Provider Access for Suburban Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Suburban Areas of New York State Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's proposed standard of __%) for any Calendar Year in which the Participating Provider Access for Suburban Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror.

(c) *The Standard Credit Amount for each .01% to 1.0% below the ninety-five percent (95%) minimum access standard in which the Participating Provider*

*Access for Rural Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Rural Areas of New York State Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's proposed standard of __%) for any Calendar Year in which the Participating Provider Access for Rural Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror."

**Laser Vision Correction Participating Provider Network**

The Offeror must develop and contract a network of Laser Vision Correction Participating Providers to provide eligible Enrollees with a covered laser vision correction benefit. The covered benefit includes a pre-operative evaluation, laser vision correction surgery, and necessary follow-up visits once every five (5) years. Prior utilization data for the covered benefit is set forth in Exhibit III.H. of this RFP.

Ineligible Enrollees and Dependents are, however, provided with an Enrollee-pay-all discounted Laser Vision Correction program through the Offeror's contracted Laser Vision Correction Network. The incumbent contractor currently offers a minimum fifteen percent (15%) discount off usual and customary fees. Utilization data for the discount program is not available.

Laser Vision Correction benefits are available to Enrollees and Dependents as set forth in the Summary of Covered Benefits, by Group in Exhibit II.D of this RFP.

**a. Duties and Responsibilities**

(1) The Offeror must develop and maintain a regional network of qualified, credentialed ophthalmologists that provides reasonable access to Enrollees and Dependents to provide laser vision correction services through both a covered benefit and discount program.

(2) The Offeror must effectively communicate the availability of the Laser Vision Correction Network to eligible Members, in addition to notifying them of their benefit and how to access their benefit. Eligible Members are eligible to use their laser vision correction benefit once every five years.

(3) At the request of the Department, the Offeror must solicit additional Laser Vision Correction Participating Providers to participate in the Laser Vision Correction Network.

**b. Required Submission**

(1) Indicate whether or not the Offeror currently has, and is proposing, a contracted Laser Vision Correction Network that provides both a covered benefit and a discount program. If so, please provide a listing of the proposed Laser Vision Correction Participating Providers located in New York State.

(2) Propose the Offeror's definition of "reasonable access" as regards the Laser Vision Correction Network.

(3) What is the minimum, maximum and average discount offered by Laser Vision Correction Participating Providers, expressed as a percentage? **Do not include any cost information in the Technical Proposal**.

(4) Confirm that the Offeror will solicit additional Laser Vision Correction Participating Providers at the Department's request.

**Participating Provider and Laser Vision Correction Provider Credentialing**

Offerors must ensure that their Participating Providers and Laser Vision Correction Participating Providers meet the licensing standards required by the State in which they operate. Participating Providers and Laser Vision Correction Participating Providers are also required to meet the credentialing criteria established by the Offeror. This additional criteria should be designed by the Offeror to ensure quality vision services.

**a. Duties and Responsibilities**

(1) The selected Offeror must assure its network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

(2) The Offeror must credential Participating Providers and Laser Vision Correction Participating Providers to ensure the quality of the network. The Offeror must also credential Participating Providers and Laser Vision Correction Participating Providers in a timely manner and shall have an effective process by which to confirm Participating Provider's and Laser Vision Correction Participating Provider's continuing compliance with credentialing standards.

**b. Required Submission**

(1) Describe the Offeror's proposed process to ensure that the Participating Providers and Laser Vision Correction Participating Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information that will be used by the Offeror to verify this information?

(2) Describe the Offeror's proposed approach for credentialing Participating Providers and Laser Vision Correction Participating Providers. Specify if the Offeror is proposing to utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is the Offeror's process for confirming continued compliance with credentialing standards? How often does/will the Offeror conduct a complete review?

(3) What steps will the Offeror take between credentialing periods to ensure that Participating Providers and Laser Vision Correction Participating Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Participating Provider Network and/or Laser Vision Correction Network as soon as possible? What steps will the Offeror take, if any, to advise members when a Participating Provider/Laser Vision Correction Participating Provider has been removed from the associated network(s)?

## Participating Provider and Laser Vision Correction Provider Contracting

Contracts with Participating Providers and Laser Vision Correction Providers should be written to utilize the Plan's market strength to obtain cost-effective pricing while ensuring Plan access standards are met, where applicable. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts that reflect the best interests of the Plan. The Offeror must ensure that all Participating Providers and Laser Vision Correction Participating Providers contractually agree and comply with the Plan's requirements and benefit design.

### a. Duties and Responsibilities

The Offeror will be responsible for providing Participating Provider and Laser Vision Correction Participating Provider contracting services including but not limited to:

(1) Ensuring that all Participating Providers and Laser Vision Correction Participating Providers contractually agree to and comply with all of the Plan's requirements and benefit design specifications.

(2) Ensuring that Participating Providers and Laser Vision Correction Participating Providers accept as payment-in-full the Offeror's reimbursement, plus copayments and upgrade fees, as applicable, for covered services.

### b. Required Submission

(1) Explain the Offeror's proposed contracting process. Describe the type of data analysis or access analysis that is/will be performed before extending participation into your network(s) to a new Provider. Provide a copy of the Offeror's proposed Participating Provider and Laser Vision Correction Participating Provider contracts, rate sheets (if applicable), and provider manual.

(2) Explain the legal and operational relationship between the Offeror and any optical labs that are used to supply materials provided by Participating Providers.

**Network Administration and Quality Assurance**

The successful Offeror should have a good working relationship with Participating Providers and Laser Vision Correction Participating Providers to ensure that NYS Vision Plan initiatives are accurately communicated and implemented, Enrollee questions or complaints are resolved timely, and that quality eyewear products are dispensed on a timely basis by Participating Providers. Network administration duties shall include, but not be limited to:

**a. Duties and Responsibilities**

The Offeror shall be responsible for:

(1) Developing and distributing communication materials to Participating Providers and Laser Vision Correction Participating Providers introducing the Plan and describing changes, when necessary;

(2) Working with Participating Providers and Laser Vision Correction Participating Providers to resolve Enrollee billing disputes and complaints about the quality of services or eyewear received , including on-site audits of facilities, as needed; and

(3) Notifying the Department in writing of any decision where a Participating Provider or Laser Vision Correction Participating Provider is suspended or terminated from participation as a result of serious quality deficiencies.

(4) ***Turnaround Time for Receiving Eyewear Service Level Standard***:
The Plan's Service Level Standard requires that ninety-five percent (95%) of all orders placed with a Participating Provider for covered eyewear will be available to the Member within seven (7) Calendar Days after placing the order.

**b. Required Submission**

(1) Describe the Offeror's proposed method(s) for communicating with Participating Providers and Laser Vision Correction Participating Providers to advise them of Plan benefits and modifications. Include copies of newsletters or other correspondence, as applicable.

(2) How does/will the Offeror monitor Participating Provider and Laser Vision Correction Participating Providers compliance with Plan benefits? What steps will the Offeror take when notified by an enrollee of a billing dispute with a Participating Provider/ Laser Vision Correction Participating Provider or dissatisfaction with services received?

(3) ***Turnaround Time for Receiving Eyewear Performance Guarantee:*** The Plan's Service Level Standard requires that ninety-five percent (95%) of all orders placed with a Participating Provider for covered eyewear will be available to the Member within seven (7) Calendar Days after placing the order. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Monthly Administrative Fee for failure to meet this standard.

*The Standard Credit Amount for each .01 to 1.0% below the standard of ninety-fine percent (95%) of all orders from a Participating Provider for covered eyewear that are not available to the Member within seven (7) Calendar Days after placing the order, is as calculated on a Calendar Year basis, $500. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Turnaround Time for Receiving Eyewear Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed standard of __%) of all orders from a Participating Provider for covered eyewear that are not available to the Member within seven (7) Calendar Days of placing the order, as calculated on an annual calendar year basis, is $_____.

## 10. Claims Processing

The Offeror is required to process all claims submitted under the Plan. The selected Offeror must be capable of processing Participating Providers and Laser Vision Correction Participating Provider claims as well as Enrollee submitted claims for non-network benefits. Enrollees are required to submit claim forms to the Offeror for non-network services no later than ninety (90) days after the end of the calendar year in which the vision services were

rendered, unless it was not reasonably possible for the Enrollee to meet this deadline. The Plan's claim utilization data for Participating Providers, non-network services and Laser Vision Correction Participating Providers and can be found in Exhibits III.A, III.A.1, III.B and III.H, respectively.

**a. Duties and Responsibilities**

(1) The Offeror must provide all aspects of claims processing. Such responsibility shall include, but not be limited to:

(a) Verifying that the Plan's benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

(b) Accurate and timely processing of all claims submitted under the Plan in accordance with the benefit design(s) applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Department.

(c) Charging the Plan consistent with the Offeror's proposed pricing quotes.

(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered services only.

(e) Maintaining records necessary to support claim payments, legal responsibilities, and reporting, and providing direct access to all NYS Vision Plan records for State audit requests;

(f) Utilizing the auditing tools and performance measures proposed by the Contractor to identify potential fraud and abuse by Participating and Laser Vision Correction Participating Providers;

(g) Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for up to six (6) years with procedures to easily retrieve and load claim records;

(h) Reversing all attributes of claim records processed in error or due to fraud or abuse and crediting the Plan for all costs associated such claim:

(i) Maintaining the security of the claim files and ensuring HIPAA compliance;

(j) Agreeing that all claim data is the property of the State. Upon request of the Plan, the Offeror shall share appropriate claims data with other Department consultants and contractors for various program analysis. The Offeror cannot sell, release, or make the data available to third parties in any manner without the prior consent of the Department.

(2) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

(3) Analyzing and monitoring claim submission to identify errors, fraud or abuse and reporting to the Department in a timely fashion in accordance with a Department approved process. The Plan will be charged for only accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Offeror shall credit the Plan the amount of any overpayment regardless of whether any overpayments are recovered from Provider and/or Enrollees in instances where a claim is paid in error due to Offeror error or due to fraud or abuse. In cases of overpayments resulting from errors found to be the responsibility of the Department, the Offeror shall use reasonable efforts to recover any overpayment and credit them to the Plan upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered. The Offeror shall report fraud and abuse to the appropriate authorities.

(4) Processing Enrollee submitted claims using the non-network fee schedule set forth in Exhibit III.E.

**b. <u>Required Submission</u>**

(1) Provide a flow chart and step-by-step description of the Offeror's proposed methodology for processing Participating Provider, Laser Vision Correction Participating Provider and Enrollee-submitted claims for the Plan. Provide a description of the edits implemented to ensure proper claim adjudication.

(2) Describe the Offeror's claims processing system platform including any backup system utilized. Describe the Offeror's disaster recovery plan and how Enrollee disruption will

be kept to a minimum during a system failure. What will be the process for Enrollees trying to receive Vision Plan Services when the claim payment system is down or not available?

(3) Describe the capabilities of the Offeror's claim processing system addressing each of the following Plan components:

(a) Eligibility verification;

(b) Prior authorization for Medical Exception Program benefits;

(c) Variations in covered Plan benefits for various employer groups;

(d) Duplicate claims; and

(e) Accurate claims pricing.

(4) Describe how any changes to the benefit design would be monitored, verified and tested for the Plan, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Plan.

(5) What steps will you take to ensure that Participating Providers and Laser Vision Correction Participating Providers comply with the HIPAA requirement for use of National Provider Identifiers for all electronic claims submissions?

(6) Describe how the Offeror's adjudication system will feed the reporting and billing systems.

**11. <u>Frame and Lens Selections</u>**

The Offeror may propose a standardized selection of Plan frames available at each Participating Provider or a frame allowance. The incumbent contractor utilizes a frame allowance with price points set at $80, $100 and $130 for basic, standard and enhanced frames. Participating Providers must offer all covered Lens types and options, as set forth in the Summary of Covered Benefits in Exhibit II.D of this RFP. Frame and Lens Plan Utilization data is set forth in Exhibit III.A and III.A.1 of this RFP.

**a. Duties and Responsibilities**

(1) The Offeror shall be responsible for ensuring that Participating Providers maintain a varied and contemporary selection of Plan frames, including but not limited to styles in metal or plastic for men, women and children, half-eye styles, protective sport goggles and designer models. Plan frames must be available at three separate benefit levels, Basic, Standard, and Enhanced. The Offeror must contractually require Participating Providers to stock a minimum of 10 Basic frame styles, 25 Standard frame styles and 10 Enhanced frame styles. The Offeror may not count a different size or different color of the same frame when assessing compliance with the minimum frame selection.

(2) The Offeror is responsible for ensuring that all Participating Providers will dispense all covered lens types and lens options, including combination of two or more lens types and options.

(3) The Offeror must provide a one-year unconditional warranty against breakage for all Plan frames and lenses that are fabricated in laboratories at manufacturing companies that are either a parent or subsidiary company of the Offeror.

**b. Required Submission**

(1) Describe in detail how the Offeror proposes to develop and maintain the three levels of Plan frames required under the Plan, including whether the Offeror is proposing a standardized Plan frame selection or allowance method, a description of the variety of frame options, and the minimum contractual and average number of frames available in each level. How will Plan Enrollees be made aware of the available Plan frame selection when receiving services from a Participating Provider (i.e., separate location of frames, color coding of UPC codes, price tag, etc….)?

(2) State the retail price points for a standard collection or the Offeror's proposed allowances for frames covered at each of the three (3) levels. If an allowance method is proposed, confirm the allowances are adequate to ensure that Participating Providers stock the minimum contractual number of frames.

(3) Describe in detail how lens types and lens options will be classified as either Standard (covered) material or premium material, eligible for the upgrade program.

(a) Provide a listing of the currently manufactured lens products that are/will be classified as Standard or premium for the following categories of lens types: progressive, high index, photochromatic and polycarbonate.

(b) Confirm which covered lens options are/will be available in both basic and premium classifications.

(c) Confirm that Enrollees eligible for multiple covered lens types and options will be able to select a combination of covered eyewear with no out-of-pocket cost, for example, a photochromatic single vision high index lens with Standard scratch-resistance and ultraviolet coating.

(4) Describe the Offeror's proposed product guarantees for Plan frames and lenses dispensed by a Participating Provider. How does/will the Offeror ensure that Participating Providers perform product repairs and replacements for eyewear which are under warranty?

## 12. Contact Lens Selection

The Offeror may propose a standardized contact lens selection or a contact lens allowance for PEF, GSEU, M/C and unrepresented Employees and their covered Dependents. A $200 contact lens allowance benefit is available for the other employee groups.

### a. Duties and Responsibilities

(1) The Offeror must ensure that Participating Providers maintain a varied selection of Plan contact lenses, including soft, daily-wear, planned replacement and disposable contact lenses, subject to Plan benefit coverages set forth in Exhibit II.D.

(2) If proposed, the standardized contact lens selection should be updated periodically to reflect current products and preferences. Conversely, if an allowance method is proposed, the allowances must be adequate to ensure a wide variety of contact lens selection.

(3) The Offeror must administer a $200 contact lens benefit for Enrollees and covered Dependents in NYSCOPBA, Council 82, ALESU, PBA and PIA, which includes the cost of the eye examination, standard or premium contact lens fitting and contact lens material.

**b. Required Submission**

(1) State whether a Standardized contact lens selection or contact lens allowance is proposed.

(2) If a Standardized contact lens selection is proposed:

(a) Describe how the Offeror will develop and maintain the selection of Plan contact lenses. Complete Exhibit III.G, Summary of Contact Lenses Covered by the Plan to detail the Plan contact lenses the Offeror is proposing.

(b) State the Offeror's proposed criteria for classifying contact lenses as either standard or premium (which are subject to the higher copay level for PEF, GSEU, M/C and unrepresented Employee and their covered Dependents).

(3) If a contact lens allowance is proposed, state the proposed allowance for standard and premium contact lenses. Do not include any cost information in the Technical Proposal.

(4) State how the Offeror proposes to administer the $200 contact lens benefit for other employee groups, and confirm that the eye exam, contact lens fitting, and contact lens material will be included.

**13. Occupational Vision Program**

The Plan's Occupational Vision Program enables eligible Enrollees to obtain a second eyewear selection (intended for occupational use) from a Participating Provider, at the time the primary eyewear is ordered. The occupational eyewear must differ from the primary eyewear based on criteria established by the Offeror and consistent with the Occupational Vision Program benefits specified in the Summary of Covered Benefit by Group,

Exhibit II.D of this RFP. The Occupational Vision Program is not available to Dependents. Further, as a health and safety measure, Enrollees in the State Police covered under PBA-Troopers, PBA-Supervisors and PIA are entitled to an additional set of occupational lenses, if needed, for insertion into respirators. See insert specifications on Exhibit II.H of this RFP.

**a. Duties and Responsibilities**

(1) The Offeror must develop sound eligibility criteria for the Occupational Vision Program, e.g., variations in lens type, strength, or tint, for occupational vision needs, in accordance with the negotiated benefit design by employee group;

(2) The Offeror must communicate Occupation Vision Program eligibility criteria to Participating Providers and ensure that they properly administer the program.

(3) The Offeror must work with the Department and the State Police to develop a procedure to order and fabricate prescription lenses for insertion into respirators.

**b. Required Submission**

(1) Does the Offeror currently administer an Occupational Vision Program for an Employer? If so, please describe the Offeror's experience administering an Occupational Vision Program and state what percentage of Enrollees receive Occupational Vision eyewear for a similar client, using the same criteria that the Offeror proposes for the NYS Plan.

(2) State the Offeror's proposed eligibility criteria for the Occupational Vision Program. Be specific. Based on the proposed criteria, are there additional procedures outside of the regular, comprehensive eye examination required under this Program that Participating Providers will be required to perform? If so, please describe the additional procedures.

(3) Does the Offeror's lens fabricator have experience with or the ability to fabricate lenses for insertion into respirators, as specified in Exhibit II.H? If so, please describe that experience.

(4) Describe how the Offeror will communicate the Occupational Vision Program and monitor Participating Provider compliance.

## 14. Medical Exception Program

The Plan's Medical Exception Program benefit is available to eligible Enrollees and Dependents as specified in the Summary of Benefit Variances by Group, Exhibit II.C of the RFP. Under the Medical Exception Program, Enrollees and Dependents with a medical condition that may impact vision refraction, when referred by the physician caring for that medical condition, are eligible for benefits sooner than the usual twenty-four (24) month period, but not less than one year from last exam. Medical Exception Program utilization is presented in Exhibit III.F of this RFP.

### a. Duties and Responsibilities

(1) The Offeror must communicate Medical Exception Program eligibility criteria to Participating Providers and ensure that they properly administer the program.

(2) In consultation with their medical director, the Offeror must establish and maintain a listing of medical conditions that would qualify an Enrollee or Dependent to receive services under the program. The listing of medical conditions must include, but not be limited to: diabetes, cataracts, keratoconus, eye surgery within two years of last Rx, taking a prescription drug whose side effects cause vision changes, and any other documented medical condition which could reasonably be expected to result in a change in refractive status, and;

(3) The Offeror must administer a process for Participating Providers to request prior authorization of medical exception benefits for eligible Enrollees and Dependents. As part of this process, the Offeror must develop sound criteria for authorizing eyewear benefits.

### b. Required Submission

(1) Does the Offeror currently administer a Medical Exception Program for an employer? If so, please describe the Offeror's experience administering a Medical Exception Program.

(2) Provide a listing of medical conditions that the Offeror is proposing to use to qualify an Enrollee or Dependent to receive services under this program.

(3) Describe the Offeror's proposed authorization process for the Medical Exception Program. Include a sample of any Medical Exception Program authorization forms that the Offeror is proposing to use under the program, timeframes for authorization and eyewear benefit criteria.

(4) Describe how the Offeror will communicate the Medical Exception Program and monitor Participating Provider compliance.

## 15. Upgrade Program

Through the Upgrade Program, eligible Enrollees and their Dependents may select certain non-Plan eyewear from a Participating Provider and pay a discounted surcharge (in addition to the Participating Provider fee paid by the Plan). The goal of the program is to make available, at a discounted price, a wider selection of frames, lens types (including contact lenses) and lens options, than is otherwise covered under the Plan.

### a. Duties and Responsibilities

(1) The Offeror must communicate the Upgrade Program requirements and pricing methodology to Participating Providers and ensure that they properly administer the Program.

(2) The Offeror must provide a minimum discount off of retail pricing for upgrade selections that are not a covered benefit for any Employee Group covered under the Plan. The Offeror must set the Upgrade Program surcharges for selections that are a covered benefit for one or more Employee Groups under the Plan equal to the fee paid by the Plan, as set forth by the Offeror in Exhibit IV.A of the RFP.

### b. Required Submission

(1) Does the Offeror currently administer an Upgrade Program for an employer? If so, please describe the Offeror's experience in administering an upgrade program. What direction does the Offeror give to Participating Providers regarding up selling?

(2) Propose a minimum discount off of retail pricing for upgrade selections that are not a covered benefit for any Employee Group covered under the Plan. Propose a methodology for charging Enrollees for these options under the Upgrade Program, including examples of the pricing methodology for frames with a retail cost of $200 or more, premium progressive lenses and premium anti-reflective lens coating.

(3) Confirm that the Enrollee surcharge for Upgrade Program selections that are a covered benefit for one or more Employee Groups covered under the Plan will be equal to the Plan fees set forth in Exhibit IV.A. (**Note:** Do not specify the actual amount of the Participating Provider Fee Schedule when responding to this question. The amount of the Participating Provider Fee Schedule should be included in the Cost Proposal only.)