SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

# MEMORANDUM

**DATE:** October 30, 2020
**TO:** Members of the Health Service Board
**FROM:** Executive Director Abbie Yant
**RE:** Medical Plan/Request for Proposal

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Good afternoon Commissioners,

To aid in your understanding of the Medical Plan/Request for Proposal, we are delivering this partial hard copy to your home along with a guide to Health Services Board meetings where related topics were presented and discussed.

Please be assured that the evaluation of the proposals is a robust and comprehensive process that includes review of responses to a detailed questionnaire, written proposals in addition to the oral interviews. The evaluation criteria, scoring, and the names of panelists will be made public once the staff recommendation is brought before the Board on February 11, 2021. At that time your questions can be responded to publicly. Should the Health Service Board decide that it needs additional time to consider the staff recommendation, the Board can make a decision regarding the staff recommendation at a special meeting on February 18, 2021.

Abbie Yant

Executive Director

San Francisco Health Service System

RFP Content and Related Health Service Board Topics

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SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

# REQUEST FOR PROPOSALS
# Health Plans—2022 Plan Year
## RFPQ#HSS2020.M1
**CONTACT: Michael Visconti, michael.visconti@sfgov.org, (628) 652-4645**

**Purpose:**
The San Francisco Health Service System (SFHSS) is issuing this Request for Proposal (RFP) to enter into one or more agreements with Selected Respondent(s) to provide comprehensive medical and pharmacy health benefits and coverage solutions for SFHSS Members who are active employees, non-Medicare-eligible retirees and non-Medicare-eligible dependents, with coverage beginning January 1, 2022.

**Population:**
As of January 1, 2020, the total enrolled population eligible for plans resulting from this RFP is 94,452 (with 56,124 enrolled in our fully insured staff-model HMO plan that will continue through the 2022 plan year).

See Section 5.2 for links to SFHSS Demographics Reports.

**Existing Plan Offerings & Plan Year 2021:**
SFHSS offers non-Medicare-eligible Members the following plans:

- Two (2) Flex-funded Health Maintenance Organization (HMO) plans, where SFHSS directly pays medical group capitation and claims (medical and prescription drug) with Accountable Care Organization (ACO) network partnerships;
- A self-funded PPO plan (Administrative Services Only or ASO-PPO);
- One (1) fully insured staff-model HMO plan for active and non-Medicare-eligible retirees in California;
- Three (3) fully insured HMO plans for non-Medicare-eligible retirees in HI, OR and WA.

**Plan Year 2022:**

- Value-based payment models for sustainable, high-quality, cost-effective health plan programs and options.
- Diversity of choices for SFHSS Members and balanced enrollment between plans.
- Long-term, stable, strategic partnerships with plans committed to the ongoing whole person health and well-being of Members.
- Better management of the drivers of risk scores.
- Minimizing disruption by maintaining a similar balance of current copays and deductibles.

**RFP Questions and Communications:**
To ensure fair and equal access to information about this RFP, all communications must be issued via email to **michael.visconti@sfgov.org**. Any unauthorized communication may be cause for disqualification. Answers to all RFP questions and any modification or addendum to the RFP will be posted on the SFHSS website at **https://sfhss.org/RFPs**.

**City Supplier Status Required:**
Each respondent to this RFP is required to become an Approved Supplier with the City and County of San Francisco (City). Approved Supplier status requires compliance with Administrative Code Chapter 12B (Equal Benefits Ordinance). SFHSS also requires compliance with Chapter 12X (Prohibition on Contracting with Entities Headquartered or with Services to be Provided in Banned States with Anti-LGBT and/or Abortion-Restrictive Laws).

- Information on becoming a City Supplier is available at **https://sfcitypartner.sfgov.org/pages/become-a-supplier.aspx**; Chapter 12B at **https://sfgov.org/cmd/**; Chapter 12X at **https://sfgsa.org/chapter-12x-state-ban-list**.

| Overview of Key Dates and Deadlines[1] | |
|---|---|
| RFP Issued | 9/14/2020 |
| Pre-Proposal Conference Call (WebEx) | 9/16/2020 |
| **Notice of Intent to Bid Due** | 9/23/2020 |
| **Deadline for RFP Questions[2]** | **9/30/2020** |
| **Conflict of Interest Disclosure Statement Due** | **10/7/2020** |
| **Deadline for Proposals** | **10/21/2020** |
| **Request for Clarification to Respondents** | **10/21 – 11/18/2020** |
| Notification of Finalists for Oral Interview | 12/28/2020 |
| **Oral Interviews (WebEx)** | **1/4 – 1/8/2021** |
| Presentation of RFP Results to San Francisco Health Service Board | 2/11/2021 |
| Implementation of Plans and Benefits | 2/2021 – 9/2021 |
| **Coverage Begins** | **January 1, 2022** |

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1 Summary purposes only. Please reference Section 1.6 "RFP Schedule" below for all dates and times.

2 RFP Answers to be posted to the SFHSS website at https://sfhss.org/RFPs the week of October 5 – 9, 2020.

## 1.6 RFP SCHEDULE

| Description | Date(s) |
|---|---|
| RFP Issued | 9/14/2020 |
| Pre-Proposal Conference Call[29] | 9/16/2020<br>2:30 p.m. PDT |
| Notice of Intent to Bid | 9/23/2020 |
| **Deadline for RFP Questions[30]** | **9/30/2020<br>2:00 p.m. PDT** |
| **Conflict of Interest Disclosure Statement Due to SFHSS** | **10/7/2020** |
| Answers to RFP Questions Posted | 10/5/2020 – 10/9/2020 |
| Deadline for Objections to RFP Terms[31] | 10/11/2020<br>11:59 p.m. PDT |
| **Deadline for Proposals (Questionnaire, Financial and Non-Financial Proposal) due to SFHSS** | **10/21/2020<br>12:00 p.m. PDT** |
| Notification of Finalists for Oral Interview | 12/28/2020 |
| **Oral Interviews (via WebEx / Video Conferencing)** | **1/4/2021 – 1/7/2021** |
| RFP Results Announced | 1/11/2021 |
| Presentation of RFP Results to San Francisco Health Service Board | 2/11/2021 |
| Implementation of Plans and Benefits | 2/2021 – 9/2021 |
| Open Enrollment Period for 2022 Plan Year | October 2021 |
| **Coverage Begins** | **January 1, 2022** |

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29 RFP Sec. 3.1 (Pre-Proposal Conference Call)

30 RFP Sec. 3.3 (RFP Questions and Answers)

31 RFP Sec. 3.5.5.11 (Objection to RFP Terms)

# 1. INTRODUCTION

## 1.1 OVERVIEW OF SFHSS

The San Francisco Health Service System (SFHSS) serves over 126,000 individuals, including both active and retired employees of the City, the San Francisco Unified School District, the Community College of San Francisco, and the San Francisco Superior Court (Participating Employers) as well as their covered dependents (SFHSS active members, retiree members, and their eligible dependents, as defined by the SFHSS Member Rules, shall be referred to as "Members" unless otherwise specified herein). SFHSS executes all process phases related to benefit operations and administration of non-pension benefits including health, dental and vision, and other voluntary benefits.

SFHSS strives to provide its Members with outstanding health, dental, vision and other employee benefits, preserving and improving these quality health benefits in a sustainable manner, while enhancing the well-being of employees, retirees and their families, and adhering to the highest standards of customer service, including:

- Negotiating lower premiums and maintaining or expanding benefit offerings for Members;
- Improving benefit and claims data, analytics, and transparency to mitigate rising health care and benefit costs;
- Enhancing existing performance guarantees, service level agreements, and minimum requirements, and establishing new performance guarantees that reflect current industry standards and benefit administration best practices; and
- Improving overall Member experience.

SFHSS provides a broad spectrum of benefit options and coverage levels and stands at the forefront of current healthcare trends, including extensive fertility coverage and infertility treatment options and integrated mental health partnerships, as part of a total health and well-being approach for Members. SFHSS requires and actively pursues greater transparency into aggregate non-pension benefit spend while ensuring year-to-year cost increases remain below national averages.

SFHSS seeks reasonable and affordable Member shares-of-costs, without sacrificing the quality or extent of benefit coverage, or discouraging Members from seeking necessary care. In addition, SFHSS aims to meet or exceed the coverage levels offered by both large public-sector employers in California and nationwide, and private-sector employers, including those headquartered here in the San Francisco Bay Area.

### 1.1.1 GOVERNANCE AND AUTHORITY

SFHSS was created by Charter Amendment No. 3 in 1937 to provide medical care for municipal employees. Today, SFHSS executes benefit operations and administration pursuant to the authority granted by The City Charter (Charter) Sections 12.200-12.203 and A8.420-A8.432, and City Administrative Code Sections 16.700-16.703,16.902.[3]

### 1.1.2 CITY AND COUNTY OF SAN FRANCISCO ORGANIZATIONAL STRUCTURE

SFHSS is one of 95 departments within the City. The City is organized as a mayor-council system with an executive mayor, elected by the voting public, and a separately elected legislative city council, the San

[3] See Sec. 4 (Glossary) for Charter and Administrative Code links.

Francisco Board of Supervisors (BoS). Certain department heads are elected by the voters, e.g., City Attorney, and Treasurer/Tax Collector, others are appointed by the Mayor and confirmed by the Board of Supervisors, e.g., Controller, while others, including the San Francisco Health Service System and the San Francisco Health Service Board (Health Service Board), include a combination of appointed and elected Members. For the seven-member Health Service Board, three Commissioners are elected, and four are appointed, comprised of a San Francisco Supervisor, two Commissioners selected by the Mayor, and one selected by the Controller.

### 1.1.3 SAN FRANCISCO HEALTH SERVICE BOARD AND BOARD POLICIES

The San Francisco Health Service System Board (Health Service Board) is dedicated to making available high quality and affordable medical, dental and vision care to its active members and retiree members and their eligible covered dependents (collectively, "Members"), applying benefits without special favor or privilege, and administering the Health Service System Trust Fund (Trust) in accordance with the Charter and solely for the benefit of SFHSS Members. The Health Service Board oversees SFHSS and its administration of non-pension benefits which may be available to employees of the four Participating Employers.

The Health Service Board maintains a set of policies that govern SFHSS' trust reserves including, but not limited to, an incurred-but-not-reported (IBNR) Reserve Policy, a Contingency Reserve Policy and a Self-Funded Plan Stabilization Policy. These policies are periodically reviewed by the Health Service Board as recommended by SFHSS' actuary.[4]

An IBNR reserve, also known as an operating reserve, is an estimate of the unpaid claims liability for runout claims where services were incurred on or before a given date, but for which claims have not yet been paid as of that date. This is calculated as of June 30th each year for SFHSS. To accurately project SFHSS self-funded plan outstanding claims liability, the SFHSS actuary estimates the cost of claims rendered but not yet paid based on past claim experience. The IBNR reserve serves as a set-aside for these funds for unpaid claims liability from run-out claims.

A contingency reserve, also known as an excess loss reserve, is a statistically determined amount which protects against potential for funding estimate shortfalls. It is a prudent measure to avoid the financial ill-effects of adverse claims experiences that exceed expected claims targets. This is calculated as of June 30th each year for applicable SFHSS plans. The contingency reserve serves to set-aside funds for excess losses from adverse Member claim experience over a given plan year. This is particularly important with respect to the current SFHSS self-funded PPO plan where there is no reinsurance policy and the Trust must absorb all potential excess costs over expected costs and therefore hold an excess loss reserve.

The stabilization reserve distributes Member claims experience gains or losses into the following year's premium calculation in a balanced manner to reduce year-to-year premium volatility. The Health Service Board's Rate Stabilization Policy requires an annual determination of the financial gain or loss over a calendar year for each self-funded SFHSS health plan. The difference between the expected and actual plan costs for the just-completed plan year is added to the existing stabilization reserve balance and, under the policy, is amortized over a three-year rating period. The Health Service Board's Self-Funded Plans' Stabilization Policy is also known as the Funding Policy.

The Trust is audited annually by an independent auditor for the accuracy of financial statements and appropriateness of accounting policies. The Trust operates as a pay-as-you-go system meaning that

4 Information regarding the Health Service Board and Board Policies may be found on the SFHSS website at http://www.sfhss.org/health-service-board.

payments for current Member benefits come from current payments into the Trust. Outside the reserves already discussed, the Trust does not maintain funds for future benefits or asset building.

### 1.1.4 SFHSS RESOURCES AND DIVISIONS

1. **Aon Consulting, Inc.** Aon Consulting, Inc. (Aon) is the actuary and benefit consultant for SFHSS and the Health Service Board. Aon has served SFHSS and Health Service Board since 2011. Aon's overall Health segment supports a team of over 1,500 United States (U.S.) -based health care experts including actuaries, physicians, clinicians, pharmacists, attorneys, and consultants and has over 70 years of experience in human resources, health care and benefits. Aon will assist SFHSS in the administration of the RFP including hosting the secure TBS/Greater Insight platform.

2. **Enterprise Systems and Analytics and All-Payer Claims Database.** The SFHSS Enterprise Systems & Analytics (ESA) Division supports all the technical infrastructure for SFHSS from information technology (IT) support to systems configuration and development, implementation of cybersecurity safeguards, and project management. This division annually configures all the system modifications required to administer benefits for the plan year which includes the financial, benefit plan and enrollment components. ESA also provides production support for the benefits administration system and the eligibility and payment interfaces.

   ESA leverages the All Payer Claims Database data warehouse (APCD) to conduct analyses of the Member population to evaluate quality of care, trend cost and utilization, and support plan design and population health considerations. Additionally, ESA fulfils all internal and external data and report requests, including data to support rate setting, budgeting, and internal and external audits.[5]

3. **Communications Division.** The SFHSS Communications Division provides Members with accurate and timely benefits information to enable Members to make informed decisions in selecting benefits, appropriately utilize those benefits, and actively manage their health. Selected Respondent(s) will be expected to produce Member-facing materials and obtain written confirmation from the Communications Division prior to distribution or publication. Minimum requirements and standards for communications with Members by Selected Respondent(s) are contained in Sec. 5.7.20.

4. **Members Services.** The SFHSS Member Services Division handles day-to-day enrollment transactions, provides benefits decision support to Members, coordinates premium contribution transactions with the internal SFHSS Finance division, and acts as a liaison between Members and health benefit vendors. The Member Services Divisions is also responsible for monthly reconciliation of enrollment data with plans and employers, and processing enrollment changes (e.g., births, deaths, leaves, new hires and retirements). The Member Services Division answers direct Member calls and meets in-person with SFHSS Members during standard SFHSS office hours.

5. **Well-being Division.** SFHSS supports Members with a comprehensive in-house well-being program and dedicated well-being staff (Well-Being Division). Partnership with our current health plans and health benefit vendors is integral to the success of the Well-Being Division and SFHSS Well-Being programs. The Well-Being Division has several core functions, including: (i) an in-house non-clinical Employee Assistance Program (EAP), (ii) developing employee well-being communities and expanding department-level well-being buy-in (Well-being Key Players and the Well-Being@Work initiatives), (iii) retiree-support services, (iv) healthy behavior campaigns and challenges, (v) targeted interventions and activities including a diabetes prevention programs (Sec. 1.2.3.2), healthy weight programs, flu clinics, health screenings, seminars, coaching, and group exercise classes, and (vi) staffing a centrally-located Wellness Center available to Members.[6]

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5 See RFP Sec. 1.2.4, 1.5.2, Sec. 2,2.1.1.5 and 5.7.22 (Data Requirements).

6 Pursuant to COVID-19 and the City's stay-at-home/work-from-home policies and City emergency orders, the Wellness Center has been temporarily closed to members. However, virtual resources and wellness support continues to be provided to

### 1.1.5 SFHSS MISSION AND STRATEGIC GOALS

The SFHSS Strategic Plan, 2020-2022 (SFHSS Strategic Plan) features six guiding principles and five strategic goals aimed at improving the affordability, delivery, experience and outcomes for SFHSS Members. Successful Respondent(s) will align and support the SFHSS Strategic Plan, goals, values and guiding principles.

The five strategic goals of the SFHSS Strategic Plan are as follows[7]:

- Affordable and sustainable: acknowledging Member costs (both through contributions and plan design) as well as the financial sustainability of the overall program
- Reduce complexity and fragmentation: selecting vendor partner(s) who provide comprehensive and integrated health plans
- Engage and support: identifying vendor partner(s) who will promote health literacy and provide Member advocacy care coordination and addresses racial equity and other negative Social Determinants of Health (SDoH)
- Choice and flexibility: appreciating the various needs of Members and providing meaningful opportunity in the areas of health plan, plan design, and network/health systems
- Whole person health and well-being: seeking vendor partners who will support SFHSS' ongoing health and well-being activities and look to shift from sick care to health care and reduce barriers to care (e.g., negative SDoH).

### 1.1.6 STAKEHOLDERS

1. **The San Francisco Board of Supervisors**

   The San Francisco Board of Supervisors (BoS) is the legislative branch of the City and County of San Francisco. The BoS consists of eleven (11) Members elected by the City's voting public. The BoS approves the inclusion of benefit plans qualifying under the employee cafeteria plan as provided and regulated under Section 125 of Title 26 of the United States Code. The BoS approves the medical care plans adopted by the Health Service Board annually pursuant to Section A8.422 of the Charter and Section 16.703 of the San Francisco Administrative Code. Approved medical plans remain on file with the Clerk of the BoS.

2. **The Office of Public Policy and Finance**

   The Mayor's Office of Public Policy and Finance (OPPF) works closely with City departments and agencies to responsibly build and maintain a balanced budget for the City. The OPPF submits a balanced budget to the BoS in June of each year (delayed in 2020 due to COVID-19). The OPPF participates in the development and monitoring of the Mayor's policy initiatives, provides the public with information about complex financial issues and information about government operations, and participates in the development and monitoring of performance measurement tools and government efficiency.

3. **Controller**

   The Controller serves as the City's chief accounting officer and auditor. The Controller's Office is responsible for governance and conduct of key aspects of the City's financial operations,

Members by SFHSS Well-being staff through Microsoft Teams/WebEx/Zoom, webinars, emails, phone calls, the Well-being web pages https://sfhss.org/well-being.

7 https://sfhss.org/sfhss-strategic-plan-2020-2022.

including operating the City's financial systems and procedures, maintaining the City's internal control environment, processing payroll for City employees, managing the City's bonds and debt portfolio, and processing and monitoring the City's budget.[8] Further information on the Controller may be found at: https://sfcontroller.org.

4. **Department of Human Resources**

The San Francisco Department of Human Resources (DHR) administers the City's civil service system, ensures payment of Workers' Compensation benefits to injured employees, negotiates and administers labor agreements, ensures equal employment opportunities for employees and applicants, recruits talent for the City and manages training and developing the City workforce. Further information on DHR may be found at: https://sfdhr.org/.

5. **San Francisco Employees' Retirement System**

The San Francisco Employees' Retirement System (SFERS) administers two benefit programs for active and retired Members—a Pension Plan (defined benefit plan) and a 457(b) Deferred Compensation Plan (defined contribution plan). The SFERS Pension Plan is a defined benefit plan that provides service retirement benefits calculated using a formula based on age at retirement, years of service and final compensation. The Deferred Compensation Plan is a voluntary IRS Sec. 457(b) plan that allows participants to voluntarily defer receipt and taxation of a portion of their regular earnings until after they retire or separate from service. Under the direction of the Retirement Board, the Executive Director and senior staff team manage the day-to-day activities of the system including investments, Member services, finance, actuarial services, information technology, human resources and communications.[9]

6. **Labor Negotiations and Unions**

The City engages in bargaining with its unions whose collective bargaining agreements are open for negotiation. The number of union labor agreements negotiated each year varies greatly. The 2019 bargaining process encompassed 37 unions covered by 26 different contracts, affecting about 30,000 employees. The Charter provides the process by which contract agreements must be completed and sent to the BoS in May of each year. Information about labor negotiations and bargaining process, timeline, Memoranda of Understanding with each union, and links to the Administrative Code may be found on the website of the Department of Human Resources.[10]

7. **Advocacy Organizations Representing Retired Members**

SFHSS retired members may elect to participate in non-profit organizations that advocate on their behalf with SFHSS and the Health Service Board. These organization can also serve as a communication channel to their membership.

## 1.2 Background and Current State

### 1.2.1 Regulatory Compliance, Member Rules and Sec. 125

As the Plan Administrator for the City's Internal Revenue Code (IRC) Section 125 Cafeteria Plan, SFHSS must comply with relevant regulations, the Health Insurance Portability and Accountability Act of 1996 (Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996), as amended (HIPAA), the Consolidated

8 Further information on the Office of the Controller may be found at: https://sfcontroller.org/about-controller%E2%80%99s-office.

9 Further information about SFERS may be found at: https://mysfers.org/.

10 Department of Human Resources labor negotiations timeline: https://sfdhr.org/2019-contract-negotiations#Timeline; Memoranda of Understanding: https://sfdhr.org/memoranda-understanding.

Omnibus Budget Reconciliation Act of 1985 (26 CFR Sec. 54.4980), as amended (COBRA), the Patient Protection and Affordable Care Act (Pub.L. 111-148, 124 Stat. 119, enacted March 23, 2010), as amended (PPACA) and other federal, state and local laws regarding the administration of employer health plans and benefit programs. The SFHSS Member Rules and the 125 Cafeteria Plan document are under the purview of the Health Service Board. Any changes to these documents must approved by the Health Service Board.[11]

The SFHSS Member Rules combined with the 125 Cafeteria Plan document govern SFHSS active and retiree member and eligible dependent benefits. The Member Rules cover a wide range of topics including but not limited to eligibility, coverage periods, requirements for continuing SFHSS administered health coverage in retirement, and the process for Member appeals and grievances.

Every year during Open Enrollment (October 1, or the next City working day, through October 31, or the prior City working day), SFHSS publishes and distributes benefit guides to provide Members with the negotiated premium contribution rates and other relevant plan information and comparisons, so that Members can make informed decisions regarding which plans to choose from for the next plan year.

Respondents are advised that the determination of eligibility criteria for coverage for all plans is the responsibility of SFHSS and is not open for alternative proposals under this RFP.

### 1.2.2 DEMOGRAPHICS

1. **Non-Medicare Population, Defined.** Proposed healthcare coverage in response to this RFP will be available to all SFHSS active employee members, non-Medicare-eligible (also commonly referred to in the City as "early retiree") retiree members, and their eligible dependents (collectively the "Non-Medicare Population").

2. **Non-Medicare Population, by Plan.** The total Non-Medicare Population contains 94,452 total covered lives as of January 1, 2020. The plans available to this population and the covered lives (as of January 1, 2020) were as follows:
   - Blue Shield Access+ HMO (23,273)
   - Blue Shield Trio HMO (12,053)
   - Kaiser Permanente HMO (56,124)
   - UnitedHealthcare PPO (3,002)[12]

   For reference, the plans available to the SFHSS Medicare-eligible population and covered lives (as of January 1, 2020) are as follows:
   - Kaiser Permanente Senior Advantage HMO (13,463)
   - United Healthcare Medicare Advantage (MAPD) PPO (16,316)

   Additionally, SFHSS currently has 12,252 individuals who have waived health benefit coverage as of January 1, 2020.

3. **Non-Medicare Population and Risk Pool.** As a result of this RFP, SFHSS expects to achieve a greater diversity of choices for the Non-Medicare Population and balanced enrollment between

11 Both the 2020 Member Rules and the 2020 Section 125 Cafeteria Plan documents can be found on the SFHSS website at http://www.myhss.org/san-francisco-health-service-system-member-rules.

12 Respondents are advised that this population includes 121 Medicare-eligible Members not enrolled in Medicare, who are enrolled in the UnitedHealthcare ASO Choice Plus or "City 20" plan. The Summary of Benefits for the City 20 Plan is available at: https://sfhss.org/sites/default/files/2019-09/2020%20City%2020%20Choice%20Plus%20SOB_Combined.pdf.

the non-Medicare plans. Respondents are advised to review Section 5.2 for Non-Medicare Population Trends and Member migration between SFHSS health plans between 2016 and 2020.

- The entire Non-Medicare Population (94,452 covered lives) will be eligible to select a new health plan or plan(s) resulting from this RFP in October 2021 for the 2022 plan year.
  - Respondents are advised that to reduce disruption in plan year 2022, the current staff-model[13] HMO plan offered through Kaiser Permanente, will remain available to eligible Members of the Non-Medicare Population for the 2022 plan year.
  - Respondents are advised to reference the discussion of a balanced health plan solutions for the 2022 plan year as presented to the Health Service Board at the Governance Committee Meeting on September 3, 2020.[14] The presentation and discussion included demonstrative representations of both (i) the current state of SFHSS health plans (Sec. 1.2.2.2., above), and (ii) a System Competition model (Sec. 1.3, below).
  - Respondents are advised that pursuant to the System Competition model, as a result of the RFP the HMO plan(s) and PPO plan(s) may be provided by a single carrier.

Respondents are encouraged to collaborate or subcontract with other entities to propose innovative, high quality and cost-effective solutions and networks.

- Selected Respondent(s) will be solely responsible for managing the work, costs, quality and compliance of any and all subcontractors it intends to use in the full performance of all contractual duties assigned to the Respondent.
- Successful Respondents will work with regional (Northern California) and local (Bay Area) community health partners to promote best practices and evidence-based care.
- Successful Respondents will submit proposals that will lead to improved health outcomes for Non-Medicare Population.
- Successful Respondents will leverage innovative collaborations with delivery systems or other forms of subcontracts and partnerships.

Respondents are advised that Proposals must clearly identify all subcontractors and vendor partners, the task(s) performed, and are encouraged to highlight the expertise and advantage(s) offered through the partnership.[15]

### 1.2.3 PROGRAMS

1. **24/7 Tele-Counseling and Employee Assistance Program**

   SFHSS offers a variety of confidential counseling, consultation, coaching and education services through the Well-being Division's Employee Assistance Program (EAP) counselors. EAP counselors are licensed therapists with many years of diverse experience in mental health, business and as City employees. As of April 2020, SFHSS expanded tele-counseling through a partnership with ComPsych (https://www.compsych.com/), emphasizing 24/7 access and additional counseling services tailored to the needs of our frontline medical and emergency staff and first responders.

2. **Diabetes Prevention Program**

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13 Kaiser Permanente own facilities and employs physicians/contracts with Permanente Medical Group.

14 https://sfhss.org/board-meeting/2020-09-03t200000

15 Pursuant to the subcontracting clause located in Appendix E-1, all City and County of San Francisco and San Francisco Health Service System group and professional service agreements, Selected Respondent(s) bear sole responsibility for the actions of any subcontractor.

The Well-being Division and the YMCA of San Francisco have partnered to offer Members the SFHSS Diabetes Prevention Program.[16] This year-long program is based on a successful diabetes prevention program developed by Centers for Disease Control and Prevention (CDC). The DPP launched in 2020 as a more limited distance-based approach with in-person program options delayed until the lifting of shelter-in-place and other public health orders surrounding COVID-19.

### 1.2.4 SFHSS PARTNERS

SFHSS places a high value on its health plan partnerships. Successful Respondent(s) will coordinate with other SFHSS health benefit partners and support SFHSS Stakeholders, such as those providing ancillary benefits, analytical services, actuarial services, auditing and benefit consulting services to SFHSS and Members. Such partners include the following and may be subject to change prior to the 2022 plan year:

- Aon Consulting, Inc. (actuary, benefits consultant) (Sec. 1.1.4.1)
- City and County of San Francisco, the San Francisco Unified School District, the Community College of San Francisco, and the San Francisco Superior Court (Participating Employers).
- Cordico (on-demand access to mental and behavioral health resources for first responders and emergency management personnel)
- CredibleMind (Peer-reviewed mental health and well-being resources for Members)
- ComPsych (24/7/365 EAP counseling support services)
- Delta Dental of California
- International Business Machines Corporation (IBM, formerly Truven Health Analytics LLC, an SFHSS vendor partner since 2015).[17]
- K&H Printers-Lithographers, Inc. (print, mail and open enrollment communications services and support)
- Kaiser Permanente (Active Employees, Non-Medicare Retirees, and Medicare retirees)
- MGO [Macias Gini & O'Connell LLP] (auditors)
- P&A Group (COBRA and AB528 administrator)
- UnitedHealthcare (Active Employees, Non-Medicare Retirees, and Medicare retirees)
- VSP (Vision Benefits)
- Well-being Division (Sec. 1.1.4.5) and annual wellness program partners
- Workterra (formerly EBS; voluntary benefits administration)
- YMCA of San Francisco (Diabetes Prevention Program)

### 1.2.5 CURRENT SFHSS HEALTH PLANS FOR THE NON-MEDICARE POPULATION

Current SFHSS active members and non-Medicare eligible (early) retiree members may select one of the following plans or waive medical coverage entirely for themselves and any eligible dependents:

- Two (2) Flex-funded HMO plans, where SFHSS directly pays medical group capitation and claims [medical and prescription drug], inclusive of strategic ACO network partnerships

16 https://sfhss.org/dpp

17 See 5.7.22 (Data Requirements).

- A self-funded PPO plan (ASO-PPO)
- Four (4) fully insured Staff-model HMO plans[18]

1. **Flex-Funded HMO Plans (BSC).** SFHSS provides two flex-funded HMO plan options managed by Blue Shield of California (Blue Shield): Access+ and Trio HMO. Trio HMO debuted on January 1, 2018. Prior to the January 2013 plan year, SFHSS offered a fully-insured HMO plan managed by Blue Shield. However, on January 1, 2013, the Blue Shield Plan was converted from a fully-insured external health maintenance plan into a flex-funded plan, the Access+ plan. This flex-funded plan has a fully-insured capitation component for services provided by Medical Groups, where the Medical Groups are financially responsible. Hospital and pharmacy services are self-insured, and the risk of loss due to such claims in excess of revenues is borne by the Trust.

   Blue Shield absorbs financial responsibility for any single claimant who exceeds $1 million in incurred claims in a calendar year (funded through a large claim pooling fee SFHSS pays to Blue Shield), as well as financial responsibility for aggregate claims and administration expense (less individual large claim pooling reimbursements) that exceed 125% of target for Access+ and 115% of target for the Trio HMO.

   Financial collaboration with ACOs is critical to improving quality and lowering healthcare costs within the flex-funded HMO plans. SFHSS-ACO collaborations provide patient-centered care, leveraging defined networks of high-performance primary care, specialty providers, and inpatient and outpatient facilities, through a value-oriented payment structure. Within each ACO partnership, global per-member per-month (PMPM) healthcare cost targets and quality goals are negotiated for each plan year. SFHSS-ACO collaborations for the 2020 plan year include Brown and Toland, Hill Physicians, Dignity Health, California Pacific Medical Center, and the University of California San Francisco (UCSF).

2. **PPO Plan (UHC).** The current SFHSS PPO plan, which includes medical and prescription drug benefits, is a self-insured indemnity plan, where the risk of loss due to claims in excess of revenues is borne by the Trust. The PPO plan is administered by United HealthCare (UHC). There is a separate rate calculated for "out-of-area" Members as is identified by the name "Choice Not Available" plan.

3. **Fully-Insured HMO Plans (Kaiser Permanente).** The four (4) fully-insured HMO plans are external HMO's, where the risk of loss due to excess claims for a given fiscal year is borne by the plans. Our fully insured HMO's are managed by Kaiser Permanente in the Northern and Southern California Regions, and Kaiser Permanente in the Hawaii, Northwest and Washington Regions.

4. **Split Enrollment.** The San Francisco Health Service System collaborates with Blue Shield and UHC to offer Members the unique ability to "split enrollment" across some of our plans, when a primary member (active employee or retiree member), or a dependent of that primary member becomes eligible to enroll in Medicare. Currently, Kaiser Permanente is not required to accommodate split enrollment with the other health plans.

   In the case where a primary member is enrolled with Blue Shield or UHC, and either the primary member or a dependent of the primary member, becomes eligible to enroll in Medicare, and the Medicare beneficiary elects to enroll in the UHC MAPD PPO plan, the non-Medicare eligible members and/or non-Medicare eligible dependents may elect to enroll in either the UHC PPO, Blue Shield Access+, or Blue Shield Trio HMO plans.

[18] SFHSS offers four (4) fully-insured HMO plans, each with unique benefits for Early Retirees, for the following Kaiser regions: California, Hawaii, Northwest and Washington. Active SFHSS Members may select Kaiser California.

This unique enrollment requires additional eligibility file and programmatic requirements and if requested by SFHSS, will be required for any Selected Respondent(s).

5. **Member Support, Navigation and Advocacy.** SFHSS plan partners and Selected Respondents are expected to support Members through a variety of services and systems designed to reduce barriers to care, improve overall access to care, and increase Member self-advocacy and knowledge of benefits available to them. In addition to the services and support provided by our plan partners, SFHSS supports Members directly through our Member Services Division (Sec. 1.1.4.4.).

   Between January 1, 2017 and December 31, 2019, SFHSS partnered with Teladoc (formerly Best Doctors) to offer expert medical opinion services to Members. Teladoc's services included InterConsultation and Expert Medical Option Services:

   - InterConsultation services, through which Teladoc reviewed diagnoses and treatment plans, and either confirmed or recommended modifications to diagnoses, and/or recommended alternative courses of treatment.
   - Expert Medical Opinion services, through which Teladoc assists Member by identifying potential misdiagnoses, recommending potentially cost-saving alternative courses of treatment, and/or flagging potentially inappropriate, excessive or unnecessary treatments.

   Following the conclusion of the SFHSS partnership with Teladoc, SFHSS placed increased focus on ensuring that Members are aware of procedures for obtaining in- and out-of-plan expert second opinion services.

### 1.2.6 Out of Scope Benefits and Plans

For the purposes of submitting a Proposal, the following plans and benefit offerings are outside of the scope of this RFP (Out-of-Scope Services):

- Medicare Advantage Plans
  - Kaiser Permanente
  - UHC
- Vision Benefits
  - Vision Service Plan (VSP)
- Dental Benefits
  - Delta Dental PPO
  - Delta Care PMI DMO
  - UHC Dental DMO
- Flexible Spending Accounts (FSAs)
  - P&A Group
- Long Term Disability
  - The Hartford (formerly Aetna Life and Casualty prior to January 1, 2020) ("Hartford")
- Term Life and Accident Insurance
  - Hartford
- Workers Compensation
  - Administered by the San Francisco Department of Human Resources (DHR), Sec. 1.1.6.4.
- COBRA

- P&A Group
- AB528 Continuation Coverage Administration
  - San Francisco Community College District and San Francisco Unified School District
- Voluntary Benefits Administration
  - Workterra (formerly EBS)
- Benefits Administrator print, mail and open enrollment communications services and support
  - K&H Printers-Lithographers, Inc.

While Medicare plans are not within the scope of this RFP, SFHSS is interested in learning more about each Respondent's potential capabilities for Medicare plans, alignment with Medicare plans and transition planning for Members reaching Medicare-eligibility. As such, a non-scored Medicare questionnaire has been included for your response.

### 1.2.7 FINANCIALS

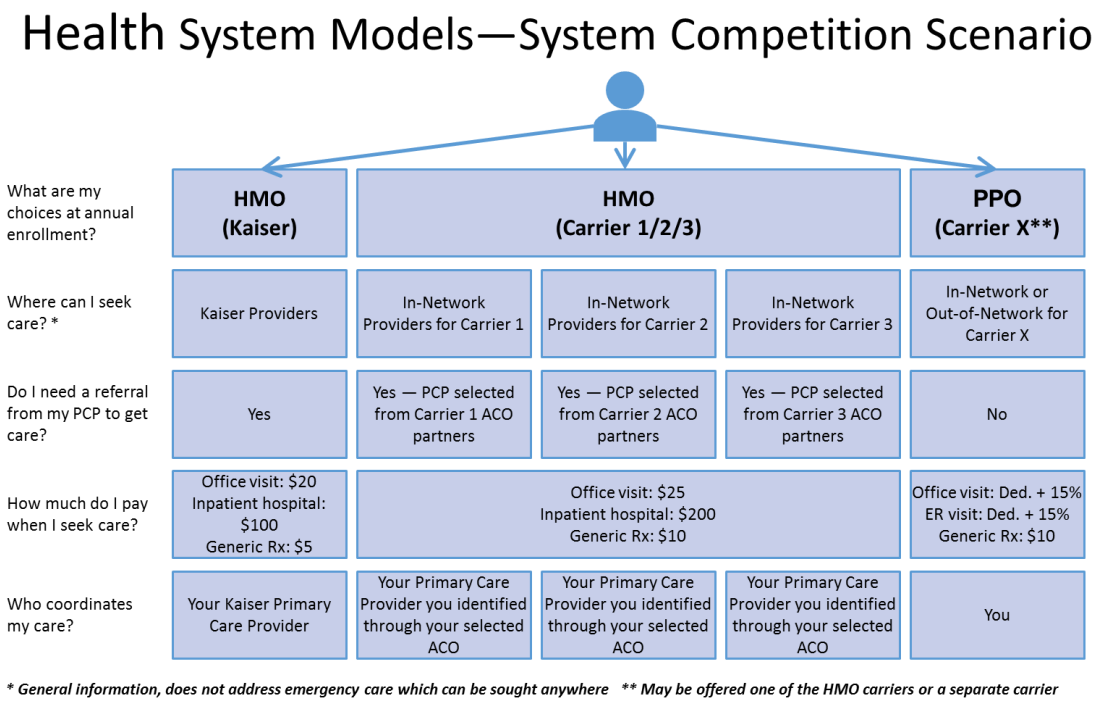
1. **Established Financial Stability.** SFHSS seeks Respondent(s) that can demonstrate financial stability and have the capacity to manage the additional Members from SFHSS that will enroll in its health plan products. Respondent(s) should be ranked by Standard and Poor's', Moody's or AM Best with a rating of "A-" or greater to ensure the City is partnering with a financially stable provider capable of sustaining a multi-year contract to provide high quality benefits to the City, SFHSS and our Non-Medicare Population. Respondent(s) must demonstrate no material statutory or regulatory deficiencies, insolvency or inadequate reserves over the past two (2) fiscal years. A Respondent shall be prepared to produce recent financial exams or audited financial statements to support its Proposal upon request by SFHSS.
2. **Assumption of Underwriting Provisions.** Proposals may not include any language related to any right by Respondent to modify rates based on expected versus actual enrollment.
3. **Value-Based Advancements.** In addition to established financial stability, SFHSS seeks health plan partners that will use their financial resources to advance and develop programs and foster incentives towards the goals of the Quadruple Aim.[19] Successful Respondents will demonstrate the movement away from fee-for-service to adoption of alternative payment methods, value-base benefits and reimbursement, and quality-based and population health-based risk sharing arrangements.

*The remainder of this page intentionally left blank*

19 Institute for Healthcare Improvement, http://www.ihi.org/.

## 1.3 OBJECTIVES

SFHSS issues this RFP to enter into one or more agreements with qualified organizations for health care benefits and coverage for the Non-Medicare Population, with coverage beginning January 1, 2022. This is based on the "System Competition" model as developed by SFHSS:




As a result of this RFP, SFHSS expects to:

- Enhance value-based payment models for sustainable, high-quality, cost-effective health plan programs and options demonstrating movement away from fee-for-service models
- Address financial stability for PPO (or "non-HMO") plans
- Enhance diversity of plan choices, models, and integrated delivery systems for Members and balanced enrollment between SFHSS non-Medicare plans
- Partner with plans committed to the ongoing whole person health and well-being of Members and reduced health disparities
- Innovate for better management of the drivers of risk scores through comprehensive data analytics and integrated care delivery models
- Minimize disruption by maintaining a similar balance of current copays and deductibles

Successful Respondent(s) will propose health care plans available to the Non-Medicare Population through at minimum, the 2026 plan year.

However, nothing in this RFP limits SFHSS's ability to change benefits during the annual plan year renewal.

Successful Respondents are further advised to consider the following:

### 1.3.1 VALUE-BASED PAYMENT MODELS

Proposed health plans should support and advance the following:

- High performing networks and centers of excellence, integrated delivery system and varied sites of care (office, telehealth, virtual, in-home, remote monitoring) with bundled payment and/or cost- and quality-based pay for performance provider contracts
- Transparency in reporting and maintaining constructive cost and quality metrics
- Data integration and interoperability within the provider community as well as between traditional care delivery classifications
- Network steerage towards high quality, integrated health providers that will advance primary care practitioners

### 1.3.2 DIVERSITY OF CHOICES

Proposed health plans should support and advance the following:

- Financial sustainability of SFHSS health plans and programs through a combination of approaches
- Recognize the development of integrated networks that advance the shared goals of reduce costs and improved quality of care, offer clinically integrated services for our members, and that pursuant to the Charter, every Member shall have the right to select their own physician through the available SFHSS plans
- Advancements in telehealth and real-time scheduling and support

### 1.3.3 WHOLE PERSON HEALTH AND WELL-BEING OF MEMBERS

Proposed health plans should support and advance the following:

- Improve population health and focus on the total health and well-being of Members, including consideration and support of racial equity and social determinants of health
- Engagement of Members in care decision-making and setting short- and long-term health goals
- Optimize Member experience through convenient, coordinated and tailored care management, coordination, advocacy and navigation of systems, benefits and third-party/partner programs
- Person-centric, culturally-sensitive care delivery systems and the incorporation of resources to address negative SDoH
- Innovative approaches to integrated care management and coordination for acute and chronically ill Members attending to the transitions between levels of care

### 1.3.4 MANAGEMENT OF DRIVERS OF RISK SCORES

Proposed health plans should support and advance the following:

- Proactive, efficient, coordinated identification and management of high-cost claimants ($100K and higher)
- Proactive identification and efficient, coordinated management of patients with chronic health conditions by supporting those at risk for chronic disease and engaging those who are at risk for developing a chronic health condition

- Ensuring that financial and non-financial incentives are aligned among the health plan, providers, and facilities to promote superior care management
- Ensuring support systems are in place for high risk and advanced illness, and that palliative care needs are proactively managed
- Premium redistribution (up to a pre-set percentage of premium cap) among multiple health plans based on evaluation of population health risk scores of SFHSS population enrolled in each plan, using a nationally recognized health risk scoring methodology based on pharmacy data

### 1.3.5 MINIMIZING DISRUPTION

Proposed health plans should support and advance the following:

- Comprehensive provider, facility, and retail pharmacy network footprint with minimal disruption due to provider contracting issues, including real-time provider network accuracy
- Ensuring comprehensive network for Members outside of the HMO geographic footprint, currently served by the PPO "Choice Not Available" plan
- High-touch Member services to support those with chronic and acute issues during the transition of care
- High-touch Member services to support those transitioning enrollment or employment status, e.g., active employment to retirement (Non-Medicare and Medicare-eligible), non-Medicare eligible to Medicare eligible, overage dependents, or COBRA

## 1.4 INSTRUCTIONS FOR THE TBS / GREATER INSIGHT WEB-BASED RFP PLATFORM

Respondents **must submit Proposals via Aon's TBS / Greater Insight platform (Greater Insight).**

Respondents will be provided with login access directly from TBS / Greater Insight.

Once received, please follow these instructions:

1. Access the login screen via: **https://tbs.aon.com**
2. Click on 'Forgot My Password/First Time User' on the login screen
3. Enter your username as well as your email address
4. Click 'Submit'
5. An email will be sent to you asking you to create a password
6. Return to the login screen and enter your username and the password you just created

For help with login issues please send an email to Greater.Insight.Service.Desk@aon.com. All other RFP communications must be issued via email to michael.visconti@sfgov.org. Any unauthorized communication may be cause for disqualification. Answers to all RFP questions will be posted on the SFHSS website at https://sfhss.org/RFPs.

## 1.5 MINIMUM QUALIFICATIONS

### 1.5.1 MINIMUM QUALIFICATIONS

Respondents must meet the following minimum requirements at the time their Proposal is submitted to SFHSS (Minimum Qualifications):

1. Respondent is a Corporation, Limited Liability Company or Non-Profit entity in Good Standing with the State of California (or Respondent's state of formation).
2. Respondent is licensed to do business in California.
3. Respondent is licensed with the California Department of Insurance (CDI) and/or the California Department of Managed Health Care (DMHC).
4. Respondent maintains a business presence within the state of California.
5. Respondent has three (3) years of experience providing the proposed insurance and claims administration services to public sector employers.
6. Respondent is currently in compliance with all state and federal privacy and security laws, statues and regulations for protecting health plan subscriber/enrollee/Member data, including HIPAA and the HIPAA Security, Privacy, and Breach Notification Rules.
7. Respondent is currently or will be able to comply as of the date of its Proposal with the data sharing and security requirements listed in Section 5.5. (Standard Agreement), including, but not limited to, Article 13, and the Business Associates Agreement (BAA).
8. Respondent possesses the minimum insurance coverages set forth in Section 5.5. (Standard Agreement).
9. Respondent meets a Standard and Poor's', Moody's or AM Best financial rating of "A-" at the time Proposal is submitted.
10. Respondent has reviewed the conditions of becoming an Approved City Supplier including, but not limited to, San Francisco Administrative Code Chapter 12B, and agrees to become an Approved City Supplier by or before July 1, 2021.

### 1.5.2 BASELINE EXPECTATIONS, PLAN YEAR 2022

Baseline expectations are the minimum necessary service and performance objectives and standards SFHSS will expect of Selected Respondent(s) and ongoing health plan partnerships beginning January 1, 2022. These baseline expectations include, but are not limited to, the following:

1. **Alignment with SFHSS strategic goals.** SFHSS expects well-articulated and successfully-demonstrated services, programs and resources to support its five strategic goals.
2. **Innovation and partnership for the future.** Demonstration that Selected Respondent(s) offer flexibility and innovation to address future goals and collaborative approaches for the Non-Medicare Population.
3. **Commitment to value-based payment to reduce costs and improve quality of care for SFHSS members.** Catalyze payment reform with providers by paying for value, reducing cost, reducing waste and recognizing providers for improvement in the delivery of quality care.
4. **An investment in operations and care delivery.** Major identifiable investments in operations and a proven track record of delivering well above average results in all facets of customer service, claim processing, network management, and other operational elements (backed by aggressive

operational performance guarantees, including Catalyst for Payment Reform's Standardized Plan ACO Reporting for Customers (SPARC) tool.[20]

5. **Account management performance including high connectivity to the health plan partner's top leadership.** Top-level service from Selected Respondent(s) account teams, including a broad range of resources within the health plan's organization (e.g. day-to-day Member services, claims resolution escalation, underwriting, data analytics, etc.). SFHSS also expects direct contact with a senior level executive sponsor.

6. **Provider network accessibility and stability to Members that does not compromise SFHSS health plan financial targets.** SFHSS seeks to collaborate with Selected Respondent(s) early and often beginning in early 2021 to mitigate Member and network disruption by expanding network access in key areas.

7. **Timely information on claim experience pressure points and measurement of partner initiatives / programs.** Robust standard reporting packages as well as flexibility in creating *ad hoc* analyses at SFHSS request. This includes both reporting of data as well as identification of issues, proposed resolution and timeline.

8. **Quadruple Aim.** SFHSS expects well-articulated and successfully-demonstrated services, programs and resources to support the Quadruple Aim.[21]

9. **Care delivery and management outcomes.** SFHSS expects Selected Respondent(s) to employ equitable, clinically evidenced, high-touch, creative and innovative care delivery and care management models, leveraging advances in technology and multiple communications modalities, to improve Member health that is both equitable and specifically addresses the diverse Non-Medicare Population. Programs should include aspects that mitigate negative Member SDoH.

10. **Proactive approach to the annual renewal cycle.** SFHSS expects Selected Respondent(s) to be active participants in SFHSS annual renewal activities, including timely delivery of renewal responses, materials and follow-ups to requests, and well-prepared meetings and materials for SFHSS, the Health Service Board, the SFHSS actuary and consultants, and Stakeholders.[22]

11. **Health Service Board meeting attendance, preparation, and participation.** SFHSS expects Selected Respondent(s) to actively participate and leverage fully-prepared Respondent personnel (based on meeting topic) at regularly scheduled Health Service Board and related meetings.

12. **Active support of annual Open Enrollment.** SFHSS expects active and collaborative support of SFHSS annual Open Enrollment needs, including but not limited to, plan material creation/review (Evidence of Coverage, Summary of Benefits Coverage, language for SFHSS created Open Enrollment guides, etc.), support for IT and ESA, and support for the Well-being Division including attendance at health fairs (virtual or in-person, as appropriate).[23]

13. **Support for SFHSS APCD.** SFHSS expects Selected Respondent(s) and health plan partners and their providers to submit timely, complete, accessible and accurate data for the APCD, currently managed by a third-party administrator, IBM (formerly Truven Health Analytics).[24]

14. **Collaborative approach to Member communications.** SFHSS expects Selected Respondent(s) and health plan partners to provide thorough and timely responses to SFHSS and other SFHSS third-

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20 See Section 5.5 and Appendix E-1 – Standard Agreement, Attachment 3 – ACO Standards and Reporting.

21 Institute for Healthcare Improvement, http://www.ihi.org/.

22 See Sec. 5.7.24 – Implementation and Annual Renewal.

23 Id.

24 See Sec. 5.7.22 – Data Requirements.

party administrator and partner inquiries. Selected Respondent(s) are also expected to preview and distribute any Member-facing materials to SFHSS staff for review (with modifications as allowed by state and federal law) and approval, in advance of the distribution of materials to Members.[25]

15. **Social Determinants of Health and Health Equity.** SFHSS and our partners strive to achieve widespread health equity among our entire Member population. Selected Respondent(s) are expected to integrate SDoH indicators into standard reporting and demonstrate a commitment to expansion and/or customization of current and future programs that address recognized SDoH within the SFHSS Member population to advance health equity for all Members.[26]

16. **Targeting health disparities in vulnerable populations.** SFHSS seeks a collaborative and proactive partnership to target health disparities for our most vulnerable populations including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Selected Respondent(s) and health plan partners are expected to integrate quality and disparities metrics into standard reporting and demonstrate a commitment to expansion and/or customization of current and future programs that address recognized disparities within the SFHSS Member population to reduce variations in quality of care for all Members.[27]

17. **Culturally and linguistically appropriate services and clinical care.** SFHSS strives to ensure that our plans and partners approach all health benefit services, and most notably clinical care, in a culturally and linguistically appropriate manner. Selected Respondent(s) are expected to leverage the National Culturally and Linguistically Appropriate Services (CLAS) standards issued by the U.S. Department of Health and Human Services, Office of Minority Health.[28]

18. **Coordinated and integrated care.** SFHSS expects Selected Respondent(s) to provide integrated, member-centric clinical care, across the full health care continuum, to the Non-Medicare Population to provide comprehensive care, reduce errors, and eliminate waste and reduce inefficiencies.

*The remainder of this page intentionally left blank, RFP Schedule on following page*

25 See Sec. 5.7.20 – Communications Services.

26 See Sec. 5.7.11 – Reporting; see also https://minorityhealth.hhs.gov/npa/files/Plans/NSS/CompleteNSS.pdf.

27 See Sec. 5.7.11 – Reporting; see also https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html.

28 See 5.7.11 – Reporting; see also https://thinkculturalhealth.hhs.gov/pdfs/enhancednationalclasstandards.pdf.

# 5.7 SCOPE OF WORK

## 5.7.1 ADMINISTRATIVE SERVICES

### 5.7.1.1 CLAIMS PROCESSING AND ADJUDICATION [NON-NEGOTIABLE]

#### 5.7.1.1.1 DETERMINATION OF PAYABLE BENEFITS

Respondent will determine whether a benefit is payable under the Plans' provisions in accordance with the plan and benefit designs and will use claim procedures and standards that Respondent develops for benefit claim determination. With respect to these functions, SFHSS delegates to Respondent the discretionary authority to (a) make factual determinations relating to any benefit decision; and (b) determine the validity of charges submitted to Respondent under the Plans. Benefits shall be payable to a Member or to the provider of a Member only if Respondent, at its discretion, determines that such benefits are payable.

#### 5.7.1.1.2 PAYMENT, NON-PAYMENT AND NOTICE TO CLAIMANT

If Respondent determines that a benefit is payable, Respondent will issue a check, electronic remittance, or otherwise credit, the benefit payment to the appropriate payee. If Respondent determines that all or a part of the benefit is not payable under the Plans, Respondent will notify the claimant of the denial and of the claimant's right to appeal the denial. This notification will be designed to comply with the Department of Labor (DoL) requirements, California Department of Managed Health Care or California Department of Insurance rules as applicable to the Plan for claim denial notices and with applicable SFHSS administrative rules. Evidence of Benefit (EOB) and Evidence of Payment or Remittance Advices will be issued to Members and providers, respectively in accordance to timely issuance requirements and compliant formats.

## 5.7.2 COORDINATION OF BENEFITS (COB) [NON-NEGOTIABLE]

Respondent will ensure that if a Member is covered by more than one insurance plan, the benefits available under the Plans will be coordinated with the benefits payable under the other plan, in accordance with the provisions of Member Materials and industry standards.

## 5.7.3 CLAIMS RECOVERY SERVICES [NON-NEGOTIABLE]

Respondent will provide recovery services for claims overpayments. Respondent will reimburse SFHSS for any overpayments made by Respondent due to processing errors, payment received from Third Party Liability, Other Payer, or Respondent's gross negligence as determined by a court or other tribunal. SFHSS will not be responsible for recovery costs associated with any administrative activities in collecting overpayments.

Respondent will provide, directly or through a subcontractor, services to recover Plan benefits that were paid and are recoverable by a Plan because payment was or should have been made by a third party for the same medical or prescription expense. This is commonly referred to as "Third Party Liability Recovery" or "Subrogation." Some examples of third parties who are legally responsible for the payment of a health claim include tortfeasors, individuals involved in an accident, liability insurance carriers, automobile insurance carriers, premises medical insurance or worker's compensation carriers.

SFHSS delegates to Respondent the discretion and authority to develop and use standards and procedures for claim recoveries, including but not limited to:

- Whether or not to seek recovery;

- What steps to take if recovery is pursued; and
- Under what circumstances to compromise a claim or settle for less than the full amount of the claim.

If Respondent uses a subcontractor to pursue TPL or other Subrogation recoveries such as legal services or other contracts, SFHSS shall have the right to approve the continued use of such subcontractor.

Respondent will not pursue any recovery if any applicable law does not permit it, or if recovery would be impractical. Respondent may choose to initiate litigation in Respondent's name to recover payments, but Respondent has no obligation to pursue litigation. If Respondent initiates litigation, SFHSS will cooperate with Respondent in the litigation.

If the agreement with Respondent terminates, or if Respondent's recovery services terminate, Respondent will continue to recover any payments Respondent is in the process of recovering.

### 5.7.4 RESOLUTION OF CLAIMS DISPUTES AND APPEALS [NON-NEGOTIABLE]

Respondent must provide the following claims dispute and appeals Works:

#### 5.7.4.1 INFORMAL RESOLUTION OF CLAIM DISPUTES

If a Member believes that Respondent has issued a claim denial that is inconsistent with the terms of the Member Materials, they may contact Respondent customer service staff to seek an informal resolution of the dispute. If Respondent determines that a claim denial was issued in error, Respondent will reprocess the claim to correct the error.

#### 5.7.4.2 CLAIM APPEALS

If Respondent denies a claim under a Plan, the Member shall have the internal appeal rights set forth in the Member Materials in addition to any rights which are required under the Member Rules, or under other applicable law. Internal claim appeals shall be handled as described below.

SFHSS delegates to Respondent the discretionary authority to construe and interpret the terms of the Plans to make factual determinations relating to any benefit decision. For claim denials that Respondent issues, Respondent will notify the Member of Respondent's determination and of their right to appeal the denial to Respondent. Respondent's notice to the claimant will describe the internal appeal rights set forth in the Member Materials and will be designed to comply with the applicable DoL requirements.

#### 5.7.4.3 EXTERNAL REVIEW OF CLAIM APPEALS

As Respondent shall set forth in the Member Materials, Members shall have access to external review of claim appeals. Benefit Claim denials that are issued at the final level of internal review may be eligible for external review as set forth in the Member Materials and Respondent shall prepare and submit such cases to the external review organization. Also, Benefit Claim appeals can be escalated to SFHSS when the Member believes it is a covered benefit of their benefit plan.[38]

### 5.7.5 DISABLED DEPENDENT CERTIFICATIONS [NON-NEGOTIABLE]

Respondent must be able to process Disabled Dependent Certifications, Recertifications (annually or as requested by SFHSS), and meet notification and processing requirements established by SFHSS. While the authority for determining eligibility for these certifications is

[38] See Member Rules.

exclusively with SFHSS, Respondent is expected to perform the clinical components of the certifications.

### 5.7.6 PROVIDER NETWORK SERVICES [NEGOTIABLE]

#### 5.7.6.1 PROVIDER NETWORK

Respondent will make available to Members a network of providers (network or networks) to deliver the health services covered by the Plan. Respondent will comply with California SB 137 (2015) to provide Members with internet access to directories of network providers and with periodic updates or telephonic access to the information in the directories. Respondent shall make a hard copy of the directory available to a Member upon request.

#### 5.7.6.2 NOTICE OF NETWORK CHANGES

The composition of the Respondent's network(s) may change at any time. Respondent will give SFHSS notice of material changes in advance, or as soon as reasonably possible, along with a plan to ensure appropriate Member access to services and transfer of care occurs timely and seamlessly.

#### 5.7.6.3 ACCESSIBILITY

Respondent shall ensure that the network(s) available to Members satisfies State of California Timely Access standards[39] for appointments with providers and complies with access to interpretive services for Members with Limited English proficiency.

#### 5.7.6.4 SUSTAINABILITY

Respondent will ensure contracted physicians, providers and facilities render quality care at sustainable payment levels. Unsustainable reimbursement rates would be determined by Respondent within reasonable ranges, for example those that are higher than regional reimbursement for the same services without any demonstration of improved health outcomes or rational for higher rate reimbursement. Providers that do not meet this standard will be reimbursed at the out-of-network rate. Respondents are strongly encouraged to require pay for performance reimbursement methods in provider contract s to improve health outcomes.

#### 5.7.6.5 REGULAR REVIEW

Respondent will review all contracted fees of its network(s) on a regular basis.

#### 5.7.6.6 NOTICE OF FEE ADJUSTMENTS AND COST REPORTING

Respondent will inform SFHSS and appropriate finance and operations staff when adjustments are made to the fees, no less frequently than annually or more frequently if changes occur in the network(s) impacting fees. Furthermore, Respondent will produce *ad hoc* reports when reasonably requested by SFHSS that relate to current and future costs associated with Respondent's network(s).

### 5.7.7 CERTIFICATES OF CREDITABLE COVERAGE [NEGOTIABLE]

Respondent shall comply with the Medicare Modernization Act (MMA) which requires entities providing prescription drug coverage to notify Medicare-eligible policyholders whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. For these entities, there are two disclosure requirements:

- The first disclosure requirement is to provide a written disclosure notice to all Medicare

39 https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx.

eligible individuals annually who are covered under its prescription drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare eligible individual when he/she joins the plan. This disclosure must be provided to Medicare eligible active working individuals and their Dependents, Medicare eligible COBRA individuals and their Dependents, Medicare eligible disabled individuals covered under your prescription drug plan and any retirees and their Dependents.

- The second disclosure requirement is for entities to complete the Online Disclosure to CMS Form to report the creditable coverage status of their prescription drug plan. The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status.

## 5.7.8 CUSTOMER SERVICE [NEGOTIABLE]

### 5.7.8.1 CUSTOMER SERVICE LINE

Respondent shall provide a dedicated toll-free telephone line for Members, as well as a TTY line and other measures that meet the requirements of the Americans with Disabilities Act, at no additional cost. Member Representatives will transfer non-English speaking Members to a Member Representative who speaks the Member's language fluently or to a Language Interpretive Services Vendor.

### 5.7.8.2 SERVICE LINE MINIMUM STANDARDS

Respondent's Member Service Representatives shall at minimum maintain prevailing industry standards for call centers servicing similar populations. The lines shall be available on regular business days between the hours of 7:30 a.m. and 5:30 p.m. Pacific Time, Monday through Friday (except for nationally recognized holidays). SFHSS will be notified at least five (5) business days in advance of special events affecting customer service phone coverage. Respondent shall ensure that its Customer Service lines are staffed by trained member service representatives who are knowledgeable about SFHSS's benefit plans and can provide Member education about Respondent's SFHSS plans.

### 5.7.8.3 CUSTOMER SERVICE RECORDS

Respondent shall maintain a recording or written record of all customer service telephone conversations for use by SFHSS in the event of Member disputes. Recordings will be maintained for 12 months, or if a dispute is in process, until the dispute is resolved whichever is greater.

### 5.7.8.4 WEBSITE

Respondent shall provide Members access to Respondent's website 24 hours per day, seven days per week, 365 days per year providing a secure environment for customer service including, but not limited to: the ability to search for physicians and other health care providers and facilities, medical offices and hospital locations; research cost of procedures by location or provider; and health and well-being information. Website uptime guarantees or SLA at or above 99.999%.

### 5.7.8.5 SECURE MEMBER PORTAL

Respondent will provide Members with access to information specific to their covered benefits and will allow Members to securely access their claims, covered services, and historical and year-to-date benefits. Through the secure portal, Members will be able to securely request new Member ID cards, make new or change a PCP assignment, and file or managed grievances and appeals. In addition, Respondent shall develop or obtain a tool, accessible through the Respondent's website that allows Members to compare provider cost for common services as well as compare network provider quality performance.

Information shall be available for services representing at least 50% of SFHSS spend.

#### 5.7.8.6 MEDICAL ADVICE LINE

Respondent shall provide toll-free access to a medical advice line for non-emergency medical advice that is staffed by qualified medical practitioners. This service will operate 24 hours per day, seven days per week, 365 days per year. The service will have a local access number and a toll-free number (interpreter service available), and a TTY line. All calls will be recorded.

### 5.7.9 MARKETING [NON-NEGOTIABLE]

Respondent agrees to limit their marketing to the following permitted activities:

- Distribution of marketing materials with general information on the specific carrier or benefit plans not specific to SFHSS programs or benefit plans;
- Distribution of marketing materials with information on SFHSS programs or benefit plans that have been approved by SFHSS;
- Participation in conferences and events hosted by outside organizations that represent a segment of SFHSS Members;
- SFHSS selection and republishing of any original content or Member marketing materials on SFHSS owned channels such as website, social media, email, etc.

All media or legislative inquiries and the proposed responses regarding SFHSS programs or benefit plans must be forwarded to the SFHSS Executive Director and must be authorized in writing by SFHSS prior to any response.

### 5.7.10 MEMBER COMMUNICATIONS [NON-NEGOTIABLE]

Respondent shall create the Evidence of Coverage/Summary of Plan Description, Summary of Benefits, Summary of Benefits and Coverage, Member Materials and any other publications for use in the administration of SFHSS health insurance benefits (collectively, "Member Materials". All will be subject to SFHSS approval, which must be received in writing, before being posted electronically or distributed to SFHSS Members,

Respondent shall provide the following services in a timely fashion, not to exceed the timelines established under Communications Services (Sec. 5.7.20) and Implementation and Annual Renewal (Sec. 5.7.24) and the Member Rules (Sec. 4):

- Respondent will issue an Identification (ID) Card to each enrolled individual or family within five (5) business days of receiving the Membership enrollment download and provide ID card replacement or additional ID cards as requested.
- Respondent will issue information within five (5) business days of receiving the Membership enrollment download regarding how to access the Member Materials, provider directory and other SFHSS-related information electronically.
- Respondent will issue replacements for lost cards at no charge to the Member or SFHSS.
- Respondent will reissue identification cards to all Members when directed by SFHSS

### 5.7.11 REPORTING [NEGOTIABLE]

The reports required in Section 5.7.22 (Data Requirements) and Reporting[40] represent the minimum reporting requirements under an agreement resulting from this RFP and will be

40 See Sections 5.7.11 and 5.7.23; see also Sections 1.5.2.15, 2.1.5, 2.1.11, 2.1.13, 5.5. (Appendix E-1, Attachment 3), 5.6, 5.7.2.1.16, 5.7.2.2.7, 5.7.66, 5.7.15, 5.7.16.41, 5.7.21.16, 5.7.22.7, 5.7.22.11.

provided at no cost to SFHSS or Members. Respondent will notify SFHSS when reports have been submitted to SFHSS. Reporting needs are subject to change to meet the needs of Members, the Health Service Board, SFHSS, and Participating Employers.

### 5.7.12 RECORD-KEEPING [NON-NEGOTIABLE]

Respondent will keep records relating to services Respondent provides to Members as described in Reporting as well as Data Requirements.

### 5.7.13 INFORMATION ACCESS [NEGOTIABLE]

#### 5.7.13.1 SFHSS ACCESS

Respondent will provide SFHSS access to any information, in Respondent's possession, required by SFHSS to administer the Plans, at no cost, so long as the requested information relates to Respondent's services under its agreement with SFHSS and SFHSS gives Respondent reasonable prior notice of the need for the information.

#### 5.7.13.2 THIRD-PARTY ACCESS

Respondent will also provide reasonable access to Plan information to any third-party(ies) providing services to SFHSS, such as an auditor or other consultant, upon SFHSS's request. Before Respondent will provide such access, however, a third party must sign any of Respondent's applicable information disclosure agreements provided each is reasonable and necessary to protect and safeguard the information provided.

### 5.7.14 AUDITS [NON-NEGOTIABLE]

During the term of any agreement between Respondent and SFHSS as a result of this RFP, and for any run-out period following termination of the agreement, SFHSS (itself, or through a third-party consultant) may, at no cost to SFHSS, audit Respondent to assess its performance under the terms of the agreement. The place, time, type, duration and frequency of all audits must be reasonable. Upon completion of the audit, SFHSS will provide Respondent with a copy of the final audit report.

### 5.7.15 DATA TRANSFER [NON-NEGOTIABLE]

Respondent agrees to complete business associate agreements prior to data being delivered.

Data will include at minimum the following [see Data Requirements (Sec. 5.7.22) and Implementation and Annual Renewal (Sec. 5.7.24) for more detail]:

- All data related to eligibility, claims, or services received by SFHSS Members as specified by SFHSS and is available electronically, and other data specified by SFHSS (e.g., data warehousing, APCD);
- Extract data as mutually agreed upon to other program vendors and researchers;
- Standard financial management reporting and analysis;
- Scheduled reports by plan administrator;
- Key financial, utilization and quality of care benchmarks appropriate to SFHSS, benchmark SFHSS to similar groups or commercial Book of Business;
- Respondent's performance as to each requested guarantees, minimum requirement or service level; and
- Reports specific to SFHSS's population with comparative data from Respondent's commercial Book of Business.

### 5.7.16 HEALTH MANAGEMENT AND COORDINATION SERVICES (NEGOTIABLE)

Respondents will demonstrate a commitment to SFHSS Members whole person health in the areas of:

- Improved Quality of care and lower costs
- Enhanced delivery system integration Health Information Technology
- Care coordination
- Support of primary care physician practice models
- Attention to special populations and workplace wellness
- Attention to whole person care,
- Closing gaps in health care related to racial inequities and negative SDoH.

#### 5.7.16.1 IMPROVED QUALITY OF CARE AND LOWER COSTS

Respondent ensures that network arrangements include quality, which may include clinical quality, patient safety and patient experience, and cost in all provider and facility selection criteria when designing and composing networks.

##### 5.7.16.1.1 PRICE AND QUALITY VARIATION

Respondent(s) will measure price and quality variation within its network and establish methods to share price and quality information with Members in a usable format. Respondent(s) will actively engage Members to utilize price and quality tools; reporting annually on utilization and proposing detailed solutions and timelines for increase Member use.

Respondent(s) will disclose, upon request, the following:

(a) The factors it considers in assessing the relative unit prices and total costs of care;

(b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

(c) How such factors are used in the selection of providers or facilities in networks available to Members; and

(d) The identification of specific hospitals and their distribution by cost deciles or describe other ways providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Respondent that are expended in each cost decile. Respondent understands that it is the desire and intention of SFHSS to expand this identification process to include other providers and facilities in future years.

##### 5.7.16.1.2 ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Respondent must provide SFHSS with details on its existing or planned integrated systems of care, including the number and percent of Members who are managed under ACOs on an annual basis.

Respondent agrees to set targets annually for the percentage of Members who select or are attributed to ACOs based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

### 5.7.16.2 ENHANCED DELIVERY SYSTEM INTEGRATION HEALTH INFORMATION TECHNOLOGY

#### 5.7.16.2.1 CENTERS OF EXCELLENCE

Respondent will report how Members with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Respondent uses Centers of Excellence more broadly, it will report as requested, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

#### 5.7.16.2.2 SITE OF CARE

Respondent will support PCPs and other network providers in offering virtual care to Members including appropriate provider reimbursement and Member communication and engagement activities. Respondent will report utilization metrics.

Respondent will report on Member utilization of retail clinics.

Respondent will support Member use of birth centers (acute care facility or standalone) that are in-network and provide the necessary medical and ancillary services, as well as Member communications and engagement activities, that accompany the delivery of a newborn.

Respondent will support alternative sites of care for injectable medications, driving Members to high-quality, low-cost services including but not limited to, the Member's home.

Respondent will monitor and evaluate Member access to MAT (Medication-Assisted Treatment) services on an ongoing basis. Respondent will provide telehealth support for MAT as an alternative to ensure needed access.

#### 5.7.16.2.3 BUNDLED PAYMENT / EPISODES OF CARE

Respondent will support a network of providers that utilize Bundled payment, sometimes referred to as "episode-based payment," to lower costs and improve quality of care. Bundling payments into a single payment amount for all the services needed by a patient, across multiple providers and possibly multiple care settings, for a treatment or condition are typically used for joint replacement surgeries, bariatric surgeries and maternity care.

#### 5.7.16.2.4 DATA INTEROPERABILITY

Respondent will support providers in development and growth of systems that promote data interoperability. Respondent will report on activities annually including the initiatives the Respondent has undertaken to improve routine exchange of timely information with providers to support their delivery of high quality care. Respondents will also ensure the following:

(a) Notification of PCPs when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the knowledge of either the primary care or specialty providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings.

(c) Racial and ethnic self-reported identity collected at every patient contact.

### 5.7.16.3 CARE COORDINATION

#### 5.7.16.3.1 OVERALL CARE COORDINATION AND HEALTH MANAGEMENT

Care coordination and management services are a significant role in managing population health. Below is a partial list of elements of a comprehensive care coordination and management program. Respondents shall describe how the care coordination and management services with the plans, providers, and facilities interact and contribute to the overall management of the SFHSS Member population health. Respondents will describe how these processes and outcomes are measured.

Care Coordination services will ensure Members receive the right care at the right time; are engaged and understand the care plan; and receive ongoing support from their care team. Services will include the full range of health statuses, for Members with or complex and seriously ill, at risk for and chronic disease conditions who require significant care coordination and ongoing support.

Care Management services will address Members with one or more chronic or complex medical conditions (including, but not limited to diabetes, chronic obstructive pulmonary disease, congestive heart failure and hypertension) and are at high risk of future inpatient and ED use, and for whom care management services are assessed as likely to have an impact on health status and future service utilization.

#### 5.7.16.3.2 ENGAGEMENT STRATEGIES

Care coordination and management engagement strategies will include, at minimum, the following:

- Culturally competent Motivational interviewing;
- Teaching Member self-management skills;
- Multiple attempts using different methods to engage Members;
- Cross-training to support multi-condition management; and,
- Identification of and coordination with community supports.

Respondent's engagement strategies for care coordination and management programs will normally include telephonic outreach as well as mailed materials. When making initial contact with potential participants, Respondent will provide comprehensive educational materials even if the Member does not enroll in the program at the first contact. Respondent will continually monitor systems and re-contact Members following events such as hospitalization. Respondent will ensure that these strategies coordinate with and do not duplicate those services provided directly by a Member's PCP.

To encourage participation and provide access for Members who work during normal business hours, Respondent's care coordination and management program staff, including practitioners, will be available to work with Members, at minimum, in the evening from 5:00 pm to 7:00 pm Pacific Time.

#### 5.7.16.3.3 CARE MANAGEMENT STAFF

Respondent care coordination and management staff shall include nurses, social workers and any other licensed and certified staff deemed appropriate for care management activities. Staff shall be trained to support patients with multiple conditions, and skilled in-patient engagement techniques and in patient-centered care planning.

#### 5.7.16.3.4 SHARED DECISION-SUPPORT

Respondent will support providers and Members in establishing a shared decision-making

approach, particularly for preference sensitive care.

Respondent will consider the indications and conditions listed below to determine Member eligibility for care coordination and management services. Respondent will work with Members to actively engage in care coordination and management services with the goal of improving or stabilizing the Member's health, and in securing appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Member's condition across the continuum of care.

**5.7.16.3.5 COMPLEX AND SERIOUSLY ILL CASE MANAGEMENT**

Indicators include, but are not limited to, the following for cases involving one or more of the following:

- Transplants;
- Rare diseases;
- End stage renal disease;
- Severe brain injury;
- Severe burns;
- Cerebral vascular accident with deficits;
- High-risk obstetrics;
- Multiple trauma and spinal cord injuries;
- High-risk mothers, infants and children;
- Ventilator dependent patients;
- Complex hospital course, length of stay, or unplanned hospital admissions;
- High-cost case reviews;
- Multiple emergency department visits; and/or
- Excessive dispensing of Schedule II drugs.

**5.7.16.3.6 AT RISK AND CHRONIC DISEASE**

Respondent's population-based care management programs identify Members with chronic disease and, through the use of disease specific interventions, attempt to alter the course of the disease. Respondent qualified medical practitioners will assess Members' health status including social determinants of health, develop a plan of care, provide interventions specific to the disease process, and collect data to evaluate the effectiveness of the program. Respondent's standardized treatment strategies will ensure appropriate utilization and evidenced-based care across the continuum.

- Asthma and COPD
- Diabetes
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Heart Failure
- Congestive Heart Failure
- Depression
- Chronic Pain
- Kidney (Renal Disease)
- Cancer
- HIV
- Musculoskeletal
- Opioid use (pain management)

- Obesity management
- Social Determinants of Health

#### 5.7.16.3.7 INPATIENT CARE MANAGEMENT, POST-ACUTE CARE AND HOME CARE

Respondent's care coordination and management programs will focus on the Member's whole-person well-being and will address (see Transitions of Care and Concurrent claims review below.)

- Inpatient Utilization
- Discharge Planning
- SNF Care Coordination
- Outpatient Services
- In person office and telehealth Physician care and follow-up
- Home care
- Palliative care (both in hospital and out of hospital)
- Community Supports (transportation, meals, other)

#### 5.7.16.3.8 TRANSITION OF CARE

Respondent will have qualified medical practitioners coordinate discharge planning services with physicians, hospitals and other health care providers (such as community health workers and non-traditional health care workers) to complete an episode of care. Services typically used in discharge planning will include skilled nursing facilities, home health care agencies and hospice. Cases that require post-discharge follow-up will be referred to care management and other community resources as appropriate.

#### 5.7.16.3.9 INTEGRATED CARE AND EDUCATION

Care coordination and management services shall fully integrate medical, pharmacy, behavioral, acute care and patient education into a seamless experience, ensuring Members receive the right care at the right time, are engaged and understand their care plan and receive ongoing support from their care team. These services will address the needs of Members with complex acute care needs, at high risk of future inpatient utilization, at significant risk for declining health status and high medical expenses, as well as Members with acute and chronic care needs requiring significant care coordination and ongoing support, in order to prevent avoidable future inpatient and ED utilization.

Respondent's care coordination and management services will coordinate with the Member's PCP such that the Respondent supports the PCP providing care management, and the Respondent avoids the provision of duplicative care management services.

Respondent shall develop protocols for coordinating services with ACOs and communicate them to ACOs, allowing flexibility on a case-by-case basis as dictated by the needs and preferences of Members eligible for and receiving such services. For delegated models, the Respondent shall coordinate reporting and any audit activities requested. Additionally, the detailed terms and conditions as well as any pay for performance metrics and payments of the arrangement with the ACOs will be disclosed.

### 5.7.16.4 QUALITY

#### 5.7.16.4.1 QUALITY REPORTING

Annual reporting on how Respondent includes and develops quality in the network design and ensures metrics are meaningful. Quality outcomes metrics will be focused around the IHA AMP data set as well as other quality certification organizations (e.g., Healthcare Association: Align, Measure, Perform (IHA AMP), the National Committee for Quality

Assurance (NCQA), the Healthcare Effectively Data Information Set (HEDIS), the National Quality Forum (NQF) and Centers for Medicare and Medicaid Services (CMS) as well as other appropriate sources).

#### 5.7.16.4.2 CLINICAL CLAIMS AUDITS

Respondent will review claims that exceed a dollar threshold, as mutually agreed upon by Respondent and SFHSS, in billed charges for clinical appropriateness and potential excessive billing. Respondent will also review injectable and biotechnology medical drug and pharmacy claims for clinical appropriateness using pharmacy technician reviewers. Analysis may include provider billings, clinical information, provider contracts, coding conventions and payment rules. The qualified medical practitioner reviews the Diagnosis Related Group (DRG), case rate, coding, code modifiers and identifies issues related to Respondent interpretation, unbundling, duplicate billings, billing errors, and billing maximization. Negotiated payment and appropriate transfer of patient care is expected with out-of-state providers and facilities. These reviews should be conducted prior to actual claim payment, lowering the amount paid.

#### 5.7.16.4.3 HACS AND NEVER EVENTS

Neither Respondent, nor SFHSS, nor Members will pay for "hospital-acquired conditions" (HACs) or Never Events as identified by Medicare guidelines. Respondent also agrees to add language to its provider, ambulatory surgical center, facility and hospital contract that:

- Prohibits the hospital from charging Respondent or an SFHSS Member for HACs identified by Medicare guidelines;
- Requires hospitals to adopt the "Guidelines for Non-Payment of Serious Adverse Events";
- Requires hospitals to participate in the Adverse Events Reporting Program for Hospitals; and,
- Presents Members with options to non-Medically necessary early elective inductions and elective C-sections.

#### 5.7.16.4.4 PRIOR AUTHORIZATION

Prior authorization is required for selected services and facility admissions, consistent with the Plans or Respondents general practice guidelines. As appropriate, Respondent will perform a prior authorization to determine the level of care before an admission occurs or prior to a selected procedure is performed to assess the clinical indications and appropriateness of services requested or planned. Respondent may request a second opinion when clinical indications are not clearly established, or when the indications given for a procedure or treatment do not clearly meet Respondent's approved criteria.

#### 5.7.16.4.5 CONCURRENT REVIEW

Respondent will have qualified medical practitioners review medical and surgical inpatient hospital and skilled nursing facility stays. Qualified medical practitioners will review cases to determine the appropriateness of the setting, level of care and length of stay. The qualified medical practitioner will conduct an initial review and certification of the admission and follow the case concurrently. If the qualified medical practitioner is unable to certify the request or certify a continuation of the hospital stay, the Respondent's medical director will conduct a review of the case to determine medical necessity of the facility admission or transfer, course of treatment and continued stay.

#### 5.7.16.4.6 RE-ADMISSION RATES AND PREVENTABLE EMERGENCY DEPARTMENT VISITS

Respondent shall work towards reducing re-admissions and report on its efforts to decrease re-admission rates and to reduce preventable emergency department visits.

#### 5.7.16.4.7 SMART CARE CALIFORNIA

Respondent will follow guidance from Smart Care California: Sponsored by Covered California, DHCS, and CalPERS and facilitated by the Integrated Healthcare Association (IHA) to provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

### 5.7.16.5 SUPPORT OF PRIMARY CARE PHYSICIAN PRACTICE MODELS

Respondent will promote the Quadruple Aim as a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Respondent agrees to actively promote the development and use of care models that promote access, care coordination, and early identification of at-risk enrollees and consideration of total costs of care. Respondent agrees to design networks and payment models for providers serving Members to reflect these priorities.

Care Models which align with the CMS requirements under the QIS, are as follows:

**1)** Effective primary care services, including ensuring that all Members have a PCP,

**2)** Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

**3)** Accountable Care Organizations (ACOs) are integrated, coordinated, and accountable systems of care including multi-discipline physician practices, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between Respondent and providers.

#### 5.7.16.5.1 PRIMARY CARE

Respondent must ensure that all Members either select or be provisionally assigned to a PCP within sixty (60) days of effectuation into the plan. If a Member does not select a PCP, Respondent must provisionally assign the Member to a PCP, inform the Member of the assignment, and provide the enrollee with an opportunity to select a different PCP. When assigning a PCP, Respondent shall use commercially reasonable efforts to assign a PCP consistent with an Member's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior PCP. Respondent will be required to report on this requirement annually.

#### 5.7.16.5.2 PATIENT-CENTERED MEDICAL HOMES

Respondent must provide the following information on an annual basis:

**1)** NCQA Patient-Centered Medical Home recognition

**2)** The Joint Commission Primary Care Medical Home certification

**3)** Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) Medical Home accreditation

**4)** URAC Patient-Centered Medical Home (PCMH) Certification

**5)** The number and percent of Members who obtain their primary care in a PCMH. Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

**6)** How Respondent's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

**7)** If Respondent participates in primary care improvement collaboratives like the

California Quality Collaborative or the California Improvement Network.

**8)** If or how Respondent supports providers in primary care practice transformation through efforts such as providing practice coaches or investments in information technology.

Respondent agrees to work with SFHSS to provide comparison reporting for its other lines of business to compare performance and inform future SFHSS requirements where comparative data can offer meaningful reference points.

Respondent agrees to work with SFHSS to provide comparison reporting for all lines of business to compare performance and inform future SFHSS requirements where comparative data can offer meaningful reference points. The basis for analysis of variation in performance of different ACO models shall be the Commercial ACO Measure Set as updated by the Integrated Healthcare Association (IHA) and published at: http://www.iha.org/our-work/accountability/commercial-aco.

### 5.7.16.6 ATTENTION TO SPECIAL POPULATIONS AND WORKPLACE WELLNESS

#### 5.7.16.6.1 BEHAVIORAL HEALTH

Respondent will reimburse providers for PHQ9/PHQ2, GAD-7 and AUDIT (Alcohol Use Disorders Identification Test) screening. Respondent will monitor and report use.

Respondent will comply with the Mental Health Parity and Addiction Equity Act and reduce barriers to behavioral health services caused by prior authorization, step therapy and other treatment limits. Respondent will administer a lower member cost-share (e.g., copay, deductible, or coinsurance) for behavioral health services if requested.

Respondent will monitor and report on provider reimbursement for in-network behavioral health providers to ensure appropriate financial incentives are in place to attract and retain quality in-network providers.

Respondent will reimburse providers for providing virtual behavioral health services, as clinically appropriate.

Respondent will ensure timely access to behavioral health specialty areas, including but not limited to, black indigenous people of color, public safety Members, Members seeking support around gender dysphoria, and Members where English is not their first language. Respondent will ensure provider directories are up to date to identify providers certified to address these areas and customer service will provide Member support in identifying appropriate providers and ensuring timely access.

Respondent will engage and integrate with SFHSS' onsite EAP providers as well as any third-party EAP or behavioral health providers that SFHSS engages.

Respondent will integrate behavioral health services within medical services.

#### 5.7.16.6.2 DIABETES

Respondent must offer a CDC-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP), to all Members ages 18 and older who meet the participation criteria. The DPP shall be available to all Members in the geographic service area and covered under the $0 preventive services benefit or

diabetes education benefit in the Patient-Centered Benefit Design Plans. Respondent's DPP must have pending or full recognition by CDC as a DPP and be accessed either online or in person. A list of recognized programs in California can be found at https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

#### 5.7.16.6.3 MATERNITY, FERTILITY AND INFERTILITY

Respondent will implement maternity care episode-based payments or "bundled payments" to pay providers one rate to cover services related to a defined episode of care. The financial incentives should apply to clinicians and hospitals. Respondent will provide full transparency to these contracts including how the Respondent evaluates quality and cost of providers (including the discount) as well as the total cost of pregnancy care under their control. To reduce incentives for unnecessary cesarean births further, the bundled payment amount will be the same regardless of mode of delivery so that providers stand to gain with every vaginal delivery and reduce earnings with each cesarean delivery.

Respondent will collaborate with SFHSS on opportunities to steer pregnant mothers to high-value providers. Steerage may include use of Centers of Excellence and/or alternative sites of care.

Respondent will educate Members on the importance of full-term births, the health consequences of elective inductions and unnecessary cesarean deliveries, and the high-value care available to them. Educational tools may include smart phone apps, maternity-specific advocacy solutions, and telephonic or virtual coaching. Education and coaching will be culturally sensitive and work to address the health equity issues that occur within maternity care.

Respondent will provide full coverage for certified nurse midwives and doulas. Encouraging health plan members to use high-value care options, like continuous labor support (doula care), requires that these services be covered by the benefits package and made easily accessible to maternity care patients.

Respondent will administer SFHSS' custom infertility benefit with the goal to provide non-discriminatory access to care that leads to services that may lead to diagnosis and treatment of infertility. Respondent will support the family planning goals of SFHSS' diverse population in a culturally sensitive manner. Respondent will provide enhanced, high-touch customer care resources for Members seeking family planning support, including but not limited to, identifying high quality providers, education on cost of care variations and identification of alternative, high-quality, low-cost resources.

#### 5.7.16.6.4 GENDER DYSPHORIA

Respondent will administer SFHSS' custom gender dysphoria benefits. Health care includes culturally sensitive care, access to gender specific care, and transition-related care. This includes access to quality primary care that includes preventive care (such as screening for diseases like cancer and diabetes as well as access to gender-specific care such as prostate cancer screening for transgender women and pap smears for transgender men); acute care of injuries and illnesses; and diagnosis and management of chronic diseases.

Respondent will provide enhanced, high-touch customer care resources for Members seeking services related to gender dysphoria, including but not limited to, identifying high quality providers, Centers of Excellence, and education on cost of care variations.

#### 5.7.16.6.5 HIV

Respondent will provide enhanced, high-touch customer care resources for Members newly diagnosed with HIV or maintaining HIV diagnosis, including but not limited to, identifying high quality providers, Centers of Excellence, and education on cost of care variations.

### 5.7.16.7 ATTENTION TO WHOLE PERSON CARE

#### 5.7.16.7.1 PREVENTIVE SERVICES

Respondent shall provide all services to enrolled Members that have received an A or B recommendations from the U.S. Preventive Services Task Force (USPSTF) as identified at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm, which will be automatically updated during the Term of this Contract to reflect changes to USPSTF Recommendations. Respondent shall make its Best Efforts to encourage screenings for obesity according to the USPSTF guidelines. Respondent shall provide the services without Member cost sharing if obtained in-network.

Additionally, Respondent will not pay for D-rated procedures and services as defined by the USPSTF.

Respondent will ensure Members have access to whole person, preventive health and wellness services. For the services described below, Respondent must identify Members who are eligible, notify Members of their availability, and report utilization.

**1)** Necessary preventive services appropriate for each Member. Respondent must report the number and percent of Members who utilize preventive services.

**2)** Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Respondent must report the number and percent of Members who take advantage of the tobacco cessation benefit.

**3)** Obesity management. Respondent must report to SFHSS the number and percent of its Members who take advantage of the obesity benefit. As part of the obesity management program, Respondent will:

- Ensure providers are reimbursed for obesity screenings for members age 6 or older.
- Review and measure current weight loss programs and confirm they address the combination of behavioral, nutritional and physical activity; identify areas for improvement and/or participation growth.
- Measure and consider other obesity interventions such as pharmacotherapy and bariatric surgery, etc.

**4)** To ensure the Members health and wellness process is supported, Respondent must report on the following:

(a) Health and wellness communication processes delivered to its Members and applicable providers, that account for and support cultural and linguistic diversity; and

(b) Processes to incorporate Members' health and wellness information into Respondent's data and information specific to each individual Member. The Member's data is Respondent's most complete information on each Member and is distinct from the Member's medical record maintained by the provider.

### 5.7.16.8 CLOSING GAPS IN HEALTH CARE RELATED TO RACIAL INEQUITIES AND SOCIAL DETERMINANTS OF HEALTH

In alignment with SFHSS strategic plan, Respondents will recognize that promoting better

health requires a focus on addressing health disparities and health equity. Respondent will incorporate health equity goals within their own organization as well as within third-party contracts and contracted providers.

Respondents will track, trend and reduce health disparities through a variety of methods, some of which are outlined below.

Respondent must track and trend quality measures by racial or ethnic group, or both, and by gender for the SFHSS population. Respondent must achieve eighty percent (80%) self-identification of racial or ethnic identity for Members. To the extent the Respondent does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to ill any gaps in information.

Disparities in care by racial and ethnic identity and by gender will be reported annually. The Respondent agrees to work with SFHSS to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points. Special areas of focus for the initial contract year include Diabetes, Hypertension, Asthma (control plus hospital admission rates), and Depression (HEDIS appropriate use of medications). SFHSS will consider adding additional measures in the future.

Respondent will include the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) standards.

Respondent agrees that future analysis of disparities may include: income, disability status, sexual orientation, gender identity, and Limited English Proficiency (LEP).

### 5.7.17 PHARMACY BENEFIT MANAGEMENT SERVICES (NEGOTIABLE)

Pharmacy Benefit Management Services will include pharmacy claims adjudication including Point of Service (POS) processing, pharmacy network management, drug formulary management, prior authorizations, refill exceptions and pharmacy discounts and rebates.

#### 5.7.17.1 PHARMACY ADMINISTRATION

Pharmacy benefits and coverage solutions shall be comprehensive, innovative and transparent, including:

- Coordination and integration of Pharmacy benefits and program services with other vendors, if applicable
- Pharmacy Network Management with associated pharmacy audit program (waste and abuse)
- Specialty Drug Management Program, inclusive of trend mitigation and focus on increased education and utilization of approved biosimilar agents, over innovators
- Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
- Coverage of outpatient vaccinations and vaccine administration

#### 5.7.17.2 NETWORK PHARMACIES

Respondent will provide pharmacy benefit management services and will determine which pharmacies will be Network Pharmacies for retail, specialty and mail-order pharmacies while ensuring no significant disruption occurs due to contracting issues throughout the year.

#### 5.7.17.3 MAIL-ORDER PHARMACY

Respondent will provide a mail order pharmacy program for Members, including website

access and the necessary forms and procedures to obtain mail order prescriptions. This will include 100% pass-through of lowest and current contracted rates, with zero spread-pricing.

#### 5.7.17.4 CLAIM PROCESSING

Respondent will electronically process the claims of Network Pharmacies in accordance with the Member Materials.

#### 5.7.17.5 DRUG FORMULARY

Respondent will furnish a drug formulary for the purpose of copayment and coverage determination that aligns with the plan's pharmacy tiers and ensures whenever possible that each tier contains medications within a therapeutic class. Formulary changes that increase the Member copay for a drug will not occur more than semi-annually. All changes will be communicated to SFHSS and Members at least 90 days in advance.

#### 5.7.17.6 PRIOR AUTHORIZATION

Respondent will have a Prior Authorization process that includes refills for lost or stolen prescription, or beyond a 30-day supply in the event the Member will not have access to Network Pharmacy for an extended period of time, and allows coverage of certain medications in the event documented evidence is submitted that the Member has tried other alternatives that have not been effective in treating the condition. Any costs related to prior authorization services must be included in proposed pharmacy rates.

#### 5.7.17.7 PHARMACY REBATE

Under the pharmacy rebate program Respondent will negotiate, directly or indirectly, with drug manufacturers regarding the terms of the rebate program and arrange for the payment of rebates on certain prescription drug services utilized by Members that will be directly passed through to SFHSS and include a minimum rebate guarantee. The Respondent will pass 100% of all rebates and any other credits or refunded amounts to SFHSS. Respondent shall agree to provide supporting documentation of manufacturing rebates upon request by the City and/or subcontractor used to review pharmacy rebates.

Respondents are advised that Rebates are defined as any fees paid by intermediaries to promote one drug over another, including but not limited to drug or prescription drug rebates, stocking fees.

#### 5.7.17.8 SMART CARE CALIFORNIA (OPIOID USE INITIATIVE)

Respondent shall actively participate in the statewide effort through Smart Care California to promote the appropriate use of opioids and lower opioid overdose deaths.[1] To the extent possible, Respondent will also continue to implement policies and programs that align with the following Smart Care California priority areas:

**1)** Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations;

**2)** Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers;

**3)** Treat: streamline access to evidence-based treatment for substance use disorder at all points in the health care system; and

**4)** Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

[1] https://www.iha.org/our-work/insights/smart-care-california/focus-area-opioids.

#### 5.7.17.9 SFHSS AUDIT RIGHTS

SFHSS retains audit rights of the prime vendor and its subcontractor(s) and full transparency in reporting at no cost to SFHSS.

### 5.7.18 BEHAVIORAL HEALTH AND ADDICTION SERVICES [NON-NEGOTIABLE]

Respondent will provide behavioral health and addiction services including access to appropriate providers, services and treatments and coordination with the SFHSS internal and external employee assistance programs (EAPs) to ensure continuity of care. Respondent shall provide fully integrated administrative and utilization management services for behavioral health and addiction services coverage consistent with the Plans. To the greatest extent possible, Respondent shall encourage co-location of physical and behavioral health care professionals in community settings or within the ACOs. Integrated care delivery shall include use of an integrated medical record and shared treatment plan. Members shall have access to the full continuum of behavioral health and addiction services integrated through the application of evidence-based practice, with a focus on health promotion and prevention, early intervention, and community supports to help improve the health and well-being of Members.

### 5.7.19 HEALTHCARE REFORM AND TRANSFORMATION SUPPORT SERVICES (NEGOTIABLE)

Respondent will provide Healthcare Reform and Transformation Support Services including Member access to ACOs; development of, and ongoing support, to increase use of electronic health records and health information exchange; implementation and ongoing support of patient safety measures; implementation and ongoing support of alternative payment methodologies and other payment reform measures; effective Member engagement; and development and ongoing support of partnerships, coordinated efforts, and innovations that support SFHSS's health care transformation efforts.

#### 5.7.19.1 ADVANCED PRIMARY CARE FIRST MODEL

Respondent will support the Advanced Primary Care First model as outlined by CMS.

#### 5.7.19.2 ELECTRONIC MEDICAL RECORDS (EMRS)

Respondent will increase utilization of robust and interactive electronic medical records systems as reflected in CMS' meaningful use objectives, which include, but are not limited to, the electronic exchange of health information between providers. Respondent also agrees to actively participate in efforts to develop and facilitate the health information exchange between providers and EMR systems and health plans.

#### 5.7.19.3 PAYMENT REFORM

Respondent will develop and implement payment models that may include (but are not limited to) pay-for- performance, global budgets with shared savings or shared risk, episode-based payment, capitation and other reimbursement methods that support innovative models and system transformation such as the Accountable Care Organization model. All innovative payment models shall either make savings distributions contingent on quality performance or include a quality incentive opportunity.

#### 5.7.19.4 MEMBER ENGAGEMENT

Respondent shall provide required services in a manner that meaningfully and actively engages Members in a culturally and linguistically appropriate manner. Respondent shall support network provider efforts at patient activation through training, provision of standardized assessment tools, and requirements for network provider deployment of different activation strategies based on assessment results. Respondent shall make tools to support shared- decision making available to network providers and to Members. Such

tools shall advise Members of the potential benefits and risks associated with different treatment options.

#### 5.7.19.5 COORDINATION WITH OTHER SERVICE PROVIDERS

Respondent shall, when appropriate for Member care, coordinate care with other services providers such as, but not limited to, dental providers or carriers, vision providers or carriers and employee assistance program (EAP), disability, and long-term care benefit or service providers.

#### 5.7.19.6 PRICE AND QUALITY TRANSPARENCY

Respondent will provide innovative cost and quality information tools for Members to guide Members in understanding their own out-of-pocket costs for services, and in comparing the quality and safety of providers. They may include decision-support tools to help Members understand the availability, cost, and quality.

#### 5.7.19.7 PROMOTION OF EVIDENCE-BASED PRACTICES AND MEASUREMENT OF CLINICAL OUTCOMES AND QUALITY OF CARE

Respondent will implement the Integrated Healthcare Association: Align, Measure, Perform (IHA AMP) performance measures in managing quality of care for all segments of SFHSS's populations. This includes quarterly reporting on the IHA AMP metrics.

#### 5.7.19.8 INNOVATIONS IN CARE COORDINATION AND PROVIDER PAYMENT

Respondent will provide specialized chronic care models and incentives or provider payment arrangements that foster improved patient outcomes and improved delivery of care. These innovations also include provider information systems that promote the rapid exchange of patient health care information among multiple providers, support administrative efficiencies and streamline use of network resources. It also includes incentive systems to improve clinical outcomes for chronically ill and other vulnerable or high-risk populations that support prevention and self-management of conditions.

#### 5.7.19.9 PAYMENT REFORM

Respondent shall reimburse hospitals for services using Medicare Severity DRGs for inpatient services and Ambulatory Payment Classification (APC) for outpatient services; except that Respondent may substitute alternative payment methods such as population-based budgets with shared savings or shared risk, episode-based payment capitation, or other alternative payment methods, but shall not reimburse hospitals based on percentage of billed charges.

Respondent will maintain or seek to implement innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. Respondent will develop and implement payment models that may include (but are not limited to) population-based budgets with shared savings or shared risk, episode-based payment, capitation and other reimbursement methods.

#### 5.7.19.10 LEVERAGE EMRS, HEALTH INFORMATION EXCHANGE

Respondent acknowledges the importance of utilizing robust and interactive electronic medical record systems as reflected in the Federal Meaningful Use (MU) objectives, including the electronic exchange of health information between providers. Respondent shall make its Best Efforts, when entering into or renewing its provider contracts, to request its providers to adopt and demonstrate the use of certified EMRs. Respondent shall participate in local and statewide efforts to facilitate the health information exchange between providers and EMR systems.

### 5.7.20 ACCOUNT MANAGEMENT [NON-NEGOTIABLE]

Respondent will adhere to the following expectations and levels of effort:

#### 5.7.20.1 BENEFIT AND PROGRAM COLLABORATION

Respondent will attend and participate in Board of Supervisors, Health Service Board and SFHSS requested meetings. Respondent shall work with SFHSS and other meeting attendees to review and evaluate SFHSS benefits and programs to collaborate on establishing criteria and benchmark reporting and monitoring. Respondent acknowledges that collaboration efforts may result in program and reporting changes over time and that such changes will be addressed in future contract amendments or letters of understanding.

#### 5.7.20.2 QUALITY ACTIVITIES PARTICIPATION

Respondent will actively participate Board of Supervisors, Health Service Board and SFHSS requested meetings focused on quality initiatives and to work collaboratively with SFHSS and partners to adopt coverage and clinical guidelines mutually agreed to by SFHSS. Respondent shall include the guidelines in its providers' contracts as they are renewed or amended. Respondent shall participate, in quality improvement activities promoted by SFHSS.

#### 5.7.20.3 EXECUTIVE SPONSORSHIP

Respondent will provide an executive sponsor within the organization with decision-making authority. This person will, at a minimum, provide quarterly feedback sessions and be available for *ad hoc* meetings and issue escalation.

### 5.7.21 COMMUNICATIONS SERVICES [NEGOTIABLE]

Respondent will be required to provide the following Communications Services to SFHSS.

Respondent will staff a communications team (including writers, copy editors, web developers and graphic designers) that will work directly with the SFHSS Communications Division.

#### 5.7.21.1 EFFECTIVE AND EFFICIENT COMMUNICATIONS

Respondent will provide effective and efficient communications to Members and potential Members to enable them to make informed decisions in selecting a medical and/or pharmacy coverage, appropriately utilize any and all available benefits, and actively engage in managing their health.

#### 5.7.21.2 READABILITY

Respondent will provide all communications in an understandable format at a fifth-grade reading level and meet Americans with Disabilities Act and best practices for public sector group benefits, Department of Labor (DoL), Employee Retirement Income Security Act, California Department of Insurance and California Department of Managed Healthcare (DMHC) communications and language access guidelines.

#### 5.7.21.3 LANGUAGE AND CULTURAL DIVERSITY

Respondent will provide communication services for our culturally and linguistically diverse Member population, including, but not limited to, materials in Spanish, Chinese (Mandarin and Cantonese), and Tagalog, as well as legally required accommodations for communications and access to services that are consistent with Americans with Disabilities Act (ADA) requirements for all Member-oriented activities, tools and communications.

#### 5.7.21.4 DOCUMENT CONTROL

Respondent will comply with the document control policies and procedures that are established by SFHSS.

### 5.7.21.5 SINGLE POINT OF CONTACT

Respondent will provide SFHSS with a single point of contact regarding communications services. This single point of contact will be considered a key staff member and will be subject to Sec. 3.6.6 (Proposal Provisions), as applicable, including, the Consent to Reassign Personnel, Substitute Personnel, and Removal of Personnel.

### 5.7.21.6 REQUIRED DOCUMENTS

Respondent will write, design, print, and distribute the Certificates of Coverage/Evidence of Coverage and Disclosure Forms/Summary of Plan Description, benefit summaries, and the summary of benefits and coverage for plans annually, ensuring their compatibility with SFHSS's administration of the plan and SFHSS's responsibility for defining eligibility and benefits. Selected Respondents will develop a review schedule and obtain SFHSS's approval of schedule components and timing. SFHSS shall retain the right for final approval of the description of benefits, content, and design, which must be finalized and approved by SFHSS, in PDF format no later than September 30th of each year.

Respondent will write, design, print, and distribute agreed upon Open Enrollment materials, such as benefits fair handouts, digital content for website use, social media content, FAQs, and other print, electronic and digital collateral to promote benefit plans.

Respondent will develop quarterly communications calendar for all emails, mailers, texts and social media channels to engage Members in preventative care and health management that will be reviewed with SFHSS three (3) months in advance of distribution.

Respondent will develop quarterly communications calendar for all emails, mailers, texts and social media channels to engage Members in preventative care and health management that will be reviewed with SFHSS three (3) months in advance of distribution.

### 5.7.21.7 COMMUNICATION REQUIREMENTS

Respondent will comply with San Francisco Health Service System Member Communications requirements, as indicated in Article 12 of Sec. 5.5 (Appendix E-1 - Standard Agreement – Attachment 1).

### 5.7.21.8 MEMBER ID CARDS

Respondent will design custom co-branded Member identification (ID) cards. The SFHSS Logo and information on Member ID cards must include and not be limited to: PCP name and contact information, medical group name and number, customer service contact information, prescription drug plan name with BIN and PCN numbers, and other information as requested by SFHSS. SFHSS retains final approval to all ID card proofs prior to production and distribution to SFHSS Members.

Respondent will submit Member identification card design to SFHSS for approval, in advance of printing or distribution of the cards, by or before 15th of September of each year.

### 5.7.21.9 WELCOME PACKETS

Respondent will distribute welcome packets and new plan year ID cards to all Members no later than 1st of January of each year, unless otherwise agreed upon by SFHSS.

### 5.7.21.10 SCOPE OF MEMBER COMMUNICATIONS

All Respondent communications will relate directly to only plans made available to Member by SFHSS, unless authorized in writing in advance by SFHSS.

### 5.7.21.11 CO-BRANDING

If requested by SFHSS, Respondent will provide communications with both Respondent plan logo and SFHSS or City branding.

#### 5.7.21.12 MEMBER MICROSITE

Respondent will develop a co-branded SFHSS Members microsite which shall serve as the entry point to the health plan's secure website, that will include and not be limited to SFHSS plan information and materials, access search tools for finding a provider, researching covered prescription drugs, medical articles and information, Member well-being resources, access to plan EOB's, and other Member Materials. The plan shall ensure to work with SFHSS to keep information on the co-branded website up to date, while making modifications as requested by SFHSS.

#### 5.7.21.13 ANNUAL MEMBER PREVENTIVE CARE REMINDER

By April 30 of each year (unless otherwise approved by SFHSS), Respondent will develop and mail out a printed letter on vendor letterhead or sealed card reminder to enrolled SFHSS Members and Dependents to schedule annual medical exam/check-up during the current calendar year. The annual reminder shall be limited to the annual check-up reminder described herein, and avoid distracting artwork, graphics, and marketing information. The annual reminder shall include personalized salutation and date of last annual exam. The annual reminder shall include information on how Member can select a new or change their existing primary care physician. The annual reminder shall provide information on how Member can make an appointment by phone and provide contact phone numbers and hours of service. Annual reminder shall be developed in coordination with SFHSS and printed and mailed by vendor free of charge. Draft content shall be provided to SFHSS by February 1st of each year for input and review. Final approval of content and mailing date shall be with SFHSS.

#### 5.7.21.14 OTHER WELL-BEING COMMUNICATIONS

Respondent will communicate well-being benefits to Members at a minimum four times a year on well-being benefits.

Respondent will communicate benefits and services to SFHSS Members who are at risk for type 2 diabetes, exhibit pre-diabetic risk factors, or have been diagnosed with type 2 diabetes no less than twice per calendar year and upon diagnosis of type 2 diabetes or pre-diabetes.

### 5.7.22 WELL-BEING SERVICES [NEGOTIABLE]

Respondent will be required to provide the following well-being services to SFHSS.

#### 5.7.22.1 WELLNESS CREDIT

Respondent will provide a defined wellness credit in their financial proposal. Respondent may define which well-being services shall be supported by this credit. Respondent will be required to review and confirm the amount of the credit and the services covered thereunder as part of the annual rates and renewal process (Sec. 5.7.24 - Implementation and Annual Renewal).

#### 5.7.22.2 WELLNESS EDUCATION AND TOOLS

Respondent will provide virtual and on-site health education on demand and live classes.

Respondent will provide virtual and in-person programs and tools that enable Members to participate in classes, workshops and health coaching, to manage aspects of their health related to chronic disease.

#### 5.7.22.3 INFLUENZA VACCINATIONS

Respondent will provide or support free on-site influenza vaccinations for Members during the annual flu season period, including high-dose influenza vaccinations for high-risk populations and those Members over 65 years of age ("Flu Clinics"). Flu Clinics will be staffed by appropriately licensed professionals and overseen by a dedicated account manager or delegate.

#### 5.7.22.4 BIOMETRIC SCREENINGS

Respondent will provide biometric screenings for Members.

#### 5.7.22.5 ONSITE VACCINATIONS

Respondent will provide or support on-site vaccinations in response to national or state pandemic response efforts, including, but not limited to, the virus (severe acute respiratory syndrome coronavirus 2 or "SARS-CoV-2") responsible for the COVID-19 disease, as available.

#### 5.7.22.6 HEALTH PROMOTION INVENTORY

Annually, respondent will outline in its included Health Promotion Programs to be available to Members (including any pre-qualification criteria).

#### 5.7.22.7 PREVENTION PROGRAMS

Respondent will provide a Diabetes Prevention Program for qualifying Members.

Respondent will provide a tobacco / vaping cessation program for qualifying Members.

#### 5.7.22.8 WELL-BEING STRATEGY

Respondent will provide administrative and programmatic support to integrate well-being services into an overall behavioral health strategy for Members, including, but not limited to, comprehensive reporting of active programs and well-being services and maintaining an up-to-date online dashboard for SFHSS and the Well-being Division.

#### 5.7.22.9 ANNUAL WELL-BEING CAMPAIGNS

Respondent will support annual well-being campaigns organized and managed by the SFHSS Well-being Division.

#### 5.7.22.10 WELL-BEING CHALLENGES

Respondent will provide challenges that can be delivered anywhere between 4 – 12 weeks in length through an online and app platform that focus on health topics including, but not limited to, healthy eating, physical activity, sleep, gratitude, stress management, and emotional well-being.

#### 5.7.22.11 HEALTH BEHAVIOR TRACKING

Respondent will provide a comprehensive database that allows Members to track health behaviors, challenge data and all health behaviors including access to on-demand class and health education materials.

#### 5.7.22.12 WELL-BEING REFERRALS

Respondent will facilitate appropriate and timely referrals to Respondent and SFHSS well-being programs and services, including, but not necessarily limited to, providing a scheduling tool that Respondent manages for events and reminders that allows Members to register for programs and services in addition to canceling and changing appointments.

#### 5.7.22.13 SFHSS TRAINING

Respondent will provide annual training for employees of the SFHSS Well-being Division on health and well-being programs offered directly to SFHSS Members.

Respondent will provide SFHSS opportunities to train 'Selected Respondent' and those delivering the program to SFHSS Members on SFHSS well-being services and offerings in order to cross promote offerings and support a whole person well-being approach.

#### 5.7.22.14 GYM DISCOUNTS

Respondent will provide or support a discounted gym Membership program for the non-Medicare-eligible Member population.

#### 5.7.22.15 SINGLE POINT OF CONTACT

Respondent will staff a well-being support team and single point-of-contact for the services in support of the SFHSS Well-being Division. Members of this team may overlap with Members of the communications team that will work directly with the SFHSS Communications Division. The well-being support team will schedule and host monthly meetings with the SFHSS Well-being Division.

#### 5.7.22.16 REPORTING

Respondent will provide data to SFHSS in monthly, quarterly and *ad hoc* reports regarding all well-being activities, including, but not limited to, participation rates, loyalty, communications and outreach, demographics, customer satisfaction, and Social Determinants of Health (SDoH). Data reporting may overlap or supplement a well-being dashboard.

#### 5.7.22.17 INCENTIVE AND REWARD PROGRAMS

Respondent will coordinate with SFHSS and the SFHSS Well-being Division a well-being incentive program for Members and/or select Member populations to reward behavior change, participation and/or goal achievement in Respondent's and SFHSS well-being programs and resources including, but not limited to, healthy eating, physical activity, weight management, stress management, sleep, mental and emotional well-being, and tobacco cessation.

### 5.7.23 DATA REQUIREMENTS [NEGOTIABLE]

Respondent shall meet all SFHSS technical data requirements for eligibility file feeds/interfaces.

#### 5.7.23.1 DATA SECURITY REQUIREMENTS

Respondent will ensure that secure file transfer is utilized. For file transmission encryption, we use the secure file transmission protocols (SFTP, FTPS, etc.) which is encryption during transmission.

For files, PGP encryption/decryption will be used to store the vendor keys.

Respondent will meet all City and County of San Francisco terms and conditions regarding access to data, data security, and confidentiality (Sec. 5.5, Appendix E-1, Standard Agreement).

#### 5.7.23.2 FILE TRANSFERS

SFHSS and City and County of San Francisco data file transfer requires outbound files are transmitted directly from the City to the vendor. For any inbound files the City will pull the file from a secure CCSF owned server outside the City firewall.

### 5.7.23.3 DATA COMPLIANCE

Data access requirements shall be compliant with all state and federal privacy and security laws, statues and regulations for protecting subscriber/enrollee/Member data, including HIPAA.

### 5.7.23.4 ELIGIBILITY FILES

Eligibility file layout requirements are to use the standard 834 EDI file format with custom REF segments.

Eligibility files will accept male, female, and other or non-binary values for gender.

Eligibility data is sourced from PeopleSoft HCM and the benefits administration has numerous customizations for this population.

Eligibility files are transmitted weekly.

### 5.7.23.5 TERMINATIONS

Terminations are not processed by omission on the data file. Selected Respondent must receive termination record from SFHSS.

### 5.7.23.6 INVOICE DETAIL

Respondent will provide Membership files to support monthly invoice are to be supported with the following details.

### 5.7.23.7 MONTHLY REPORTING

Respondent will provide summary and Member Level Roster for reporting period by Sub-Group Category (Active/Retiree) by Month by Plan and Premium

### 5.7.23.8 DATA WAREHOUSE

Respondent will meet all SFHSS and Third-Party Data Warehouse Vendor requirements:

**5)** Comply with the file layout being utilized by the Selected Respondent. See additional documents: (i) Medical Claims Functional Specifications, (ii) Drug Claims Functional Specification (Employer).

**6)** Comply with lab results functional specification (as applicable).

**7)** Provide medical, Rx, and mental health facility and professional claims and provider files.

**8)** Claims and encounters must be submitted with full supporting financial data, including in HIPAA standard formats: (i) Submitted Charge, (ii) Discount Amount, (iii) Allowed Amount, (iv) Net Payment, (v) Out of Pocket, (vi) Third Party, (vii) Any other amounts that are needed for each record to reconcile back to submitted charge on all records, (viii) Pharmacy records to include ingredient cost.

**9)** If Respondent is proposing any arrangement that is not fully insured, Respondent must shall also provide:

- Per Claims Run
- Summary and Member Level Claims Experience by Sub-Group Category (Active/Retiree) by claims run period by Pay Category (Inpatient, Outpatient, Rx—including MH)
- Monthly Claims Lag Triangles by Pay Category and Sub-groups of Enrollees
- Large Claims and Stop/Loss Reporting (Specific and Aggregate if applicable)
- Standard and Allowable Customer Determined Thresholds

**10)** Annually, Respondent will provide:

- Ability to provide support for the audit in terms of Membership, claim details, etc.
- SSAE 16 Audit resulting SOC reports

**11)** Respondent will place no restrictions on SFHSS use of provider IDs or ordering provider IDs.

**12)** Respondent will include all NPIs and Tax IDs on each record are provided for both facility and professional claims.

**13)** High level of data quality and completeness for all fields, with 100% completeness for the following fields: (i) Employee and Member SSN, (ii) Date of Birth, (iii) Gender, (iv) All provider/Ordering provider IDs, (v) NDC, (vi) Primary Dx, (vii) Procedure Codes, (viii) Revenue Codes (facility claims only),

**14)** All other fields should follow guidance for completeness as stated in layouts.

**15)** Receive all adjustments to paid claims.

**16)** Data in the SFHSS APCD (Data Warehouse) may be encrypted but will not be aggregated or de-identified.

**17)** Agree to full access to PHI of data and to agree to same within data supplier agreements with SFHSS third party data warehouse vendor.

**18)** Provide lab data upon expansion of APCD by SFHSS.

**19)** Deliver feeds according to the following schedules: (i) Quarterly feeds received 5 weeks after quarter end [For example, paid through Q2 / incurred through Q1 is delivered by 7/5]; (ii) Support a monthly feed should SFHSS at a future date wish to increase the frequency from quarterly.

**20)** Identify on claims data ACO vs Non-ACO claims, as applicable.

#### 5.7.23.9 AD HOC REPORTS

Respondent shall provide both standard and *ad hoc* customized reports to SFHSS on plan quality, cost, utilization and performance, Member-reported outcomes, provider performance, and population health measures.

#### 5.7.23.10 DATA INTEGRATION

Respondent shall have in-house or third-party capacity and expertise for the coordination and integration of data sets across these multiple sources.

Respondent shall support the collection, reporting and integration of data from the SFHSS Well-Being Division (Sec. 1.1.4.5) and both SFHSS and third-party well-being programs and initiatives.

#### 5.7.23.11 ADDITIONAL REPORTING MEASURES

Respondent shall possess detailed reporting capabilities to measure the following and participate in the following surveys and rating systems:

**1)** Healthcare Effectiveness Data and Information Set (HEDIS) data specified by SFHSS.

**2)** Integrated Healthcare Association (IHA) data specified by SFHSS.

**3)** Choosing Wisely recommendations specified by SFHSS

**4)** Provider performance

**5)** NCQA Health Plan report cards

**6)** Standard ACO reporting as defined by Catalyze.Org if applicable

**7)** Agency for Healthcare Research and Quality (AHRQ) quality indicators as specified by SFHSS

**8)** Respond to Leapfrog group hospital and ambulatory surgery center (ASC) surveys

on patient safety and quality.

**9)** Other State and National-level standards as determined by SFHSS in coordination with Selected Respondent.

#### 5.7.23.12 DATA EXPERIENCE

Respondent shall have experience, knowledge and expertise providing appropriate data and routine, standardized reporting on provider performance regarding various clinical and quality metrics, patient experience and population health.

#### 5.7.23.13 DATA TRANSPARENCY

Respondent shall provide data, technical support and analytical expertise to support SFHSS initiatives to improve transparency of health plan claims, clinical and financial data, including:

**1)** Fostering a culture of quality and price transparency to enable health care providers to set performance benchmarks, compare performance against their peers and measure the overall performance of our health systems.

**2)** Engage all Members in their health care decision-making as collaborative partners in care.

**3)** Providing cost and quality transparency tools that empower Members to make value-based, cost-effective health care decisions, such as:

- Patient-oriented websites designed to accommodate varying degrees of health literacy;
- Customized cost calculator tools based on a Member's benefit design, including copays, coinsurance, service limits, pharmacy benefits, deductibles and out-of-pocket limits;
- A searchable database of medical costs by procedures, drugs and episodes of care;
- Cost and quality comparisons for alternative treatments, physicians, hospitals, ambulatory surgery centers and diagnostic centers;
- Easily navigable personal health records and health education tools;
- Providing comprehensive online resources for Members, viewable from mobile, tablet, laptop and desktop devices, that includes access to the aforementioned interactive cost and quality transparency tools as well as self-management tools and wellness information, and that considers a Members' benefit design relative to different services.
- Support multiple communication mediums offered for Members to contact customer service, navigating services, referrals, second opinion services, billing questions, and communicating directly with a provider.
- Ensure all communications and services are culturally and linguistically appropriate for Members.
- Addressing and leveraging data to target Social Determinants of Health.
- Promoting executive endorsement of national claims and cost transparency efforts.
- Promoting transparency in prescription drug pricing, including the Rx rebate process.

#### 5.7.23.14 QUALITY MEASURES.

Respondent shall provide calculation of quality measures and providing data and analytic reports to providers (include examples of reports, frequency of delivery of data and reports, and technical assistance offered to providers to integrate data into workflows).

### 5.7.24 REPORTING [NEGOTIABLE]

Respondent will be required to deliver the following:

### 5.7.24.1 QUARTERLY REPORTING:

Respondent will provide the following on a quarterly basis:

**1)** Reports detailing administrative functions (e.g., customer service telephone answer time and abandonment rates) as well as care coordination and management.

**2)** Reporting on Respondent's efforts to promote price and quality transparency for health care services and providers.

**3)** Reporting on maternity, fertility, and infertility care and related health care services, including, but not limited to, delivery rates including twinning/multiple birth rates, early elective delivery rates (deliveries before 39 weeks with no medical indication for early delivery), Single Embryo Transfer (SET) rate per Transfer, live birth per transfer rate, pregnancy rate per IVF transfer, and deliveries by midwife.

**4)** Reporting on mental/behavioral health outcomes, initiatives and strategies, including, but not limited, to integration with PCPs, incentives for providers to improve access, support for SFHSS EAP and integration with third-party EAP support vendors.

### 5.7.24.2 MONTHLY AND QUARTERLY REPORTING:

Respondent will provide the following on a monthly and quarterly basis:

**1)** Reports detailing plan quality, utilization management review and performance, Member-reported outcomes, clinical and quality metrics of provider performance, and population health metrics, including tracking and analysis of Social Determinants of Health. Social Determinants of Health are the conditions in which individuals are born, grow, live, work, and age. Characteristics can include data related to race, ethnicity, socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination that are known to influence health status.

**2)** Reports detailing disparities in quality of care experienced by different group characteristics outlined in the Social Determinants of Health definition above. Quality can be described in terms of priorities including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability to reduce variations in quality of care for all.

**3)** Reports of efforts to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

**4)** Reports on Respondent's efforts to promote high-value networks and benefit design, centers of excellence, and value-based payment incentives, including process and outcome metrics.

**5)** Reports detailing appeals and grievances, including process and outcomes metrics.

**6)** Reports detailing case management services, complex care management activities, value-based payment efforts, bundled payment processes and utilization, and detailed utilization reporting on any services newly offered to Members within the prior twenty (24) months or as otherwise identified by SFHSS.

**7)** Reports detailing clinical management services, clinical management programs and Member support and advocacy services, including process and outcomes metrics.

**8)** Reports detailing quality management and improvement activities, including process and outcomes metrics.

**9)** Reports detailing case management services, complex care management activities, value-based payment efforts, bundled payment processes and utilization, and detailed utilization reporting on any services newly offered to Members within the prior

twenty (24) months or as otherwise identified by SFHSS.

**10)** Reports detailing clinical management services, clinical management programs and Member support and advocacy services, including process and outcomes metrics.

**11)** Reports detailing quality management and improvement activities, including process and outcomes metrics.

#### 5.7.24.3 ANNUAL REPORTING:

Respondent will provide the following on a monthly and quarterly basis:

**1)** Reports on maternity, fertility and infertility care delivery initiatives, including, but not limited to, maternity center of excellence programs, promoting in-network utilization (providers and pharmacy), programs to prevent avoidable maternity complications, morbidity or mortality from pregnancy and delivery, programs to maintain manageable cesarean rates, initiatives to reform maternity care payment and delivery, and efforts to address Social Determinants of Health and reduce racial disparities in pregnancy outcomes.

**2)** Reports on Healthcare Effectiveness Data and Information Set (HEDIS) data specified by SFHSS.

**3)** Reports on Integrated Healthcare Association (IHA) data specified by SFHSS.

#### 5.7.24.4 QUARTERLY AND ANNUAL REPORTING

Respondent will provide quarterly and annual tracking of performance guarantees, including reporting for all performance metrics with fees-at-risk within forty-five (45) calendar days of the end of a fiscal quarter and/or plan year-end reporting period.

#### 5.7.24.5 AUDIT REPORTING

Respondent will provide audit reports, not limited to SOC 1 and SOC 2 as requested.

#### 5.7.24.6 SFHSS REPORTING TOOLS

Respondent will provide designated SFHSS personnel access to any Respondent web-enabled online reporting tools at no additional cost.

#### 5.7.24.7 AD HOC REPORTING

Submit additional *ad hoc* reports on readily available information and data at the request of the SFHSS or at the request of the Health Service Board.

#### 5.7.24.8 REPORTING TIMELINESS

Provide all scheduled reports and *ad hoc* reports accurately and in accordance with any mutually established timelines.

### 5.7.25 IMPLEMENTATION AND ANNUAL RENEWAL [NEGOTIABLE]

Each year, SFHSS conducts a renewal process for all health plans. This process allows SFHSS to create consistency in how we communicate and validate our expectations for the upcoming plan year (beginning January 1st) and the open enrollment period (held in October of the prior year). The process also allows SFHSS to adjust benefits in response to new regulatory requirements, prior year(s) plan experience, City policies, benefit design strategies developed by SFHSS and our industry partners, Health Service Board policies, and legislative changes.

| Benefit Vendor Timeline | | |
|---|---|---|
| **Task** | **Start** | **Finish** |
| A. Rates and Benefits Negotiated, Presented, Reviewed with SFHSS | December | June |
| B. Health Service Board Review and Approval of Rates and Benefits | March | June |
| C. San Francisco Board of Supervisors Approval of Rates and Benefits | July | |
| D. SFHSS Actuary Sends Out Confirmation Letters to Benefit Vendors | July | August |
| E. Open Enrollment Communications (creation, review, release) | April | October |
| F. Open Enrollment Packets Mailed by SFHSS to Members | September | |
| G. Flu Season (communication, planning and on-site vaccinations) | April | October |
| H. Vendor Benefit Materials (review and confirmation) | June | September |
| I. On-Site, Off-Site, and/or Virtual Open Enrollment Events | October | |
| J. Next Plan Year Confirmation Letters Mailed to Members | November | |
| K. Open Enrollment Eligibility Files | November | December |
| L. Start of New Plan Year | January | |

#### 5.7.25.1 RATES AND BENEFITS NEGOTIATED, PRESENTED, REVIEWED WITH SFHSS.

##### 5.7.25.1.1 RENEWAL REQUEST LETTER.

In December of each year, SFHSS, in collaboration with our actuary and consultant, will prepare a detailed renewal request letter for the plan year beginning the following January. The letter details proposed financial and non-financial changes for the plan year, including clinical, non-clinical, data reporting, and performance metrics.

##### 5.7.25.1.2 RENEWAL RESPONSE DUE.

A detailed response is due to SFHSS between February and April with proposals regarding how each plan intends to implement the itemized changes. Plans are required to provide a clear and comprehensive evaluation and implementation plan for each benefit change.

##### 5.7.25.1.3 FOLLOW-UP RESPONSES DUE.

SFHSS will provide requests for follow-up items to be discussed at a subsequent meeting (held either in person, via web conference or a combination thereof).

#### 5.7.25.2 HEALTH SERVICE BOARD REVIEW AND APPROVAL OF RATES AND BENEFITS.

SFHSS and the SFHSS actuary, with the support of Benefit vendors, present all rates and benefits to the Health Service Board between March and June of each year.

#### 5.7.25.3 SAN FRANCISCO BOARD OF SUPERVISORS APPROVAL OF RATES AND BENEFITS.

SFHSS submits the rates and benefits for review and approval by the Board of Supervisors following approval by the Health Service Board.

#### 5.7.25.4 SFHSS ACTUARY SENDS OUT CONFIRMATION LETTERS TO BENEFIT VENDORS.

A confirmation letter summarizing the approved rates and benefits is prepared and submitted to each benefit vendor. Vendors are required to review, confirm and return the signed confirmation letter to SFHS within two (2) weeks.

**5.7.25.5 OPEN ENROLLMENT COMMUNICATIONS (CREATION, REVIEW, RELEASE).**
The process of creating, editing, reviewing and obtaining vendor feedback, and ultimately releasing open enrollment communication materials (both in print and electronic form) to Members begins in April for Open Enrollment and the following plan year. Design, proofing, printing and mailing is a collaborative process with defined deadlines. For 2020, vendor review of open enrollment materials was due by July 31st.

**5.7.25.6 OPEN ENROLLMENT PACKETS MAILED BY SFHSS TO MEMBERS.**
Open enrollment packets summarizing the current benefits (health, dental, vision, voluntary benefits) for each Member (and their dependents) are mailed in early September.

**5.7.25.7 FLU SEASON (COMMUNICATION, PLANNING AND ON-SITE VACCINATIONS).**
Flu Season. SFHSS and the Well-being Division begin planning for the flu season in April of each year. Site planning, scheduling, communications strategies, and trainings are coordinated with our vendors continues through August and into September to allow SFHSS to offer on-site vaccinations during open enrollment events or to motivate and navigate Members towards scheduling and receiving flu vaccinations from their health plan.

**5.7.25.8 VENDOR BENEFIT MATERIALS (REVIEW AND CONFIRMATION).**
SFHSS vendors prepare and submit benefit materials (Summary of Benefits and Coverage, Evidence of Coverage, Summary of Benefits, etc.) to SFHSS for review and approval by the third Monday in August. During the following six to seven weeks, SFHSS works in close collaboration with all benefit vendors to ensure all plan materials are finalized prior to open enrollment (October).

**5.7.25.9 ON-SITE, OFF-SITE, AND/OR VIRTUAL OPEN ENROLLMENT EVENTS.**
Benefit vendors support on-site, off-site and virtual open enrollment events by providing representatives, presentations and collateral to Members. This real-time support by vendors for open enrollment, coupled with benefit materials, online resources, and the Member Services Division, allow SFHSS to more fully inform Members of the all the benefit options available to them for the upcoming plan year.

**5.7.25.10 NEXT PLAN YEAR CONFIRMATION LETTERS MAILED TO MEMBERS.**
The process for preparing, reviewing and mailing benefit confirmation letters to Members begins on the last day of open enrollment. Letters are mailed the final week of November.

**5.7.25.11 OPEN ENROLLMENT ELIGIBILITY FILES.**
Open enrollment Member eligibility files are transmitted from SFHSS to benefit vendors by the first week of December. However, benefit vendors, and in particular any Selected Respondent(s) as a result of this RFP, understand that the collaborative technical processes of preparing the for open enrollment, developing any required microsite, and preparing eligibility files, begins as early as May of each year.

**5.7.25.12 START OF NEW PLAN YEAR.**
All benefits and services must be active an available to enrolled Members as of January 1st of each year.

## 5.8 FINANCIAL AND BANKING REQUIREMENTS [NEGOTIABLE]

Respondent shall demonstrate the financial experience, capacity, systems and interfaces to manage large volumes of Member transactions in the frequency requested by SFHSS. SFHSS updates enrollment files weekly. Respondent shall have the resources to perform timely reconciliations between the eligibility files and invoicing.

For fully insured plans, SFHSS performs a positive invoice and a reconciliation at the end of the month to take effect.

For self-funded and flex-funded plans, there are fixed charges and variable charges. Examples of fixed charge components such as administrative fees or partial premiums will be issued at the end of the month for the current month. For the variable components such as claims for which SFHSS is financially responsible, SFHSS is able to issue payments as frequently as daily. SFHSS expects the Respondent to be accept the funding of variable and fixed charges occurs without the use of an imprest bank account or ACH Debit (Automated Clearing House) bank transfer process.

Respondent shall make available the resources needed to implement or revise the necessary financial/banking infrastructure to have a successfully completed tested 60 days prior to the first enrolled member effective date.

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