REQUEST FOR PROPOSALS

COUNTY MEDICAL SERVICES PROGRAM (CMSP)

PROGRAM ADMINISTRATION SERVICES

Table of Contents

I. GENERAL INTRODUCTION 2

1. General Information 2
2. Background Information 3

II. SCOPE OF WORK 6

1. General Requirements 6
2. Eligibility 8
3. Network 9
4. Service Administration 13
5. Claims Payment 16
6. Utilization Management for CMSP Benefit Program 20
7. Quality Assurance 21
8. Customer Service 21
9. Interface with Pharmacy Benefits 24
10. Implementation 24
11. Account Management 25
12. Reporting 25
13. Financial Requirements 26
14. Optional Services 27
15. General Service Requirements 27
16. CMSP Requirements and Services 28

III. PROPOSAL INFORMATION 28

1. Submission of Proposals 28
2. Clarification of Requirements 29
3. Evaluation Process 29
4. Contract Award 31
5. Pricing 31
6. Renewal and Termination of Contract 32

IV. QUESTIONNAIRE 33

1. Background 33
2. Provider Network 34
3. Service Administration/Claims Processing 36
4. Utilization Management and Quality Assurance 37
5. Customer Service and Eligibility Processing 38
6. Implementation and Account Management 39
7. Reporting 40
8. Conflict of Interest 42

V. EXHIBITS 42

VI. ATTACHMENTS 42

I. GENERAL INTRODUCTION

1. General Information

The County Medical Services Program (CMSP) Governing Board is soliciting proposals for a Third Party Administrator (TPA) to administer health care services for low-income adults served by CMSP in 35 participating California counties. CMSP provides health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health care programs and is administered by the CMSP Governing Board (Governing Board). The administrative services sought include, but are not necessarily limited to, member eligibility verification, management and expansion of the established contracted provider network, claims processing (including prospective coordination of benefits and third party liability recoveries), customer service, report writing and maintenance, prior authorization, utilization management, cost containment programs, and accounting services. The Governing Board maintains a separate agreement with a Pharmacy Benefit Manager to manage retail pharmacy benefits and claims adjudication.

This document constitutes a Request for Proposals (RFP) from qualified organizations. Proposals will be accepted from those entities identified in Section II.1. Contractors should refer to the anticipated schedule:

RFP released on Governing Board's website	4/15/2025
Questions due from potential bidders	5/2/2025
Responses to questions posted on Governing Board's website	5/14/2025
Proposals due to Governing Board	5/30/2025
Proposals reviewed and interviews conducted	6/30/2025
Determination of contract award	7/23/2025
Effective date of contract	9/1/2025
Start-up	9/1/2025 – 2/28/2026
Services and enrollment begin	3/1/2026
First contract year (Service Year 1)	3/1/2026 – 2/28/2027
Second contract year (Service Year 2)	3/1/2027 – 2/29/2028

**Timeline is subject to change and may be revised by the Governing Board.*

This document is divided into the following sections:

I. General Introduction
II. Scope of Work
III. Proposal Submission Information
IV. Questionnaire
V. Exhibits
VI. Attachments

Please review this RFP carefully. If you have questions regarding any information presented in this RFP, submit the questions in writing to Alison Kellen via email to akellen@cmspcounties.org. Include your name, the name of your firm, mailing address, email address, and telephone number. Questions can be submitted at any time up to midnight on May 2, 2025. The Governing Board will post written responses on its website as soon as possible after questions are received and intends to post responses to questions by May 14, 2025. Due to time constraints, there is no guarantee that questions received after May 2, 2025, will be answered. For clarity, please cite the page and section to which your questions pertain, and if appropriate, the information you are seeking.

A copy of this RFP can be obtained from the Governing Board website at https://www.cmspcounties.org/news/.

All questions regarding technical specifications, bid process, etc. shall be directed to the contact person indicated in this RFP. Contractors or their representatives may not contact other Governing Board employees, any Governing Board members, or CMSP participating county employees concerning this procurement while the bid and evaluation are in process.

2. Background Information

CMSP was established in January 1983 when California law transferred responsibility for providing health care services to medically indigent adults from the State of California to California counties. In April 1995, California law established the Governing Board to determine CMSP policy and oversee program administration.

CMSP's reach extends over 90,000 square miles. The 35 counties that participate in CMSP represent a diverse collection of rural and frontier California counties. A map and listing of the participating counties is located at https://www.cmspcounties.org/cmsp-map/.

CMSP Benefit Program

To be eligible for CMSP, a potential enrollee must be an adult age 21 to 64 who is not enrolled in any other health coverage, has income of not more than 300% of the Federal Poverty Level (FPL), and resides in one of the 35 CMSP counties. The Governing Board establishes eligibility requirements and county social services offices in the 35 CMSP counties conduct eligibility determinations for the CMSP benefit program. Beginning in late Spring of 2025, applicants will also be able to apply for the CMSP benefit program through contracted enrollment providers. CMSP eligibility information is maintained on the Medi-Cal Eligibility Determination System (MEDS) by the California Department of Health Care Services (DHCS). CMSP enrollees are identified by one of six aid codes, summarized in the following table. The aid codes identify the scope of covered benefits, if a monthly share of cost (SOC) applies, and discern whether the CMSP member applied via a county social services department or a contracted enrollment provider. Healthcare providers enrolled in the Medi-Cal program can verify an individual's eligibility for CMSP by accessing the DHCS Medi-Cal eligibility system.

The CMSP benefit program generally covers most of the same benefits as Medi-Cal, with the exception of pregnancy-related services, breast and cervical cancer treatment services, long-term care, and services provided by acupuncturists.

Aid Code	Enrollee Description
50	CMSP Full-Scope Benefit Services (undocumented), with and without SOC, application approved by county social services department. Limited to primary and preventive services if SOC is not met.
88	CMSP Full-Scope Benefit Services, no SOC, at/below 138% FPL, application approved by county social services department.
89	CMSP Full-Scope Benefit Services, with SOC, above 138% to 300% FPL, application approved by county social services department. Limited to primary and preventive services if SOC is not met.
8F	CMSP Acute Inpatient Services only, companion aid code to Medi-Cal Long Term Care aid code 53. Application approved by county social services department.
8M	CMSP Full-Scope Benefit Services, no SOC, at/below 138% FPL, application completed at a contracted enrollment center and approved through the mCase enrollment system.
8S	CMSP Full-Scope Benefit Services, with SOC, above 138% to 300% FPL, application completed at a participating health center through the mCase enrollment system. Limited to primary and preventive services if SOC is not met.

Additional information about CMSP is located at https://www.cmspcounties.org.

Connect to Care Benefit Program

To be eligible for Connect to Care (CTC), a potential enrollee must be an adult age 21 to 64 who is not enrolled in any other health coverage, has income above 138% and not more than 300% of the Federal Poverty Level (FPL), and resides in one of the 35 CMSP counties. If these criteria are met, the potential enrollee may go to one of the contracted enrollment providers participating in the program. An application assister assists the applicant with applying to the program via the mCase Enrollment System. CTC applications are reviewed and approved by CMSP staff.

The Connect to Care benefit program covers primary and preventive services only, including pharmacy services, at an in-network provider.

Additional information about Connect to Care is located at https://myconnecttocare.org.

Other CMSP Benefit Programs

CMSP has previously operated other benefit programs, such as Path to Health.

Treatment Authorization

Claims for inpatient and selected other CMSP services are currently subject to a treatment authorization process that is based primarily on established insurance industry medical practice guidelines. The Contractor is encouraged to utilize Milliman Practice Guidelines or a comparable insurance industry standard set of practice guidelines in its prior authorization and utilization management program. No prior authorization is required for in-network, covered primary and preventive services.

Provider Contracts and Payment Rates

Under California law, the Governing Board is authorized to contract with health care providers and set payment rates for health care services covered under CMSP benefit programs. The Governing Board currently holds contracts with providers across the 35 CMSP counties and neighboring counties. A listing of CMSP contracted providers is located at https://www.cmspcounties.org/find-care/.

The Governing Board sets provider payment rates within the context of annual program revenues and expenditures. Currently, payment rates under CMSP and Connect to Care are comparable to or higher than amounts paid under the Medi-Cal fee-for-service program.

- *Payments for inpatient hospital services under CMSP.* Most hospital payments are based on hospital specific per diems based on level of care (e.g., Med/Surg, ICU, Trauma) with supplemental payments for certain services and devices. A small number of hospitals continue to participate under a percent of charges formula.

- *Payments for professional medical services, excluding dental services, under CMSP and Connect to Care.* Payment for these services is based on provider type. For Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Programs (THP), encounter-based rates, such as prospective payment system (PPS) rates, are used when applicable. For other CMSP providers a fee-for-service rate is paid that is generally forty percent or more above current Medi-Cal rates for such services.

- *Payment for dental services under CMSP.* Payment for these services is based on encounter-based rates for FQHC, RHC, and THP providers and fee-for-service rates that are comparable to current Medi-Cal rates for other providers.

The Governing Board has broad powers to negotiate or set varying rates or methods of payment on a provider-by-provider basis. In addition, the Governing Board may reduce its provider payment rates to remain within its annual program budget and funding levels. If the Governing Board proposes to reduce a payment rate, participating health care and dental providers are notified in advance of any reduction taking effect.

Contracting providers must accept CMSP and Connect to Care payment as payment in full for services provided, including any SOC payment. In addition, when a CMSP enrollee has other health coverage, providers are required to bill the other insurance carrier prior to billing CMSP and submit a denial letter from the carrier with the CMSP claim. CMSP benefit coverage is secondary to all other private and publicly funded health coverage.

Claims Processing

For dates of service in Fiscal Year 2023-24, there were approximately 6,200 claims processed under the CMSP and Connect to Care benefit programs. Of those claims, 13% were for inpatient hospital services and 87% were for other services such as clinic visits, outpatient hospital services, and physician visits.

II. SCOPE OF WORK

1. General Requirements

The Governing Board seeks a qualified Contractor to provide third party administrative services for CMSP to be managed in accordance with the provisions and requirements of this RFP on behalf of the Governing Board. CMSP provides health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health care programs and is administered by the CMSP Governing Board. The services to be provided include, but are not necessarily limited to, participant eligibility verification, management and expansion of the established contracted provider network, claims processing (including prospective coordination of benefits and third party liability recoveries), customer service, report writing and maintenance, prior authorization, utilization management, cost containment programs, and accounting services.

Bidders may subcontract with other entities to provide certain services under this contract (e.g., provider network development). Any and all subcontracts entered into by the Contractor for the purpose of meeting the requirements of this contract are the responsibility of the Contractor. The Governing Board will hold the Contractor responsible for assuring that subcontractors meet all of the requirements of this contract and all amendments thereto.

It is expected that the Contractor shall commit to negotiate and promptly respond throughout the course of negotiations to produce and execute a contract by September 1, 2025.

The Governing Board seeks a Contractor with the following attributes to administer health care benefit coverage for CMSP and Connect to Care enrollees in participating counties:

- Ability to manage the CMSP health care provider network composed of hospitals, primary care providers, specialty providers, and ancillary providers, with inclusion of traditional CMSP providers and implement cost-effective contracts with additional needed providers and manage and resolve provider payment and other disputes.

- Ability to design and administer an effective utilization management program for CMSP benefit coverage that addresses inpatient and ambulatory prior approval processes, medical case management, and inpatient concurrent review and discharge planning.
- Experience serving low-income and/or indigent populations and arranging for comprehensive and timely care in medically underserved areas where health care provider capacity, especially specialty care, may be limited.
- Ability to scale services for additional benefit programs and/or higher than estimated enrollment numbers due to policy changes.
- Experience serving a Spanish language population.
- Efficient membership system, claims processing, and reporting systems.
- Competitive financial proposal.
- Implementation plan and timetable that meets the timeline specified in Section II.
- Dedicated account management.
- Effective performance standards to assess and monitor performance.

The successful Contractor will be able to utilize and build upon the health care provider network currently serving CMSP and Connect to Care enrollees in each county. The successful Contractor must agree to comply with the following general requirements and contract terms:

- The Contractor shall be a corporation or other legal entity that is either (a) duly incorporated or formed in the State of California and in good standing under California law, or (b) incorporated or formed in another jurisdiction, with significant operations in California and in good standing under the laws of its state of incorporation or formation. In addition, the Contractor must possess all licenses and permits required under California law, or otherwise applicable, to perform the scope of work described in this Request for Proposals.
- The Contractor shall have at least one client that has at least 5,000 covered lives (unduplicated enrollees and dependents).
- The Contractor shall indemnify and defend the Governing Board for claims and losses suffered by the Governing Board that arise from the Contractor's performance of services under the terms of the contract. Such obligation shall not be limited by dollar amount or type of claim or loss suffered.
- The Contractor shall maintain commercial general liability coverage in an amount not less than $2,000,000 per occurrence and $4,000,000 in aggregate per year, excess liability insurance coverage in an amount not less than $2,000,000 per occurrence and $4,000,000 in the aggregate per year, and professional liability coverage in an amount not less than $3,000,000

per occurrence and $5,000,000 in aggregate per year.

- The Contractor shall obtain and maintain during the term of the contract a $3 million letter of credit, performance bond or comparable security, or combination of these instruments, to secure or guaranty the Contractor's performance under the terms of the contract upon such terms as approved by the Governing Board. Such security shall be located in California or provided through a California location (e.g., if a letter of credit, the issuing financial institution shall issue through a California location). The Governing Board may require additional assurances of the Contractor's performance, including but not limited to the guaranty of the Contractor's parent.

- The term of the contract shall include a start-up period beginning September 1, 2025, and ending February 28, 2026, followed by an initial two-year term commencing March 1, 2026, and ending February 29, 2028. The Governing Board may, in its sole discretion, renew the agreement for up to three (3) additional one-year terms. The start-up period is anticipated to be six (6) months, with a start date for all services no later than March 1, 2026.

- The Governing Board may terminate the contract without cause with one hundred twenty (120) calendar days prior written notice.

- The Contractor and Governing Board shall comply with all applicable federal and state laws governing the privacy and security of health information, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations, and the California Confidentiality of Medical Information Act (CMIA). Each party shall be responsible for any liability arising from the unauthorized use or disclosure of individually identifiable health information in violation of applicable law.

2. Eligibility

CMSP Benefit Program

For low-income adults that are not eligible for Medi-Cal or other subsidized health insurance coverage, participation in CMSP is based on meeting CMSP eligibility requirements that consider county of residence, age, income and assets. Generally, CMSP eligibility is available to persons age 21-64 that have incomes at or below 300% of the Federal Poverty Level (FPL); and meet specific asset requirements. Some persons eligible for CMSP have a Share of Cost (SOC) obligation and must pay or obligate to pay part of their monthly income toward their medical expenses *before* CMSP will pay for most covered benefits. Selected primary care services rendered by an in-network provider are excluded from the SOC requirement. These SOC enrollees utilize the same SOC process that is used by the Medi-Cal program.

All CMSP eligibility groups will be included in the scope of activities provided by the Contractor. The Contractor shall accept that the Governing Board or its identified eligibility agent is the sole source of information concerning CMSP eligibility. The Contractor shall also accept all eligibility

information from the Governing Board or its agent in an electronic format. The eligibility file or other media shall be processed by the Contractor within twenty-four (24) hours of receipt.

The Contractor shall develop or demonstrate a process for recouping payments from contracting CMSP providers made when a CMSP enrollee was determined retroactively eligible for Medi-Cal.

Prior to providing health services, contracting CMSP providers are required to confirm the CMSP enrollee's eligibility status. The Contractor shall develop or demonstrate a process for assuring that eligibility information provided by the Contractor to providers and CMSP enrollees is accurate and reflects summary eligibility information that is the same as that provided by the Medi-Cal Provider Portal.

Electronic CMSP eligibility information will be provided from CMSP to the TPA on a daily and monthly basis. The data will be sent securely using Secure File Transfer Protocol (SFTP) or similar. CMSP eligibility data will be formatted as listed in Attachment A, using the California Department of Health Services' FAME file format. This data will include CMSP enrollments processed through both county social services departments and the mCase enrollment system utilized by contracted enrollment providers.

The TPA will be responsible for processing CMSP member additions, changes (e.g., aid code, address, name), and updates of eligibility information. This includes identifying and processing retroactive CMSP eligibility as expressed in the monthly CMSP eligibility file. Additionally, the TPA will be responsible for processing member eligibility to Medi-Cal retroactively and removal from CMSP eligibility for up to 13 months.

Connect to Care Benefit Program

The Governing Board will provide Connect to Care eligibility information on a daily basis. The data will be sent securely using Secure File Transfer Protocol (SFTP) or similar. Connect to Care eligibility data follows industry-standard HIPAA 5010-compliant 834 enrollment and maintenance file format. The TPA will be responsible for processing CTC member additions, changes (e.g., member number, address, name), and updates of eligibility information.

3. Network

The Governing Board seeks a Contractor that can assure CMSP and Connect to Care enrollees have access to all medically necessary services covered by CMSP and Connect to Care. Such services include preventive and primary care services, inpatient hospital services, specialty medical services, ancillary services, dental services, and vision services. The health care provider network managed by the Contractor for CMSP and Connect to Care enrollees must be sufficient to provide access to providers of all of the services listed in Section 4. Prescription drug services, except home infusion, are excluded from the listing of covered services because they are administered by a pharmacy benefits manager contracted independently with the Governing Board.

The Governing Board expects that the health care provider network managed by Contractor will be sufficient to assure delivery of necessary services within the county or through referral arrangements to a location within a reasonable driving distance, as conditions otherwise require. Contractor shall assess the adequacy of the existing CMSP provider network on a county-by-county basis and identify any network deficiencies that need to be addressed. As a part of Contractor's implementation plan, Contractor shall propose strategies to resolve any identified network deficiencies. The Contractor shall propose standards for network adequacy based upon assumptions about CMSP and Connect to Care enrollment in each county participating in CMSP and the requirements set forth below:

At a minimum, Contractor shall facilitate a network that reflects the following:

- Inpatient hospital and outpatient hospital services: All hospitals currently participating in the CMSP provider network shall continue to participate in the CMSP provider network. For any county or region where an otherwise available hospital does not currently participate in the network, Contractor shall present an alternative inpatient hospital arrangement that addresses CMSP enrollee needs in the county or region.

- Primary and preventive health care services: Contractor shall assure that a sufficient number of community health centers, including FQHC, RHC and THP providers, and other private health care providers shall be contracted in each CMSP county so that CMSP enrollees in all county zip codes have access to at least one primary care provider within 20 miles or 30 minutes travel time. Toward this end, Contractor is encouraged to invite any FQHC, RHC, THP and other primary care providers not currently contracted to participate as contracting CMSP providers. Contractor may propose an alternative network standard for those zip codes where this standard is not practical due to geographic barriers.

- Specialty care services: Contractor shall assure that all necessary specialty needs are met through contracts with providers or through standing referral arrangements involving Letters of Agreement in a manner sufficient to assure delivery of all medically necessary specialty services. To the extent Letters of Agreement are utilized, Contractor shall describe all specialties for which this arrangement applies by county. Contractor shall propose network adequacy standards for all specialty care services.

- Ancillary services: Contractors shall assure that all necessary ancillary services, including but not limited to laboratory, Durable Medical Equipment, home health and home infusion services, are contracted in a manner sufficient to assure delivery of these services, as determined medically necessary. Contractor shall propose network adequacy standards for all ancillary services.

- Dental and Vision services: Contractor shall work to build upon the current network of CMSP Dental and Vision providers to ensure that a sufficient number of providers are available to enrollees in all county zip codes.

- Such other providers as requested by the Governing Board.

Provider Contracting Requirements

Required Medi-Cal Provider Participation

All contracting health care providers shall be enrolled as Medi-Cal providers. This requirement has been set for three reasons.

1. CMSP eligibility is maintained in the State's MEDS system for Medi-Cal and CMSP enrollees are designated eligibility aid codes inside the MEDS system. Based upon aid code, some CMSP enrollees have a Share of Cost (SOC).

2. A monthly and daily electronic eligibility file is produced by the MEDS system that will be transmitted to the Contractor to establish and maintain the ongoing CMSP eligibility record. This file includes eligibility data for individuals enrolled through county social services departments as well as those enrolled through the mCase system by contracted enrollment providers.

3. CMSP enrollees that have a SOC must pay or obligate to pay their full SOC each month before CMSP benefit coverage takes effect. This requirement is the same as that set for Medi-Cal. Amounts paid and obligated to be paid by the CMSP enrollee are input and tracked in the Medi-Cal SOC system.

As a part of provider network management and development, Contractor shall not be required to separately credential providers that are participating in Medi-Cal. Instead, the Contractor must verify providers are licensed to practice in the State of California. Additionally, the Contractor must verify providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider List. Terminated providers in either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List cannot participate in the Contractor's CMSP provider network.

The Governing Board will consider not requiring Medi-Cal provider participation for selected high need specialty care providers if Contractor provides an acceptable alternative mechanism for assuring that requirements such as credentialing, payment of CMSP enrollee SOC, and related matters are addressed.

Provider Payment Rates Set by Governing Board

As a part of strengthening and maintaining the CMSP provider network, Contractor shall facilitate the development of new and continuing contracts with participating providers for CMSP program participation. Toward this end, Contractor shall make offers of payment for services based solely upon the Governing Board's Rates of Payment Policy, or as otherwise directed by the Governing Board. With the exception of emergency services, which may be provided by non-contracting providers and shall be paid in accordance with the Governing Board's Rates of Payment Policy, all covered CMSP benefits must be provided by contracting health care providers.

Manage and Resolve Provider Disputes

As part of maintaining the CMSP provider network, Contractor shall facilitate, manage and resolve provider payment disputes. Toward this end, Contractor shall work with the Governing Board and its designees to provide such information as needed for Contractor and Governing Board and its designees to evaluate and resolve all such disputes.

Contract Requirements

The "form" provider participation contract for all provider types (hospital, physician, medical group, community health center or clinic, ancillary) has been developed by the Governing Board, and the Contractor shall utilize this form contract as a part of facilitating execution of future provider contracts on behalf of the Governing Board. This form provider participation contract includes the following requirements:

1. CMSP enrollees shall be seen and scheduled for services on a similar basis to Medi-Cal beneficiaries.

2. If a CMSP enrollee has other health coverage, CMSP coverage shall be the payer of last resort.

3. Providers shall not balance bill CMSP enrollees but shall accept CMSP payment as payment in full. The only exception to this requirement is those instances where a SOC applies and the CMSP enrollee is required to pay a SOC each month prior to CMSP coverage taking effect.

4. Contractor shall establish and all contracting health care providers shall comply with requirements regarding submission of complete and accurate claims and applicable utilization management/prior authorization requirements, which shall at a minimum be outlined in the provider contract and described in the provider manual.

5. Contractor shall require and hospital providers shall comply with Contractor's prior approval process before admitting CMSP enrollees for inpatient hospital services, including notification to Contractor within 24 hours of the delivery of emergency services to a CMSP enrollee.

6. Contractor shall require and all providers shall accept a requirement to repay CMSP all amounts paid to provider for services to CMSP enrollees that are determined retroactively eligible for Medi-Cal for a period in which the provider received payment from the Contractor for CMSP-covered services. Contractor shall refund amounts paid to providers in these circumstances to the Governing Board.

Provider Network Documentation

Contractor shall develop a published written listing of all CMSP contracting health care providers by county, type, and specialty. This listing shall also be provided in electronic form to the

Governing Board. This published listing shall be updated monthly and posted on Contractor's designated website location for CMSP. Prior to its first publication, the Governing Board shall approve the listing of contracting providers.

Contractor shall develop and distribute communication materials to all contracting providers describing the CMSP program, the Connect to Care program, and the new Third Party Administrator structure for authorizing services, management of benefits and payment of claims. These materials shall be updated as needed and distributed to participating providers. These materials shall be submitted to the Governing Board for review and approval prior to distribution.

4. Service Administration

CMSP Benefit Program - Covered Health Care Services

A wide range of inpatient and outpatient health care services are covered by CMSP. In general, the CMSP benefit package parallels the Medi-Cal service package, although CMSP has different limitations and exclusions for some services. The Contractor shall be responsible for reimbursing contracted participating providers for the following services:

- Acute inpatient hospital care (including acute inpatient rehabilitation and mental health)
- Adult Day Health Care
- Audiology services
- Blood and blood derivatives
- Chiropractic care
- Chronic hemodialysis services
- Dental services (including diagnostic and preventative care, oral surgery and selected endodontic, restorative and prosthodontic services)
- Durable medical equipment
- Emergency ambulance services and medically necessary transportation from the acute hospital to other facilities for medically necessary, specialized, or tertiary care
- Family planning services, including sterilization (when no other coverage, including F-PACT)
- Home Health Agency services
- Hospital outpatient and outpatient clinic services
- Infusion therapy
- Inpatient and outpatient heroin detoxification services (excluding methadone maintenance)
- Laboratory and radiology services
- Medical supplies dispensed by physicians, licensed pharmacies, or durable medical equipment dealers and prosthetic or orthotic providers
- Mental Health services
- Non-emergency medical transportation when medically necessary
- Outpatient occupational therapy services
- Outpatient physical therapy services
- Outpatient rehabilitation services in a rehabilitation facility
- Outpatient speech pathology services

- Physician services
- Podiatry services
- Prosthetic and orthotic appliances
- Psychiatric services provided by a licensed psychiatrist
- Transplants
- Vision services

In addition, the Contractor shall be responsible for reimbursing nonparticipating providers for emergency and stabilization services rendered in California and designated border state areas. Contractor shall issue enrollee ID cards, which shall state that nonparticipating providers must notify the Contractor of the delivery of emergency services to a CMSP enrollee within 24 hours for assurance of payment.

CMSP does not cover certain types of services. Specific services that are not covered by CMSP include:

- Acupuncture, including podiatry-related acupuncture services
- Breast and cervical cancer treatment services when covered by other coverage (Breast and Cervical Cancer Treatment Program/Medi-Cal)
- Contact lenses that are not medically necessary
- Cosmetic procedures
- Family planning services when covered by another coverage (F-PACT)
- Long-term care
- Methadone maintenance services
- Services provided by non-contracting providers, except providers of emergency services
- Public transportation, such as airplane, bus, car or taxi rides
- Pregnancy-related and infertility services
- Sexual reassignment surgery
- Skilled nursing facility services

Connect to Care Program Benefit – Covered Health Care Services

A broad range of primary and preventive health care services are covered by Connect to Care. The Contractor shall be responsible for reimbursing contracted participating providers for the following services:

- Adult immunizations
- In-office minor medical procedures
- Mental Health services
- Office visit with primary care provider or specialist
- Preventive screenings
- Routine lab tests
- Screening for depression, alcohol misuse, obesity counseling
- Screening for HIV, HPV, Hepatitis B/C, and STI screening

- Tobacco use counseling and intervention (performed by a physician)

Pharmacy Benefit Services

MedImpact Healthcare Systems, Inc. (MedImpact) administers the CMSP and Connect to Care prescription drug benefit, including enrollee eligibility verification, provision of a retail pharmacy network, claims processing, prescription drug pricing, cost containment programs, and accounting services. In the event the Contractor requires access to prescription utilization information to support its care coordination, the Contractor will be expected to execute a separate agreement with MedImpact for purposes of accessing this information.

Medical Policy and Medical Director

The Contractor shall provide or arrange for all medically necessary covered services for CMSP and Connect to Care enrollees. For purposes of this contract, the term "medically necessary" will include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. The Contractor shall develop appropriate medical policy and utilization management controls for the management of CMSP services. Utilization management responsibilities are discussed in greater detail in Section 6 below. The Contractor shall develop or provide a detailed medical policy which defines the services subject to prior authorization and pre-admission review. Contractor shall utilize Milliman Practice Guidelines or a similar health insurance industry standard set of guidelines to carry out prior authorization and utilization management responsibilities.

Contractor's medical policy, utilization management controls system, and structure and process for decision-making shall be overseen by a designated Medical Director, who may serve as an employee of Contractor or under subcontract. As needed, Contractor's Medical Director shall assist and advise the Governing Board concerning all issues involving Medical Policy, including but not limited to benefit coverage matters and emerging technologies or treatments.

Payment System

The Contractor shall administer the CMSP and Connect to Care benefit packages as determined by the Governing Board. These benefit packages may change from time to time. The Contractor shall be able to administer any benefit structure developed by the Governing Board. The Governing Board shall consult with the Contractor regarding the benefit structure but has the unilateral right to modify the benefit structure (e.g., covered services, application of service limitations, and imposition of copayments). The Contractor shall be able to implement changes to the program within 60 calendar days of notification by Governing Board.

As referenced elsewhere, certain CMSP enrollees have a SOC that they must meet before benefits are payable through CMSP. The Contractor shall develop or demonstrate a system/process for administering Share of Cost consistent with the requirements of the Medi-Cal program.

The Contractor shall provide a process by which appeals of benefit decisions by contracting providers and CMSP or CTC enrollees (or his/her designee) are acted upon immediately and resolved. This system shall be compatible with and be completed prior to the Medical Benefit Hearing process conducted by the Governing Board

The Governing Board shall have final approval of the contracting provider and CMSP or CTC enrollee appeal process.

5. Claims Payment

Claims processing is a central feature of the scope of the Third Party Administrator responsibilities. The Contractor shall process claims received from providers and determine whether such claims qualify for reimbursement in accordance with the CMSP and Connect to Care benefit packages, enrollee eligibility, and sources of other primary payer liability, and determine the payment applicable to them. The Contractor shall process claims within the time frames established by applicable state and federal law and the contract with the Governing Board.

The Contractor will be responsible for all claims for services on and after March 1, 2026, excluding pharmacy claims that are the responsibility of MedImpact, the Governing Board's Pharmacy Benefit Manager. The Contractor will not be responsible for claims for services before March 1, 2026, except for potential processing of certain "run-out" claims submitted for services delivered to CMSP enrollees between March 1, 2025 through February 28, 2026. However, to the extent that services beyond this period are required, Governing Board and Contractor will work together to come to an agreeable arrangement regarding Contractor's provision of these services. The Governing Board shall notify Contractor of the estimated claims volume of such "run-out" claims by June 15, 2026. Upon termination of this contract, Contractor shall be obligated to process only those claims which are for services provided before the termination date and which are received by the Contractor within 180 calendar days following the termination date.

Basic Requirements

The Contractor shall have a claims processing system capable of accepting claims submitted on standard provider claim forms and through electronic mechanisms (computer media claims). The Contractor shall have electronic billing capability that is compliant with the Health Insurance Portability and Accountability Act of 1996 and its enacted implementing regulations. The claims processing system shall ensure timely reimbursement of contracting and non-contracting health care service providers that render services to eligible CMSP or CTC enrollees.

Except in specified circumstances (e.g., applicable SOC), the Contractor and its affiliates and subcontractors shall not submit a claim or collect reimbursement from a CMSP or CTC enrollee for the balance of any claim paid for a covered service.

Both contracting and non-contracting health care service providers shall be given an opportunity to challenge and resolve denied or modified claims through a fair and systematic provider appeal process.

The Contractor shall maintain procedures for prepayment and post-payment claims review, including review of data related to provider, enrollee, and covered services for which payment is claimed. The Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable state and federal law, regulations and contract requirements; verify the billing provider is a qualifying contracted provider; screen for claims accuracy, medical necessity, duplicate billing, and potential fraud; determine the status of received claims; and calculate the estimate for incurred but not unreported claims.

The Contractor shall adjudicate claims prior to payment to verify the billed service is valid. Verification must be done in accordance with all required policies and procedures. To verify that a service billed is valid the Contractor must determine that a service provided is:

- A covered service under the CMSP benefit package or Connect to Care benefit package;
- Authorized in advanced, if required;
- Consistent with the diagnosis reported, or the age and/or gender of the enrollee;
- Not a duplicate of a service previously paid;
- Performed in a selective place of service that is allowed for the procedure;
- Not in excess of approved service limits, if applicable;
- Properly identified by modifiers for multiple or bilateral procedure billings;
- Supported by documentation, such as invoices and medical records, when required;
- The net payment calculated reflects the appropriate fee and is net of any known other primary insurance coverage and CMSP Share of Cost obligation.

The Contractor must pay ninety percent (90%) of clean CMSP and Connect to Care claims within 30 calendar days and ninety-nine percent (99%) of clean claims within 60 calendar days.

The Contractor shall correct and verify all claims errors and related data and reports prior to reimbursing providers. Errors in adjudication discovered at a later date but within two (2) years after the provider was reimbursed will be corrected by and at the Contractor's expense within thirty (30) business days of receipt of written notification.

The Contractor must have the ability to:

- Issue resubmission advice when claim errors or omissions can be corrected only through changed or additional data from the billing provider. The resubmission advice must supply the health care provider with all necessary information to research the original claim and

resolve the errors cited. If the provider fails to respond within sixty (60) calendar days, the claims shall be denied.

- Respond to claims inquiries from providers.
- Identify providers who are restricted or have billed a restricted item.
- Update and review all pricing tables and diagnosis files; and
- Ensure all medical policy is consistently applied to all claims.
- The Contractor must provide electronic Claims information on a run-batch basis. The data must be transferred from the TPA to CMSP securely using Secure File Transfer Protocol (SFTP) or similar. The claims information must follow the industry-standard HIPAA 5010-compliant 837 claims file format.
- Additionally, CMSP will securely send a daily EVCOI file which is created by the California Department of Health Services. This file contains Share of Costs information on the CMSP benefit program. The TPA will use the EVCOI file to validate the Share of Cost calculations used in claims. See Attachment B for EVCOI file layout.

Emergency Services

The CMSP Benefit Program provides payment of medically necessary emergency services received by a CMSP enrollee from a non-contracting provider until the time that enrollee's condition has stabilized sufficiently to permit discharge or referral and transfer. The Contractor shall ensure timely emergency claims processing and reimbursement for contracting and non-contracting providers. A notice shall be included on enrollee identification cards requesting that non-network hospitals must notify Contractor within 24 hours of the delivery of emergency services. At a minimum, Contractor must reimburse a non-contracting emergency department, hospital, and, where applicable, physician providers, in accordance with the Governing Board's Rates for Health Care Services Policy (available at https://cmspcounties.org/wp-content/uploads/2025/04/Rates-for-Health-Care-Services-Policy_Effective-January-2024.pdf).

Coordination of Benefits

The Governing Board is the payer of last resort and recognizes other private and public health coverage as the primary carrier. The Contractor shall require contracting providers to bill and recover directly from all other carriers before billing the CMSP Benefit Program for reimbursement for services to eligible enrollees.

The Contractor shall ensure that all reasonable measures are taken to identify liable third parties and that claims submitted for services rendered to enrollees identified having other health insurance are cost-avoided. Third-party liability includes:

- Identify other sources of health insurance held by CMSP or CTC enrollees;

- Assure that Medicare, Medi-Cal, and all other forms of health insurance are used before reimbursement;
- Recover expenditures from all other health insurance sources;
- Recover expenditures in certain tort liability cases;
- Retroactive Medi-Cal coverage granted to CMSP enrollees;
- Recover expenditures from providers in the case of overpayment; and
- Ensure CMSP SOC enrollees have met their financial obligation in the month of any CMSP reimbursed service.

Specific types of claims should receive enhanced review for potential third-party billing, including, but not limited to:

- Claims with trauma related procedure and/or diagnosis codes (to be identified by the Contractor and approved by CMSP);
- Claims with an indicator of an accident-related injury;
- Claims with an indicator of employment-related illness or injury; and
- Claims with payment by a third-party or indication by a provider of other coverage although eligibility records indicate no third-party resources.

Fraud and Abuse

The Contractor shall have a documented antifraud strategy to identify and reduce costs to the Governing Board, contracting providers, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

Certain provider claims may be placed in special review status due to potential fraud or abuse and medical review may be required.

The Contractor is required to report to the Governing Board potential abusers of the program, which may include contracting health care providers, other service providers, and CMSP and Connect to Care Benefit Program enrollees. Potential abusers may be identified through review of claims suspended for manual review or through referrals, complaints or inquiries received by the Contractor.

Banking Arrangements

Governing Board shall open and maintain one bank account and will maintain funds at appropriate levels mutually satisfactory to the parties to cover obligations of the Governing Board to fund

health care services to eligible CMSP and Connect to Care Benefit Program members. Governing Board shall be solely responsible for the adequate funding of the Program. Governing Board will authorize Contractor to process payments from this account. On or before the tenth (10th) of each month, Contractor shall 1) reconcile the account and submit the reconciliation report to the Governing Board; 2) provide in an electronic format paid claims data documenting payments made during the preceding month from the account; and 3) submit the check register that will tie to the paid claims data. All reports and electronic data will be in a form mutually agreed to by the Contractor and the Governing Board.

6. Utilization Management for CMSP Benefit Program

Basic Requirements

For the CMSP Benefit Program, Contractor shall provide a range of Utilization Management (UM) services, including prior authorization of inpatient medical services and specialty services, concurrent review of inpatient medical services, retrospective review of inpatient medical and specialty services, management of specialty referrals, discharge planning and care coordination services to enrollees leaving inpatient hospital care, coordination of medically necessary home and community-based services, and case management services.

The Contractor shall implement a UM program to ensure appropriate processes are used to review and approve the provision of selected medical care services. At a minimum, the utilization management program shall include the following components:

- Identification of the services and procedures that require utilization management;
- Established criteria for approving, modifying, or denying requested services based on medical necessity;
- A process for providers to obtain prior approval for services for which it is required, including referrals to specialists and prior authorization for inpatient hospital services;
- A process for communicating to providers the services and procedures that require utilization management and the specific procedures and timeframes necessary to obtain prior approval for these services;
- A case management/care coordination function to monitor the coordination of medically necessary services delivered within the provider network and help clients navigate the system in order to gain access to medically necessary services.
- High-dollar claim review process.

7. Quality Assurance

The Contractor shall have a quality assurance program in place and shall be accountable for the quality of all covered services provided under direct contract or subcontract. At a minimum this program shall include the following components:

- A process for monitoring the delivery of health care services under this contract to ensure that services delivered by contracting providers are medically necessary and are provided at a level of care that meets professionally recognized standards of practice;

- Mechanisms to review, evaluate, and improve access to and availability of services, including monitoring methods and approaches to ensure that enrollees are able to obtain appointments within reasonable timeframes for all covered services;

- Policies to ensure that contracting providers maintain complete and up-to-date medical records for each enrollee and that records are available to each health care practitioner who is responsible to provide care to the enrollee;

- A complaint/grievance process for enrollees and providers to express dissatisfaction with services received from the Contractor or appeal the denial, deferral, or modification of requests for services that require prior authorization. This process shall ensure timely resolution and feedback to complainant. The Contractor shall participate in the Governing Board's Medical Benefit Hearing process as necessary;

- Policies to ensure that the credentials of network providers (including nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants) have been verified in accordance with state requirements. Note that for purposes of this contract, providers who have been accepted by the Medi-Cal program will be considered to be credentialed; the Contractor shall verify that the provider is currently in good standing with the Medi-Cal program and licensed to practice in the State of California;

- Policies and mechanisms to ensure the confidentiality of health care information and compliance with all applicable privacy laws, including HIPAA and CMIA. Contractor shall also ensure that enrollee’s rights to the confidentiality of their medical information are fully protected;

- Mechanisms to assure compliance with program policies and take appropriate actions to address apparent or potential abuses.

8. Customer Service

Customer Service Unit

The Contractor shall provide a high-quality customer service unit to respond to inquiries from CMSP and Connect to Care enrollees and contracting health care providers. Contractor staff shall be fully trained in the CMSP and Connect to Care benefit designs, and the Contractor shall have

the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type. The Contractor shall furnish to the Governing Board copies of this performance report on a quarterly basis.

The Contractor shall maintain a toll-free telephone line to provide prompt access for CMSP and Connect to Care enrollees and health care providers to qualified customer service personnel in both English and Spanish languages. At a minimum, customer service shall be available between the hours of 8:00 a.m. and 5:00 p.m. (PST) Monday through Friday.

The Contractor will meet the following quality measures for the customer service telephone lines:

1. No more than 5% of calls receive a busy signal

2. Weekly abandonment rate shall be no more than 5%

3. Weekly average wait or hold time shall not exceed sixty (60) seconds

4. All calls must be answered within three (3) rings

The Contractor shall provide access to oral interpretive services for languages other than English and Spanish on an as-needed basis. These requirements will extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the Contractor and providers. Oral interpretative services shall be provided free of charge to enrollees and potential enrollees. The Contractor shall also have a telecommunication device for the deaf (TDD) services available and provide appropriate methods for communicating with visually- and hearing-impaired enrollees and accommodating the physically disabled.

Enrollee Program Guides, Website Presence and Identification Cards

The Contractor shall supply a printed “CMSP Member Program Guide” to all CMSP enrollees and a “CTC Member Program Guide” to all CTC enrollees within ten (10) working days of receipt by the Contractor of the enrollment from the Governing Board. In addition, the Program Guide shall either provide a listing of contracting providers by county along with necessary contact information or provide a designated website location specifically designed to provides this information**.** The program guide will include a Notice of Privacy Practices approved by CMSP.

The initial CMSP and Connect to Care Member Program Guides developed for distribution for the Contractor’s first service year and all subsequent updates shall be reviewed and approved by the Governing Board or its designee at least thirty (30) calendar days prior to distribution to enrollees. The Contractor shall bear all costs relating to the printing and shipping of the Program Guides. The Program Guides shall be updated periodically as needed.

The Contractor shall provide all enrollees of the CMSP and Connect to Care Benefit Programs with program specific benefit identification (ID) cards in a form acceptable to the Governing Board or its designee. This benefit ID cards shall be mailed to CMSP and Connect to Care enrollees within ten (10) working days of receipt by the Contractor of the enrollment or status change notice from the

Governing Board. In addition, the Contractor shall mail the most current CMSP Program Guide in effect to new CMSP enrollees with the CMSP benefit ID card; and, the Contractor shall mail a copy of the most current Connect to Care Program Guide to Connect to Care enrollees within three (3) working days of the enrollee's written or verbal request to the Contractor.

The Contractor shall establish a designated website(s) location for CMSP and Connect to Care, which may either be separate website(s) or subsections of a company website that is easy to find and access for necessary program, provider network, and related information. On this website location, the Contractor shall provide a comprehensive listing of hospitals, primary care providers, specialty care providers and ancillary providers. This listing shall be reviewed for accuracy on a regular basis, and Contractor shall recommend a standard for such updates. The website shall also provide information on covered benefits, Customer Service Contacts, and necessary information for contracting providers, including but not limited to utilization management requirements. The contractor shall establish a quarterly review process of the website(s) to ensure that all links are working as well as all information is up to date.

Provider Manuals

The Contractor shall develop, distribute, and maintain a CMSP and Connect to Care Provider Manual containing the relevant policies and procedures, including a definition and description of all procedures used in the billing and processing of claims, and ensure that each provider (individual or group which submits claim and encounter data) is issued a copy of the provider manual. Contractor shall also assure that all contracting providers have access to a current provider listing. The Provider Manual and the current provider listing must be provided electronically (via PDF) on the designated website(s) and may also be provided via hard copy.

The Contractor shall have staff accessible via a toll-free phone line, operated at least from 8:00 a.m. to 5:00 p.m. PST, to be responsible for at least the following:

- Answering general provider questions (e.g., mailing information);
- Assisting providers with questions concerning enrollee eligibility status;
- Assisting providers with questions regarding claims status and checkwrite status;
- Providing information on covered services and the fee schedule;
- Assisting providers with utilization management procedures;
- Assisting providers with claims payment procedures; and
- Handling provider complaints.

9. Interface with Pharmacy Benefits

MedImpact, the Governing Board's contracted pharmacy benefits manager, administers prescription drug benefits for the CMSP and Connect to Care Benefit Programs. As approved by the Governing Board, these benefits emphasize the use of generic medications, where available and appropriate, and require prior authorization and other utilization controls for selected medications based upon clinical efficacy, medical necessity and cost. The Contractor shall incorporate references to MedImpact's role in administration of the CMSP and Connect to Care prescription drug benefits in all areas where it is germane, including but not limited to benefit ID cards, the Member Program Guides, the Provider Manual, and associated materials.

10. Implementation

The Contractor shall provide a "high-level" written implementation plan and timetable with its proposal. Within fifteen (15) calendar days of contract award, the Contractor shall provide the Governing Board a proposed final implementation plan and timetable.

The proposed implementation plan shall set forth the steps and milestones for developing capabilities addressing all aspects of the scope of work, including but not limited to:

- Review of template provider contracts;
- Determination of provider network adequacy, identification of deficiencies, and plan for development of strengthened provider network;
- Testing of provider enrollment;
- Testing of CMSP and Connect to Care eligibility files;
- Acceptable date for final CMSP and Connect to Care eligibility files;
- Testing of claims processing capabilities;
- Documentation of all Medical Policies, including utilization management and prior authorization procedures for the CMSP Benefit Program;
- Development of Provider Manual;
- ID card production and distribution;
- Training and reference materials for customer service staff;
- Development of Member Program Guides; and
- Finalization of prior authorization list.

11. Account Management

The Contractor shall establish and maintain throughout the term of the contract an Account Management team lead by an Account Manager that will work directly with Governing Board staff. This Manager shall be responsible for addressing issues pertaining but not limited to: customer service, management information reporting and information systems, claims payment, and enrollee and provider appeals and complaints. The Governing Board shall approve the Account Manager and any changes thereto.

The Contractor's Account Manager shall, at a minimum, attend all Governing Board meetings (6 – 10 per year) to discuss the status of the account, the Contractor's performance, including the Contractor's administration of the program and associated reporting. Additionally, the Contractor's Account Manager shall make periodic presentations to the Governing Board, as requested by the Governing Board. Finally, the Account Manager will have weekly conference calls with CMSP staff to ensure timely communication and a collegial, constructive working relationship.

12. Reporting

The Contractor shall submit standard reports to the Governing Board on a monthly, quarterly, and annual basis. A copy of the Contractor's proposed reporting package shall be included with the response to the RFP. The Governing Board and the Contractor shall finalize the format and content of reports upon award of this contract, but they will likely include:

- Monthly claims reports, including claims detail reports, claims aging history reports, and override activities of specific edits or audits.
- Monthly check register and bank reconciliation report.
- Monthly report on stale checks / escheatment.
- Monthly report on Accounts Receivable, Clips, Repays.
- Monthly reconciliation between claims and the check register.
- Annual report of 1099s submitted by Contractor on behalf of the Governing Board.
- Monthly financial reports on cost-avoidance and third-party recovery activities.
- Ongoing trend analysis charts identifying frequency of errors for the previous month's reporting period plus a cumulative analysis of errors from the beginning of operations.
- Monthly claims payment summary reports, including the percent of uncontested claims that are paid or denied within 30 calendar days of receipt and the percent of uncontested claims that are paid or denied within 60 calendar days of receipt.

- Monthly summary of high-cost claims, showing diagnostic and procedure codes, total allowable charges, and total paid claims for each enrollee for whom paid claims exceeds $25,000.

- Quarterly utilization reports summarizing inpatient utilization, emergency room visits, and outpatient utilization (format to be approved by the Governing Board).

- Quarterly utilization management reports, summarizing the number of prior approval requests made, approved, and denied by type of service.

- Quarterly reports on the size and composition of the provider network. In addition, the Contractor must notify the Governing Board promptly of any changes to the composition of its provider network that materially affect the Contractor's ability to deliver all services in a timely manner.

- Quarterly summaries of appeals and complaints filed by enrollees and providers, sorted by county, and including, but not limited to, complaints about waiting time for appointments, timely assignments to a provider, difficulty with accessing specialists, and grievances pertaining to the administration and delivery of medical services and benefits.

- Quarterly reports on customer service responsiveness, including telephone response time, call abandonment rate, and the number of inquiries made by type.

- Annual accuracy review reports which will test both automated and manual systems to ensure within a ninety-five (95%) level of confidence that the edits and audits chosen are processing claims according to policy.

- Monthly reports on HIPAA Requests for Access made by enrollees.

- Monthly reports on subpoena requests.

- Provide periodic presentations concerning the program to the Governing Board as requested.

At the request of the Governing Board, the Contractor shall submit up to three (3) additional ad hoc reports on information and data readily available to the Contractor each service year.

13. Financial Requirements

The Contractor shall provide the Governing Board with audited financial statements, other required regulatory reports (i.e., SSA16, 10Q) on a quarterly and annual basis, unaudited financial statements on a quarterly basis, and such financial information that the Governing Board reasonably requests on an ongoing basis so that the Governing Board is assured of the Contractor's financial abilities to perform under the terms of the contract.

The Governing Board may inspect and audit all claim data and billing records related to the payment for health care services to CMSP and Connect to Care Benefit Program enrollees, the Contractor's financial performance and any other provision of the Contractor's services under the terms of the contract on a quarterly basis. In addition, the Contractor shall provide the Governing Board with copies of all audits conducted with regard to any provision of services conducted under the contract and with regard to Contractor's financial performance within ten (10) working days of such audit. The Contractor shall commission an independent audit of claims payment accuracy following the end of Service Year 2.

14. Optional Services

Contractor may offer additional services not specifically required by this RFP including but not limited to:

- Extended customer service hours
- 24/7 nurse advice line
- Disease management and/or care management
- Other services the Contractor recommends are appropriate for overall health coverage delivery

The Governing Board may consider the value of any such services in evaluating the Contractor’s response to the RFP.

15. General Service Requirements

The Contractor shall follow all applicable rules and regulations governing CMSP. The regulations governing CMSP can be found on the Governing Board’s website at: https://www.cmspcounties.org/regulations/.

The Contractor shall agree that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by the Governing Board to necessitate a change in the contract shall be incorporated into the contract. The Governing Board will review any request for additional compensation resulting from such changes and retains final authority to make any changes.

The Contractor shall agree that during the life of the contract or any extension thereof, the Governing Board and auditors designated by the Governing Board shall have access to and the right to examine any pertinent books, documents, papers, or records of the Contractor involving any and all transactions related to the performance of the contract. Also, the Contractor shall furnish all information necessary for the Governing Board to comply with all state and/or federal regulations.

The Contractor shall agree that the Governing Board reserves the right to review and approve in advance of use all written communications and marketing materials developed and used by the Contractor to communicate specifically with CMSP and Connect to Care Benefit Program enrollees, health care providers and the public at any time during the contract period.

Contractor shall comply with all state and federal laws and regulations, including but not limited to the federal Health Insurance Portability and Accountability Act (HIPAA).

16. CMSP Requirements and Services

The Governing Board or its designees shall provide the following administrative services to assist the Contractor:

- Certification of CMSP and Connect to Care eligibility;
- CMSP and Connect to Care enrollment (new, change, and terminations) in an electronic format;
- Maintenance of individual CMSP and Connect to Care eligibility and enrollee data; and
- Payment of monies due the Contractor for payment of health care provider claims and Contractor benefit administration.

III. PROPOSAL INFORMATION

1. Submission of Proposals

Each proposal must meet the following submission requirements:

- Be signed by a duly authorized representative of the bidder's organization;
- Contain all information required by the RFP;
- Include pricing as required;
- Include a complete response to the questionnaire, with answers provided in a separate section of the proposal and in the order in which the questions are presented;
- Be submitted electronically, as follows:

An electronic copy of the entire proposal must be submitted via email to akellen@cmspcounties.org no later than 3:00 P.M. PST on May 30, 2025.

Proposals shall be valid until September 30, 2025.

2. Clarification of Requirements

It is assumed that bidders have read the entire Request for Proposals prior to the submission of a signed proposal and a submission of a signed proposal indicates that the bidder meets all requirements. Unless otherwise noted, any and all questions regarding specifications, requirements, etc. shall be in writing and directed to the contact person indicated on the third page of this RFP.

All proposals become the property of the Governing Board and will not be returned, unless the Governing Board, in its sole discretion, determines otherwise.

Any costs incurred by the responding Contractor for developing a proposal are the sole responsibility of the responding Contractor and the Governing Board shall have no obligation to compensate any responding Contractor for any costs incurred in responding to this RFP. If the Governing Board should determine that interviews are necessary, interviews will be held at the Governing Board's offices and any costs associated with such interviews will be the responsibility of the responding Contractor.

There will be no public opening of submitted proposals and proposals may remain confidential until such time as determined by the Governing Board in its sole discretion. Thereafter, all information submitted by a responding Contractor may be treated as a public record by Governing Board. Governing Board makes no guarantee that any or all of a proposal will be kept confidential, even if the proposal is marked "confidential," "proprietary," etc. Any proposal submitted identifying the proposal as confidential shall be deemed nonresponsive and may disqualify the responding Contractor.

The Governing Board reserves the right to reject any and all proposals and to terminate the RFP process at any time if deemed by the Governing Board to be in its best interests. The Governing Board reserves the right not to award a contract pursuant to this RFP.

3. Evaluation Process

Any clerical error, apparent on its face, may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, the Governing Board shall contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

Any pricing information submitted by a bidder shall be disclosed on the pricing pages as designated in this RFP. Any pricing information which appears elsewhere in the bidder's proposal shall not be considered by the Governing Board.

The Governing Board, within its sole and absolute discretion, shall evaluate all offers and may reject any or all offers. The Governing Board reserves the right to reject and not consider any proposal that is not competitive, is non-responsive, does not meet the requirements of this RFP or

are otherwise lacking in one or more categories, including but not necessarily limited to incomplete proposals and/or proposals offering alternate or non-requested services.

The bidder is advised that under the provisions of this Request for Proposals, the Governing Board may conduct negotiations of the proposals received or may award a contract without negotiations.

The Governing Board may request written clarification of any portion of the bidder's response in order to verify the intent of the bidder.

After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the technical proposal shall be evaluated in accordance with the following criteria:

- Overall quality of the proposal submitted
- Proposed approach to scope of work
- Cost and value to the Governing Board
- Network
- Implementation and account management
- Customer service
- Clinical programs and quality assurance
- Utilization management
- Claims administration
- Performance standards
- Experience, knowledge, capability and competence of the bidder and the individuals identified to work on the matter
- Ability to be responsive to the Governing Board's needs for services
- Responses from references
- Interviews, if conducted

A technical question and answer conference or interview may be conducted, if deemed necessary by the Governing Board, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. The Governing Board may interview the account management team and implementation team.

Following this process, the financial score of each bidder will be evaluated against the strength of the technical proposal to evaluate the anticipated impact on overall CMSP program costs.

The proposal of the successful bidder, with any corrections or modifications accepted by the Governing Board, shall become part of the contract upon contract execution.

4. Contract Award

Any award of a contract resulting from this RFP will be made only by written authorization from the Governing Board.

The Governing Board, within its sole discretion, may:

- Accept other than the lowest priced offer;
- Reject any and all proposals that are determined to not be responsive to this request;
- Waive or correct any minor or inadvertent defect, irregularity or technical error in any proposal;
- Request that certain or all responding Contractors supplement or modify all or certain aspects of their respective proposals or other materials submitted;
- Procure any services specified in this RFP by other means;
- Modify the specifications or requirements for services in this RFP, or the required contents or format of the proposals prior to the due date.
- Extend the deadlines specified in this RFP, including the deadline for accepting proposals;
- Negotiate with any, all, or none of the responding Contractors;
- Terminate negotiations with a responding Contractor without liability, and negotiate with other responding Contractors; and
- Award a Contract to any Contractor, including a Contractor other than the Contractor offering the lowest price.

5. Pricing

The instructions provided below for preparing price proposals includes a mandatory pricing schedule, which all bidders must complete. However, in the interest of achieving the pricing method deemed most advantageous to the Governing Board, the Governing Board reserves the right to accept alternative pricing schedules as well, and negotiate on the basis of a pricing design proposed by a bidder or jointly developed by the Governing Board and a bidder. Any pricing structure proposed must be administratively feasible for CMSP, and any Contractor-provided data necessary for implementation of the proposed pricing method must be auditable by CMSP.

The Governing Board intends to reimburse for reasonable start-up costs associated with the period from the effective date of the contract, currently anticipated to be September 1, 2025 through February 28, 2026. The price bids in Exhibit A must include any proposed start-up costs and how these costs shall be reimbursed over the first Service Year.

Payment reconciliation procedures will be incorporated in the executed contract to adjust for errors due to incomplete or erroneous data used in the determination of any payments or financial penalties. The reconciliation procedures will depend upon the structure of the final pricing schedule incorporated and will be subject to negotiation prior to contract execution.

Instructions for Price Proposal Submission

1. For purposes of understanding the administrative fees proposed, please categorize the costs associated with start-up and ongoing administrative functions as set forth in Exhibit A. Please note that all start-up costs shall be distributed over the first Service Year only.

2. Reimbursement structure and price bids

   Bidders shall complete Exhibit A and provide a written description of their overall proposed pricing structure and fees. Bidders may propose an administrative cost that is charged and paid on a monthly basis; an administrative cost that is based on a Per Member Per Month (PMPM) basis tied to monthly enrollment; or a combination of these approaches. Bidders must provide sufficient detail and description to permit the evaluation of all proposed pricing structures and fees. Bidders must also separately break down fees charged for administration of the CMSP Benefit Program and the Connect to Care Benefit Program.

3. Termination without cause

   As stated in Section II.1, the Governing Board reserves the right to terminate the contract without cause with one hundred twenty (120) calendar days prior notice. The Governing Board will consider a negotiated settlement with the Contractor in the event of termination without cause to cover the administrative costs (less profit) for services associated with start-up functions not yet recovered during the first Service Year. Bidders may propose a method for determining actual administrative costs exclusively attributable to the start-up functions associated with the scope of work not yet recovered during the first Service Year as described in this RFP and a proposal to recover these costs.

6. Renewal and Termination of Contract

The term of the contract shall include a start-up period beginning September 1, 2025, and ending February 28, 2026, followed by an initial two-year term commencing March 1, 2026, and ending February 29, 2028. The Governing Board may, in its sole discretion, renew the agreement for up to three (3) additional one-year terms. The start-up period is anticipated to be six (6) months, with a start date for all services no later than March 1, 2026.

The Governing Board may terminate the contract without cause on one hundred twenty (120) calendar days prior written notice.

The Governing Board may also terminate the contract by giving written notice to the Contractor of material failure to perform any of its obligations under the terms of the contract or within the time and manner provided in the contract, or violation of any of the terms of the contract. The notice shall state the reasons for the termination.

This agreement is for the period of September 1, 2025 (the anticipated effective date of the contract), through February 28, 2026 (start-up), and March 1, 2026, through February 29, 2028 (operation).

IV. QUESTIONNAIRE

1. Background

1. Provide the following information:

    a. The full legal name of your organization;

    b. The address and telephone number of your corporate office and;

    c. The current ownership of the company, along with the name of any individual holding 10% or more of the stock or value of the organization, if applicable.

2. Provide a copy of a current Administrator's Certificate indicating that your organization is certified to adjust and settle health insurance claims in the State of California. If your organization does not currently have this certificate, please indicate the timeframe for obtaining one or provide evidence of alternate certification or licensure to process claims in the State of California.

3. Describe your plan for obtaining the required letter of credit, performance bond or comparable security, or combination of these instruments, to secure your performance under the contract.

4. Will any of the services provided under this contract be subcontracted to outside vendors? Describe the scope of work to be performed by such subcontractor with an accompanying overview description of Contractor's intended contractual relationship with, and plan for managing the performance of, such subcontractor. If you are unable to confirm that core TPA functions will not be subcontracted, describe which core functions you propose to subcontract and why such functions cannot be performed in-house. Describe the contracts, including services provided, duration of contract and oversight of quality of services provided to your clients. If more than 10 percent of the value of this contract is expected to be passed through to a subcontractor, please provide a copy of the subcontract or proposed subcontract including payment and performance terms.

For each proposed subcontractor, identify the key personnel and qualifications of the subcontractor. The description should include all information requested of your firm in the relevant sections of this RFP, to the extent relevant to the subcontractor.

Describe your firm's experience in working with proposed subcontractors. Identify other plans in which you provide TPA services and the proposed subcontractor performed the service that it will perform for the Governing Board.

5. Name all other public entities which the organization has had contracts during the past five years. If the organization does business outside of the State of California, you may restrict this list to public entities within the State of California, and the five largest contracts (as measured by covered lives or revenue) with public entities outside of the state.

6. Provide references (company name, contact names, titles, and phone numbers) for a. and/or b. below.

   a. One or more company or governmental entity with 5,000 or more covered enrollees that currently receives TPA services from your company. Indicate the time period during which initial TPA implementation occurred.

   b. Two or more companies or governmental entities with 2,000 or more covered enrollees that currently receives TPA services from your company. Indicate the time period during which initial TPA implementation occurred.

7. Provide a copy of the organization's standard health benefits administration contract.

8. Provide your audited year-end financial statements and SSAE 18 (e.g., SOC 1) report(s) for the most recent two years. Also provide any quarterly financial statements that have been issued since the most recent annual statements were issued, and indicate whether the quarterly statements have been reviewed by an independent auditor. If you are a subsidiary, please provide this information for your parent company.

9. If the bidder has a credit rating from an independent rating organization such as S&P or Moody's, please provide that rating, along with any narrative issued by the rating organization to describe, explain, or qualify the rating it assigned. (NOTE: This requirement does NOT refer to the insurer financial strength ratings issued by such organizations as S&P or A.M. Best).

10. Describe any past or pending litigation with contingent liability over $350,000 in judgments or settlements involving your firm's health benefit administration services.

2. Provider Network

11. Based on your assessment of current provider network adequacy, provide the number of primary care and specialty providers by type, clinics, and hospitals you propose for

contracting. Identify the number of those providers that you propose be recruited into the network. Provide separate totals for the following: 1) the 35 CMSP counties; 2) the twenty-three non-CMSP counties.

12. Describe your proposed approach for assessing network adequacy at the county level.

13. Describe your plan for executing CMSP contracts with the required providers (hospitals, FQHC, RHC, and THP providers, dental and vision providers) as referenced in Section 3, Network Development (page 10).

14. Describe your plan for soliciting the involvement of specialty care and ancillary care providers and steps you will take to assure timely and reliable access to the range of covered CMSP benefits in the 35 participating counties.

15. Describe the criteria you will use for selecting network providers. How often and what criteria do you use to re-evaluate existing providers?

16. Describe the hours of operation and functions of the provider services department. Describe the methods through which you communicate with contracting providers and answer provider inquiries.

17. Describe how providers will be informed about the requirements of the CMSP and CTC programs and provider participation in the programs, as set forth in the Provider Manual.

18. Describe your ability to manage multiple provider reimbursement levels.

19. Describe your experience contracting with safety net providers, such as FQHC, RHC, and THP providers, and county health and behavioral health programs.

20. Describe your proposed approach for handling health care treatment in process as of March 1, 2026. How do you propose to transition enrollees to continuing care arrangements? Over what time period do you propose to accomplish this transition?

21. Describe the process for processing claims associated with non-contracting providers and describe any potential problems you see with the processing of such claims.

22. Describe how you will monitor the provision of care to CMSP and Connect to Care Benefit Program enrollees and how you will assure necessary services are provided in a timely manner.

23. Describe your proposed accessibility standards (e.g., office waiting times, response to telephone calls, and waiting times for appointments) and how provider compliance with those standards is communicated, enforced, and monitored. Describe any special mechanisms to monitor and promote access in rural areas.

24. Describe how urgent and after-hours care is handled.

3. Service Administration/Claims Processing

25. Describe the claims payment system, including the handling of in-network and non-network claims that you propose to use for the TPA program. How long has the system been operational? Are in-network and non-network claims processed on the same system?

26. Define date of receipt (in mail room or processor) and date of processing for purposes of calculating claim turnaround time. What is the plan's standard for turnaround time to process a claim? What is your actual performance? Are you able to meet the clean claims processing expectations outlined in the Scope of Work?

27. Describe how you ensure that the claims processing system complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including electronic claims submission requirements, processing timeframes, and coding requirements.

28. Describe your internal audit, internal controls and quality review procedures. What is your goal for claims processing accuracy relative to 1) payment errors, 2) coding/procedural errors? What is your actual performance?

29. Describe your ability to implement service changes within 60 calendar days, and the circumstances or types of changes that cannot be implemented within that timeframe.

30. Describe your fraud prevention and detection procedures and describe your proposed process for bringing information on fraudulent activities to the attention of the Governing Board.

31. Describe the provider claim submission process. Describe the process used in responding to and resolving provider and enrollee (claims-related) inquiries and the process for reviewing and adjusting claims based on provider or enrollee appeals.

32. Discuss how you currently administer/would administer a Share of Cost requirement, consistent with that required for CMSP, including system capabilities to track Share of Cost requirements. Are you currently administering a Medi-Cal or Medicaid Share of Cost arrangement with any customer? If so, describe the process and/or system used.

33. Describe the process and criteria for adjudicating non-network emergency service claims.

34. Briefly discuss how you gather information concerning Coordination of Benefits (COB) and Third Party Liability (TPL) and your verification procedures for enrollee-provided information. Please provide a list of procedures or diagnoses that will be reviewed for potential third party liability.

35. Describe your system/process for recouping payments made on behalf of enrollees later deemed retroactively eligible for Medi-Cal. Will provider contracts be modified to ensure that providers will re-bill Medi-Cal?

36. Will you have a designated claims processing and customer service unit for CMSP and Connect to Care? If not, how will claims processing and customer service be handled?

37. If you anticipate difficulty achieving any of the claims processing requirements outlined in the scope of work, please describe the situations in which you may be unable to comply and propose an alternative standard.

38. Describe your proposed approach to maintaining the CMSP fee schedule for allowable procedure codes and rates of payment.

39. Describe your organization's capability of adjusting to additional benefit programs and/or larger than estimated enrollment which impacts claims volume.

4. Utilization Management and Quality Assurance

40. Describe the utilization management (UM) policies, procedures, criteria, and qualifications and anticipated number of staff (either employees of your company or subcontracted employees) that will be used to administer CMSP benefit coverage. Please describe each component of your UM program separately, including prior authorization, early notification of emergency inpatient admissions in out-of-network hospitals, concurrent review, discharge planning, specialty referrals, retrospective review and medical case management. Your description should include the following information:

    a. For which services and conditions do you propose to apply UM techniques?

    b. Explain your level of experience administering UM techniques.

    c. Will your management information systems be used to assist in administering UM program? If so, describe how your MIS will be utilized (e.g., claims review for past utilization history, eligibility linkages).

    d. If you anticipate developing new policies, please describe the process you will undertake to identify the new areas and to design procedures and criteria.

41. Describe the criteria you will use for defining medical necessity and approving, modifying, or denying requested services. Are the criteria insurance industry standard criteria (e.g., Milliman)? How often are the criteria reviewed/updated, and how are new technologies and procedures reviewed?

42. How will you communicate to providers about the procedures and services that require prior authorization and ensure that all providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services?

43. Describe any current working relationships you have with pharmacy benefit managers for existing clients. Describe how utilization management activities and analysis are coordinated with these organizations. Describe any information or reports you will seek from the Governing Board's Pharmacy Benefits Manager.

44. Describe your ability to use paid claims and/or authorization data to identify enrollees that may be potentially eligible for Supplemental Social Security Income, other disability coverage, or have passed away.

45. Describe your standards for appointment scheduling timeliness and after-hours access. If your current lines of business do not apply standards in these areas, describe your proposed standards for this Scope of Work.

46. Describe your mechanism for ongoing review, evaluation, and improvement in access and availability of services.

47. Describe your policies for ensuring confidentiality of health care information as required under HIPAA.

5. Customer Service and Eligibility Processing

48. Describe the following:

    a. Days and hours of operation for the toll-free number(s);

    b. Whether the number(s) will be dedicated to the Governing Board's account or share with other accounts;

    c. Location(s) of call center;

    d. Whether customer service staff will be dedicated to the Governing Board's account or shared with other accounts;

    e. What languages are spoken (or can be accessed) by customer service staff; and

    f. How you segment calls (e.g., routing of inquiries about claims, requests to identify participating providers, generalized enrollee services questions).

49. Describe how customer service staff will be trained about the requirements of the CMSP and Connect to Care Benefit Programs.

50. Describe the information about network providers you will be able to provide a caller upon request (e.g., office hours, foreign languages spoken, etc.).

51. Describe how calls received after hours are handled. Is there an interactive voice response system available after hours? If so, list the information the system can provide.

52. Describe your company's Internet site and how that site, or a new site(s) developed for CMSP and Connect to Care and linked to that site, will be developed and utilized to provide information to enrollees, contracting and non-contracting health care providers, stakeholders and the public.

53. Describe your ability to prepare, print and distribute enrollee ID cards and the Member Program Guides for CMSP and Connect to Care.

54. Describe the process for enrollees and providers to file a complaint or request an appeal. Please describe how your process will interact with the Medical Benefit Hearing process.

55. The Governing Board is interested in how you assess provider and enrollee satisfaction including claims payment services, issues relating to the network and enrollee services. Provide a copy of the latest customer satisfaction survey your company has conducted and respond to the following:

    a. How was the survey instrument developed?

    b. Describe the items you survey.

    c. Do you use an independent outside party to conduct the survey?

    d. Are survey results released to the public?

    e. How are respondents to the survey selected?

56. Discuss your ability to accept, translate and upload the CMSP eligibility file (Attachment A) and EVCOI file (Attachment B) electronically into your system. Please identify any potential problems you may have with accepting these files and any proposed modifications you identify as essential.

57. Indicate whether you currently have an agreement with the California Department of Health Care Services (DHCS) to access Medi-Cal and CMSP eligibility information via the Medi-Cal Provider Portal.

58. Discuss your ability to accept the Connect to Care eligibility file electronically in a HIPAA 5010-compliant 834 file format. Please identify any potential problems you may have with accepting this file and any proposed modifications you identify as essential.

6. Implementation and Account Management

59. Provide a proposed implementation plan that includes both a high-level overview and details on specific tasks, timelines and responsibilities as described in the Scope of Work. Clearly delineate the tasks you expect the Governing Board to perform and any information you expect the Governing Board to provide. Note: A final implementation

plan, in consultation with the Governing Board, shall be developed and agreed to within 15 calendar days of contract award.

60. Provide the name, brief biographical statement, length of time with the organization and experience of the person with overall responsibility for the implementation and for the key support staff that will have major roles in the implementation process.

61. Provide the name, brief biographical statement, length of time with the organization and experience of the person with overall responsibility for management of the CMSP Account.

62. Describe the processes for ensuring regular communication between the Account Manager and Governing Board, and the Account Manager and Governing Board staff.

63. Describe your disaster recovery protocols, procedures and back-up systems. Are claim files and microfilm files stored off site? Can you rapidly shift phone service to another location if needed? What is the projected time required for full restoration of services to clients?

64. Describe your ability to comply with the invoicing requirements described in the Scope of Work. Will you submit invoices on a biweekly or monthly basis? What reports will be submitted to verify the provision of services? Will you be able to submit documentation electronically to CMSP?

65. Describe the process and controls in place between the claims and check writing system including check runs and tracking outstanding, stale and void checks as well as depositing refunds and applying them to patient accounts.

7. Reporting

66. The Governing Board will require monthly claims data and other periodic reporting. Please provide the following:

    a. The format and medium you will use to provide monthly claims data;

    b. Data elements and their descriptions, available for customized information exports; and

    c. Any interactive reporting capabilities that would be available to the Governing Board.

67. Describe your ability to customize financial reports.

68. Describe your ability to provide the following reports. Indicate the data fields that could be incorporated in the report and the time lag between the end of the period and the

date the report can be submitted. If possible, provide a copy of a similar report (or report layout) provided to another TPA client.

- Monthly claims reports, including claims detail reports, claims aging history reports, and override activities of specific edits or audits.
- Monthly check register and bank reconciliation report.
- Monthly report on stale checks / escheatment.
- Monthly report on Accounts Receivable, Clips, Repays.
- Monthly reconciliation between claims and the check register.
- Annual report of 1099s submitted by Contractor on behalf of the Governing Board.
- Monthly financial reports on cost-avoidance and third-party recovery activities.
- Monthly reports on recoveries and outstanding accounts receivable.
- Ongoing trend analysis charts identifying frequency of errors for the previous month's reporting period plus a cumulative analysis of errors from the beginning of operations.
- Monthly claims payment summary reports, including the percent of uncontested claims that are paid or denied within 30 calendar days of receipt and the percent of uncontested claims that are paid or denied within 60 calendar days of receipt.
- Quarterly utilization reports summarizing inpatient utilization, emergency room visits, and outpatient utilization (format to be approved by the Governing Board).
- Quarterly utilization management reports, summarizing the number of prior approval requests made, approved, and denied by type of service.
- Quarterly reports on the size and composition of the provider network. NOTE: The Contractor must notify the Governing Board promptly of any changes to the composition of its provider network that materially affect enrollee's ability to access services in a timely manner.
- Quarterly summaries of complaints filed by enrollees and providers, sorted by county, and including, but not limited to, complaints about waiting time for appointments, timely assignments to a provider, difficulty with accessing specialists, and complaints pertaining to the administration and delivery of medical services and provider payments.

- Quarterly reports on customer service responsiveness, including telephone response time, call abandonment rate, and the number of inquiries made by type.
- Monthly summary of high-cost claims, showing diagnostic and procedure codes, total allowable charges, and total paid claims for each enrollee for whom paid claims exceeds $25,000.
- Monthly reports on HIPAA Requests for Access made by enrollees.
- Monthly reports on subpoena request.
- Annual accuracy review reports which will test both automated and manual systems to ensure within a ninety-five (95%) level of confidence that the edits and audits chosen are processing claims according to policy.

8. Conflict of Interest

68. The successful Contractor will be required to certify, to the best of its knowledge, that its proposal and any awarded contract is not in violation of any provisions of state laws related to conflicts of interest, and that it is familiar with such laws, including but not limited to the provisions of the Political Reform Act (Government Code Section 87100 et seq.) and the prohibitions set forth in Government Code Section 1090 et seq.

Individuals who will perform work for Governing Board on behalf of the successful Contractor might be deemed public officials under state conflict of interest laws. If so, such individuals will be required to file a Statement of Economic Interests (Form 700) with the California Fair Political Practices Commission, in accordance with state law and the Governing Board's Conflict of Interest Code.

Certifications are to be executed by an authorized representative.

V. EXHIBITS

Exhibit A Pricing Proposal

Exhibit B Required Documents

VI. ATTACHMENTS

Attachment A CMSP Eligibility File Layout

Attachment B EVCOI File Layout

EXHIBIT A
PRICING PROPOSAL

The proposed prices in Exhibit A shall be based upon two alternative enrollment estimates as set forth below:

- Bidder shall propose prices in Exhibit A-1 based upon an expected average monthly CMSP and Connect to Care enrollment of 2,000 to 15,000 enrollees.
- Bidder shall propose prices in Exhibit A-2 based upon a higher average monthly CMSP and Connect to Care enrollment of 15,001 to 30,000 enrollees.

The Governing Board will consider any pricing structure presented by bidders, including but not limited to an annual service fee paid monthly; a Per Member Per Month (PMPM) fee based upon actual monthly enrollment; a combination of a base administrative fee and a PMPM paid monthly; or some other alternative.

CMSP enrollment is currently under 500 monthly members and Connect to Care enrollment is approximately 1,700 monthly members. Enrollment can grow for both programs depending on economic and public policy factors.

Start-up costs shall be separately identified and presented in Exhibit A-3. Total Start-up costs shall be included in Exhibits A-1 and A-2 and all costs for start-up operations shall be included in costs for Service Year 1 only.

EXHIBIT A-1 PRICING PROPOSAL Administrative Fee by Service Year (CMSP Enrollees Estimated at 2,000 to 15,000 Monthly Enrollees)			
Functional Area[1]	**Service Year 1**	**Service Year 2**	**TOTAL**
Start-up Cost Allocation	$	NA	$
▪ *by task*			
Contract Administration/ Project Management	$	$	$
▪ *by task*			
Eligibility/Enrollment	$	$	$
▪ *by task*			
Network Development and Management	$	$	$
▪ *by task*			
Service Administration	$	$	$
▪ *by task*			
Provider Contracting	$	$	$
▪ *by task*			
Utilization Management	$	$	$
▪ *by task*			
Customer Service	$	$	$
▪ *by task*			
Pharmacy Benefit Interface	$	$	$
▪ *by task*			
Reporting	$	$	$
▪ *by task*			
All Other Activities	$	$	$
▪ *by task*			
TOTAL	$	$	$

[1] Functional Areas listed correspond to the major task areas described in the Scope of Work. Bidders must include all costs incorporated into their bid price in this exhibit.

EXHIBIT A-2 PRICING PROPOSAL Administrative Fee by Service Year (CMSP Enrollees Estimated at 15,001 to 30,000 Monthly Enrollees)			
Functional Area[2]	**Service Year 1**	**Service Year 2**	**TOTAL**
Start-up Cost Allocation	$	NA	$
▪ *by task*			
Contract Administration/ Project Management	$	$	$
▪ *by task*			
Eligibility/Enrollment	$	$	$
▪ *by task*			
Network Development and Management	$	$	$
▪ *by task*			
Service Administration	$	$	$
▪ *by task*			
Provider Contracting	$	$	$
▪ *by task*			
Utilization Management	$	$	$
▪ *by task*			
Customer Service	$	$	$
▪ *by task*			
Pharmacy Benefit Interface	$	$	$
▪ *by task*			
Reporting	$	$	$
▪ *by task*			
All Other Activities	$	$	$
▪ *by task*			
TOTAL	$	$	$

[2] Functional Areas listed correspond to the major task areas described in the Scope of Work. Bidders must include all costs incorporated into their bid price in this exhibit.

EXHIBIT A-3 Proposed Start-up Costs & Service Year 1 Cost Distribution					
Functional Area[3]	**Start-up Term**	**3/1/26-5/31/26**	**6/1/26-8/31/26**	**9/1/26-11/30/26**	**12/1/26-2/28/27**
Contract Administration/Project Management	$	$	$	$	$
▪ *by task*					
Eligibility/Enrollment (Design and implement systems interface with eligibility files and Medi-Cal systems)	$	$	$	$	$
▪ *by task*					
Network Development and Management	$	$	$	$	$
▪ *by task*					
Service Administration	$	$	$	$	$
▪ *by task*					
Provider Contracting	$	$	$	$	$
▪ *by task*					
Claims Payment (Design and implement system, including interface with eligibility files and Medi-Cal SOC system)	$	$	$	$	$
▪ *by task*					
Utilization Management	$	$	$	$	$
▪ *by task*					
Customer Service	$	$	$	$	$
▪ *by task*					
Pharmacy Benefit Interface	$	$	$	$	$
▪ *by task*					
Reporting	$	$	$	$	$
▪ *by task*					
All Other Implementation Tasks	$	$	$	$	$
▪ *by task*					
TOTAL	$	$	$	$	$

[3] Functional Areas listed correspond to the major task areas described in the Scope of Work. Bidders must include all Start-up Costs in this table and show corresponding amounts in Exhibits A-1 and A-2.

EXHIBIT B
REQUIRED DOCUMENTS

1. Formal letter of proposal submission from duly authorized official with the firm
2. Pricing proposal (Exhibit A)
3. Responses to all questions in Section IV of the RFP, including the supporting documents referenced:
    a. Copy of current Administrator's Certificate or other licensure
    b. Copy of subcontractors, as appropriate
    c. Standard health benefits administration contract
    d. Audited year-end financial statements for most recent two years available
    e. Copy of recent member satisfaction survey
    f. Sample reports
4. Any and all other documents requested as set forth in Section IV