

REQUEST FOR PROPOSAL

**Third Party Administration
& Stop Loss**

Medical Benefit Coverage

RFP# 26-020



ARKANSAS
TECH
UNIVERSITY

Russellville Arkansas

Advisors:

Tom Kane, Executive Vice President, – Tom.Kane@stephens.com
Tyler Runnells, Senior Vice President - Tyler.runnells@stephens.com

Stephens Insurance, LLC
111 Center Street
Little Rock, AR 72201

May 8, 2026

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I. OVERVIEW

Arkansas Tech University is a state university established in 1909 with programs at the technical certification, associate, baccalaureate and graduate levels. The University has campuses in Russellville, Arkansas, and Ozark, Arkansas. The institution also operates Arkansas Tech Career Center (ATCC), a career and technical training initiative headquartered in Russellville with satellite locations at Clarksville, Danville, Ozark and Paris.

ATU Russellville-Offers 120 undergraduate degree programs and more than 25 graduate degree options.

ATCC-Serves over 1,000 students from 19 school districts across 9 program areas.

ATU Ozark-Serves over 2,100 students in 29 technical and associate programs.

ATU has approximately **780 full-time employees** located on three campuses –Russellville, Ozark and the Arkansas Tech Career Center (ATCC). ATU also provides benefits to pre-65 Retirees and post-65 Retirees.

ATU currently offers the following benefit programs:

- Fully Insured Medical
- Dental
- Vision
- Basic and Voluntary Group Term Life
- Voluntary Short Term and Long Term Disability
- Critical Care with Cancer
- Accident
- Section 125 (HSA and FSA)

B. REQUEST FOR PROPOSAL

ATU is respectfully requesting proposals for TPA Services to include the following effective January 1, 2027:

- Self-funded medical plan claims processing
- Utilization management
- Large case management
- Disease management
- Re-Insurance (Stop Loss)
- Reference Based Pricing
- Prescription Drug Management – Integrated and carved out

C. CONSULTANT

Stephens Insurance, LLC was retained to provide consulting services for ATU. There should be no commissions or any other compensation paid to brokers, agents, or consultants included in your proposed fees for any products quoted.

D. QUESTIONS

Please address all questions regarding this request for proposal to:

Tyler Runnells
Phone: 501-377-2093
E-mail: tyler.runnells@stephens.com

OR Adam Ritchie
Phone: 501-377-8415
E-mail: adam.ritchie@stephens.com

Direct all questions regarding the proposal to the above persons in writing, no later than **May 15, 2026**.

E. TIMETABLE OF SELECTION PROCESS

Activity	Completion Date
Release of RFP	May 8, 2026
Questions due from TPAs	May 15, 2026
Response to TPA questions due	May 20, 2026
Proposals due	June 8, 2026
Finalist presentations	TBA
Effective date	January 1, 2027

F. PROPOSAL DEADLINE

ATU must receive an electronic copy no later than June 8, 2026, at 12:00 p.m. Stephens Insurance must receive an electronic copy and one hard of your proposal no later than June 8, 2026 at 12:00 p.m. This includes the completion of the following questionnaires and exhibits:

- General Information Questionnaire
- Medical Claims Processing Questionnaire
- Utilization Management Questionnaire
- Disease Management Questionnaire

Mailing address for hard copy of proposal:

Stephens Insurance, LLC
Attention: Adam Ritchie
RFP# 26-020
111 Center Street, Suite 100
Little Rock, AR 72201

Electronic Copies sent to:

ATU Procurement Services
RFP# 26-020
Jennifer Warren
Jwarren2@atu.edu

Stephens Insurance
RFP# 26-020
Adam Ritchie
Adam.ritchie@stephens.com

G. REVIEW OF PROPOSALS

ATU reserves the right to:

- Reject any or all components of proposals.
- Cancel the entire RFP process.
- Remedy technical errors in the RFP.
- Negotiate with any, all or none of the respondents to the RFP.
- Solicit the best and final offers from all or some of the prospective vendors.
- Accept any or all components of the proposal as an "offer" without negotiation and issue Notice to Proceed.

H. PROVISIONS DEEMED INCLUDED IN THE PROPOSAL

A Firm may wish to propose an alternative to these specifications by expressly and specifically so stating in its proposal. Included are specific requirements in an attempt to evaluate all proposals on a uniform basis. If your firm feels that any of the provisions are unreasonable, contact Tyler Runnells and Stephens Insurance, LLC. Stephens Insurance, LLC will determine if the provision should be amended.

I. MANDATORY PROVISIONS

Each proposal received by ATU shall automatically be deemed to include the Firm's agreement to the following provisions:

1. The proposal constitutes an offer by the Firm, which shall remain open and irrevocable, for 275 days from the deadline for submitting proposals as stated in Section F.
2. The firm consents to ATU or Stephens Insurance, LLC contacting and obtaining any information relevant to this RFP from the references and others identified by the Firm in its proposal.

J. PROPOSED TPA AND REINSURANCE COVERAGE OF EMPLOYEE MEDICAL PLAN

Proposals should include the information relevant to the Firm's proposed third-party claims administration and stop-loss coverage of the employee medical plan.

Proposals should include Reference Based Pricing (RBP) as an option with 2 to 3 options both on a PEPM pricing model and a percentage of savings model in terms of the RBP vendor fees.

Proposals should include Pharmacy Services including rebate transparency. In the event pharmacy services are carved out, please provide your willingness to work with a PBM selected by a separate RFP process and costs associated with the PBM carve out including data transfer and all other fees associated with pharmacy services. Please provide names of PBM's you will work with. If there is an additional admin fee charged to work with "non-preferred" PBM's, please explain.

Each firm shall describe how it will meet the required specifications outlined in Exhibit A. Any specifications which are not met should be identified in the proposal and an alternate described.

II. GENERAL INFORMATION QUESTIONNAIRE

1. Provide the full name of your company, address, and telephone numbers. Also, provide a detailed summary of your company's structure, background, and experience in the healthcare industry. Describe the organization's resources and capabilities, including size, number of offices, locations, and number of employees.
2. Who will be the primary administrative and service contact from your company involved in this program if awarded the contract? Provide a brief resume of each individual.
3. Describe any organizational structure/operational changes, which may occur within the next eighteen months.
4. Provide a list of five (5) client references for which you provide the requested services, including clients that closely mirror the size and geographic location of ATU, with the name and telephone number of a contact person as well as the number of employees and services in place at employer.
5. Provide a list of two (2) former clients that have recently terminated their services with you, not to include any terminated due to an acquisition. Include the name and telephone number of a contact person as well as the number of employees and services terminated.
6. Please provide an implementation plan and detail the timing of when the following will be available assuming your firm is awarded the ATU account effective January 1, 2027.
 - Contracts and administrative agreements
 - Claims system loaded with the ATU benefit plans
 - Receipt and testing of eligibility files
 - Receipt and testing of history load from the current claims administrator
 - Testing of interfaces with other vendors
 - Banking arrangements
 - Reporting requirements
 - Open enrollment planning
 - Employee communication
 - Benefit Administration implementation
 - Employee access to benefits, claims, education, support information, and ID cards
7. Please describe the transition team that will work with ATU on implementation and transition issues.

III. CLAIMS PROCESSING / ELIGIBILITY & ENROLLMENT/CUSTOMER SERVICE QUESTIONNAIRE

GENERAL INFORMATION

1. Please provide the following information about the specific location from where claims, administration services, enrollment and eligibility are housed. (for the last three years):
 - Location – Please provide address, telephone and fax numbers name and title of the individual responsible for the daily operations of this location
 - the number of clients served from this location
 - the number of members served from this location
 - the number of claims processors located in this location
 - the number of lives (employee and dependent) for which medical claims are processed in this location
2. Describe your disaster recovery program concerning computer files, eligibility/enrollment information, claim system, and loss of the facility.
3. Indicate the hours/days of operation (please be time zone specific) for the office that will service this account.

CLAIM OFFICE PERFORMANCE—QUALITY AND ACCURACY

4. Provide your definition of a claim.
5. Describe the auditing program currently in place in the claims location you are recommending for ATU Include information on the following:
 - Auditing procedures (both internal and external)
 - Definition of auditing categories
 - Frequency/percentage of production audited
 - Description of staff performing the audits
 - Communication of audit results (to processors and client)
 - The latest copy of your firm's Statement of Standards for Attestation Engagement No. 16 (SSAE NO. 16) Report
 - A copy of your firm's Reporting on Controls at a Service Organization (SOC1.Type 2) Report
6. Describe your claims processing workflow from the time a claim is received in your office until the claim is resolved and/or payment is made.
7. What are your standards for claims processing?
 - Payment accuracy (%)
 - Procedural accuracy (%)
 - Financial accuracy (%)
 - Turnaround time
 - Volume per day

8. What are your 2024 and 2025 results for claims processing for the office proposed to process claims for ATU?
 - Payment accuracy (%)
 - Procedural accuracy (%)
 - Financial accuracy (%)
 - Turnaround time
 - Volume per day
9. Provide your definition of claims turnaround.
10. Indicate the average number of business days in which 90% of medical claims are paid. Indicate the average number of business days for 95%. (Should reflect statistics for calendar years 2024 and 2025).
11. Describe the procedures employed by the claims processors to review medical claims for compliance with benefits, to measure the reasonableness of charges and to determine the appropriateness of services. Are there separate groups of reviewers for network claims, appeals, etc.?
12. Describe your procedures/approach to monitor and prevent creative billing, upcoding, DRG creep, etc. What criteria are utilized to identify the appropriateness of charges? Describe any clinical edit /review procedures performed by the claims system, specifically the ability to identify and correct code "bundling." What controls are in place to prevent duplicate payments? Describe procedures employed to prevent fraudulent claims.
13. How does your system track alternate recipient information?

STAFFING

14. Provide the total number of staff, as well as a breakdown by functional area, in the claims office that will service ATU.
15. What is your average ratio of examiners to covered employee lives?
16. If awarded this account, will you need to hire additional staff? What formula and/or ratios are utilized to determine when additional staff is necessary for claims processing?
17. ATU may require a dedicated representative, other than the salesperson, to be responsible for their account. Will dedicated processors and customer service representatives be assigned to this account? If so, how many? If not, how will claims be assigned?
18. Provide the average length of service of your processors and their experience level. Additionally, provide the average length of service for those processors, if applicable, that will be assigned specifically to the ATU account.
19. What are the minimum per-day production standards, if any, expected of your claims processors?

20. If claim processors are compensated on an incentive base, please detail the specifics of the program.
21. How will backlogs in processing be handled for this account?

CLAIMS PROCESSING SYSTEM

1. What claims administration system does your firm use? (Provide specifics on both hardware and software.)
2. How long has this system been operational in the specific office that will administer this account? Provide dates and descriptions of recent upgrades as well as any upgrades anticipated in the next 24 months.
3. Describe the back-up procedures you have in place in the event of a claim system shut down.
4. Where is your claim data stored?
5. How are “rejected transactions” handled?
6. What criteria are used to determine reasonable and customary (R&C) fee allowances for out-of-network claims? What level of R&C do you typically apply? How do you ensure that reasonable and customary allowances are applied correctly to claims?
7. Describe your procedures for handling pended claims.
8. Describe the tracking mechanisms you follow for all communications requiring additional information.
9. Can your system capture primary and secondary diagnoses utilizing ICD-10 codes?
10. Describe your process for obtaining codes if the primary and secondary diagnoses are not entered.
11. Are all inpatient and outpatient procedures recorded utilizing the current CPT codes?
12. Describe what actions the Claims Administrator will take on behalf of the Plan to negotiate the provision of stop loss coverage for claims in excess of the specific limit.
13. Provide a list of reinsurance carriers from whom you requested quotes. Do these carriers provide funding for data analytics and/or wellness initiatives?
14. In addition to marketing the reinsurance through the TPA, Stephens Insurance reserves the right to shop/place reinsurance with additional markets outside of the TPA’s preferred vendors including PBM’s. Please confirm your willingness to comply.
15. Are additional fees charged when working with “non-preferred” reinsurance carriers? If so, please explain.

16. Identify all information that is integrated and online in your claim system with regard to:
 - UM decisions
 - Network procedures
 - Claims under case management
 - Pharmacy Claims and Services
17. How does your administrative system track and ensure reciprocity among networks?
18. What is your preferred process for handling exceptions and payment of claims outside the stated plan provisions?
19. Describe the process of handling claim subrogation. Do you request the covered person or the covered person's guardian to execute a subrogation agreement? Please provide a copy of your standard agreement.
20. The Claims Administrator will make available records for requested Plan audits. This will include reporting of internal audits conducted by the Claims Administrator. Confirm your willingness to comply.
21. Describe the procedures for identifying and reviewing special medical cases such as medical necessity, experimental procedures, complex cases, etc.
 - Pre-certification review
 - Concurrent review
 - Retrospective review
 - Outpatient review
 - Second surgical opinion
 - Catastrophic/large case management
 - Short term case management
 - Discharge planning
 - High-risk pregnancy
 - Pre-payment claim review
 - Chiropractic/podiatric review
 - Rehabilitation services
 - Specialty Pharmacy
22. Do you currently have the ability to automatically adjudicate claims? If so, what percentage of claims received are automatically adjudicated? If not, do you have a plan for implementation? When?
23. Are all claims accepted by electronic submission? For those that are not, how are they handled?
24. What are your requirements for submitting claim forms for in-network and out-of-network claims?
25. Describe your policies and procedures when a claim is received with incomplete information. What specific steps do you take to minimize employee involvement and inconvenience?

26. Answer the following with regards to the establishment of U&C levels:
- The database used and frequency of updates
 - Percentile typically used
 - Actions taken when the database is insufficient to set U&C for a specific service
 - Actions taken when a provider's charge exceeds U&C (identify dollar threshold)
- Are you able to vary the percentile used by client? By type of claim (inpatient charges, physician visits, surgery, etc.)?
- Are you able to run frequency tests to identify procedures without U&C, and manually rate if needed?
27. Describe your current audit programs for claim processing:
- How frequently are internal audits performed?
 - How frequently are external audits performed?
 - What is the typical audit size?
 - What is the typical audit selection criterion?
 - How is audit data employed to improve processor performance?
 - Overall, what percentage of claims is subject to internal audit? External audit?
 - What sampling procedure do you use? High dollar audit? Stratified audit? Other?
28. Describe your reporting capabilities, turnaround time, and any additional fees for reporting or ad hoc reports that may be requested.
29. Describe your experience in managing a smooth transition of a sizable block of business from another claims administrator.
30. Describe what actions the Claims Administrator will take on behalf of the Plan to negotiate payment of Stop Loss claim in excess of the specific limit.
31. Describe how the Claims Administrator will negotiate market-competitive discounts with network providers. Are discounts based on a fee for service or value/outcome basis?
32. Describe how the Claims Administrator will negotiate discounts for claim costs associated with non-network providers. Is this process done in house or by a third party? Is there a fee or a percent of savings associated with this negotiation?
33. Can out of network claims processing be outsourced? Please explain the process and include any fees associated with this process.
34. Describe your process for resolution of a mistaken or erroneous benefits payment.
35. Is subrogation recovery handled internally? If by an outside vendor, give the name of the vendor.
36. When is a subrogation claim turned over to an attorney? Who selects the attorney? Does ATU have the ability to designate the attorney who will pursue subrogation rights?

37. Please respond to the following regarding EOBs:
- Provide a copy of your medical EOB and include a listing of all message codes and their associated message description. Are they printed and mailed in-house or off-site? If off-site, indicate where.
 - Do you have the ability to include multiple message codes on each EOB to accurately communicate the resulting charge to the employee?
 - Will your system email notification to an employee when a claim has been processed? Is there an on-line portal for employees to view EOB's? If so, please provide the link.
 - Does the claims administration system automatically produce EOBs?
 - Does your firm have a standard EOB remarks table? If so, include a copy of this table.
 - Does the EOB show the amount of deductible that the employee has yet to satisfy?
 - Do the claims administrators have the ability to add free form remarks?
 - Can you customize your EOBs to incorporate the client's logo, plan name, and other specific information as contained in their current EOB? Is there an additional fee? If so, please explain.

ELIGIBILITY/ENROLLMENT DATA

1. ATU currently uses a Benefit Administration system to manage enrollment and eligibility. Please describe how you will handle loading ATU data from another administrator. Describe your procedures for the receipt of eligibility and enrollment data including frequency and your preferred method for file transfer. Please include any costs associated with this process.
2. Please provide the implementation process and time-line for the initial set-up of the Benefit Administration System including readiness for Open Enrollment in November, 2026.
3. Describe your process for establishing and verifying dependent eligibility.
4. How is the confidentiality of eligibility information secured?
5. Please provide names of Benefit Administration systems you are integrated with.
6. Where is your eligibility/enrollment data stored?
7. Are ID cards printed on-site or off-site? If printed off-site provide vendor name and location.
8. Can the ATU logo be added to the ID Card? Please include any costs associated with this.
9. Will each family member receive an ID card? Please explain.

CUSTOMER SERVICE

10. Provide the following information about the specific location from which customer service will be provided: address, telephone, and fax numbers.
11. Indicate the hours of operation and days of the week (please be time zone specific) for the Customer Service office that will service this account.

12. Describe your provisions for “after hours” customer service. Include on-line access if available.
13. Does your customer service unit have a toll-free number available for employees?
14. Do you have a dedicated customer service unit to respond to claim inquires or do the claims processors handle them?
15. How many customer service representatives will be required to service this account?
16. Please provide willingness to have a service representative on-site at ATU campus locations one day per month. Please include costs if any.
17. Would the addition of this account require the hiring of new customer service personnel? Describe ratios/formula you utilize to determine at what point additional customer service personnel are required.
18. Provide the average length of service of your customer service representatives that would be servicing ATU. Additionally, provide the average length of service for those representatives that will be assigned to the ATU account.
19. Provide the following statistics and target service goals for the customer service unit that will service this account:

	2023 Actual	2024 Actual	2025 Actual	2026 Target
Average Answer Time				
Average Hold Time				
Abandonment Rate				
Average Talk Time				

20. Does your customer service system have call tracking capabilities? If so, please describe. Are specific issues tracked and reported in the aggregate so that issues can be resolved by both your organization and ATU or outsourced Wellness Vendors?
21. As patterns are detected via call tracking, who has the responsibility for monitoring trends, for solving the identified problem, making the necessary changes and notifying the client? Please provide the availability of reporting these patterns and costs associated with reporting.
22. Are customer service policies and procedures online and readily available to the customer service representative? Plan benefit information? Participant information? Provider information? Claims information? Telephone scripts?
23. Do customer service representatives have the ability to issue ID cards? Make address changes? Any other transactions?

24. Describe any features of your systems that in your opinion give your company a competitive advantage concerning providing your clients with superior customer service.
25. Does your program include a silent monitoring program to measure quality?
26. Describe your customer service system reporting capabilities. Please provide samples of the reports that are regularly used to monitor performance. Can you produce reports by employer divisions?

PLAN DESIGN

27. Can your firm administer multiple plan design offerings, including Tiered Benefit Designs, Clinically Integrated Networks and Centers of Excellence that are not part of your network? If not, please provide a detailed description of those areas that you cannot administer and why.
28. Will you agree to provide written notice of any change in the claims administration fees six months prior to renewal?

REPORTING

29. Describe your standard offering of management reports by providing a brief description as well as a sample of each available report, including the frequency and available sorting options (sorted by age, gender, etc.).
30. Can a monthly report be supplied (medical and pharmacy) with each participant listed with the monthly charges for the Medical plan, Admin fees, Pharmacy Services, PPO access fees, Disease Management, etc.? This should include all adjustments going back at least 3 months.
31. Describe your ability to produce ad-hoc reports at the request of the client. What is the average time required to meet such requests and how are charges determined? Are you able to report on any field captured in a timely fashion, without added expense?
32. Will the ad-hoc reporting allow the employer direct access to build and print customized reports?
33. What is the time lag for claims data to be received by ATU and Stephens Insurance?
34. Please address the following items regarding data transfer:
 - Confirm your ability and willingness to provide reoccurring monthly files to Stephens Insurance and/or to other third parties, including a data analytics vendor.
 - List any requirements you have before releasing the information. Specify the process including a timeline from request to delivery.
 - Outline any fees associated with this data transfer, and if you are willing to waive those fees, or include them in the administrative fees you are quoting.
 - Include a sample eligibility and claims file specification including the list of available fields for both medical and pharmacy claims. If needed, will you add fields to the monthly claim files, which may not be included in your standard layout?

LIST OF SERVICES

35. Please provide a complete list of services that are included as part of your fee proposal.
36. Are the following online services available to members? Is there an app available? List any additional online services offered.
 - Access to benefit summaries
 - Access to EOB's
 - Provider search
 - Prescription Drug search
 - Claims status inquiry
 - Wellness programs
 - EAP Services
 - Ability to e-mail customer service
 - Request I.D. cards
 - Ability to review previous claims history
 - Ability to access third party medical and disease management information
37. What employer on-line services do you offer? ATU must have the ability to view/change eligibility, check claim status, and view reports online.
38. Indicate how the payment of run-out claims would be handled if and when ATU terminates claims administration services. Do the fees quoted above include the claims administration for run-out claims at termination? If not, please provide that fee here.

MEDICAL FEE EXHIBIT – All fees shown below (except where noted) should be on a per employee per month basis.

Fee Type	January 1, 2027	January 1, 2028	January 1, 2029
Claims Administration Fee			
Network Access/Management Fee			
Pharmacy Fees			
PBM File Transmission Fee			
PBM Carve out Fee			
Hospital Inpatient Pre-Certification			
Disease Management			
Utilization Management			
Large Case Management			
Claims Fees			
Maternity Management			
Nurse Line			
EAP			
Wellness Programs			
Special Transplant Network			
Excess Loss Administration			
ID Card Fees			
EOB Fees			
State Surcharges			
Other Fees (provide details)			
Other Fees (provide details)			
Other Fees (provide details)			

IV. UTILIZATION MANAGEMENT QUESTIONNAIRE

1. Is ATU able to carve out utilization management (pre-certification for medical and pharmacy) services to a third party? If so, have you had experience with this? Is there a fee associated with the carve-out? If so, please include.
2. Describe the integration capabilities of the utilization review systems with your claims processing system.
3. Please confirm that all UR services are performed internally. If any are subcontracted, please explain.
4. Describe your performance standards for the timeliness of reviews.
5. Does your company have a full-time Medical Director or physician advisor on-site? Describe the Medical Director’s major roles and responsibilities.
6. Describe the qualifications of nurse reviewers, case managers, and physician advisors.
7. Provide the ratio of registered nurses (full-time equivalents) per 1,000 covered lives.
8. For each of the following, indicate services provided for the fees quoted for in-network and out-of-network services and whether service is provided on-site or over the phone.

Description	Service Provided		Provision	
	In Network	Out of Network	On-site	By phone
Hospital pre-certification review				
Concurrent stay review				
Discharge planning				
Procedure specific second opinion (inpatient and outpatient)				
Large Case Management for inpatient and outpatient claims				
Mental Health and Substance Abuse Case Management				
Hospital bill audit program				
Maternity programs				
Tracking on-going treatments by specialists				
Large claim negotiations for out-of-network services				
Other services (please specify)				
Other services (please specify)				
Other services (please specify)				

9. Are all hospitalizations, regardless of diagnosis, included in pre-certification?
10. Provide a detailed description of your core capabilities and procedures for the following services:
 - Pre-certification
 - Continued stay request
 - Discharge planning
 - Post-discharge follow up with the patient
11. How is each party (patient, provider, claims payor) notified of the pre-certification?
12. Is network channeling/redirection included in the pre-certification process?
13. Provide a summary of your internal quality assurance program including the criteria used to measure and access quality.
14. What criteria standard does your company utilize in the utilization management process, including source(s) of these criteria, for pre-certification, establishing length of stay and determining medical necessity for inpatient confinements?
15. What percentage of pre-certification reviews are referred for physician review? What is the average turnaround time for such reviews?
16. How do you calculate and document savings from your Utilization Management program? Do you provide any reports that document savings? If so, please provide samples.
17. What is the turnaround time for a pre-certification review?
18. Are you in compliance with the required determination timeframes for pre-service claims?
19. Describe the scope of your Case Management program.
20. How are potentially catastrophic cases identified and managed? What are the triggers/identifiers for a claim to be referred to case management?
21. What percentage of cases have historically been referred for case management?
22. How does your organization measure and report cost savings and quality improvement resulting from case management?
23. How does the TPA communicate alternative medical and nutrition information?
24. Describe elements of your Case Management program that specifically target high-risk pregnancy and childbirth case management.
25. What are the procedures for appealing a utilization review decision, including how many levels of appeal you use, who participates on the appeal panel(s) and who are the final decision-makers at each level?

- 26. What is the turnaround time standard for responding to appeals?
- 27. What standard reports are available for your utilization management and case management programs? Provide samples and frequency of each report.
- 28. Provide any information on additional utilization management services not specifically referenced above. Include brief program descriptions as well as any related fees.

Utilization Review & Large Case Management	2027	2028	2029
Utilization Review Fee Per Employee Per Month			
Large Case Management Fee Per Employee Per Month			

V. DISEASE MANAGEMENT QUESTIONNAIRE

GENERAL INFORMATION

1. Can ATU carve out disease management to a third party? If so, is there a cost to do so? If so, what is the cost?
2. How many years has your organization been providing disease management programs? Please confirm that these services are provided internally. If any services are subcontracted, please explain.
3. Please identify the number of members enrolled in your programs for 2023, 2024 and 2025.
4. Please describe your success rate of reaching participants and subsequently encouraging them to enroll in your programs. Please provide your target population for outreach and enrollment and your performance statistics for 2023, 2024, and 2025. Include a definition of an “enrolled member.”
5. How does your organization encourage participation in disease management programs? What types of incentives have you found most effective?
6. Please describe your disease management staff. Please include level of training; education; requirements for ongoing education; member to clinician ratios; and turnover.
7. Please provide your ideal lead-time required for the most successful implementation. Please describe the best practices that your organization has learned from successful implementations. Please provide a sample implementation timeline with key milestones, target dates and responsible parties assuming a January 1, 2027 start date.

PROGRAM OVERVIEW

8. Please describe your disease management programs and your philosophy.
 - List each disease for which you offer a disease management program.
 - Identify how many years each disease program has been offered, how it was developed and how many members are currently participating in each program.
 - Describe any additional programs or enhancements planned in the future.
9. ATU is exploring the start-up of an on-site staff/faculty clinic. Once operational, can your Disease Management program be must be integrated with the ATU on-site employee clinic and/ or the Management Vendor. Please address if your firm can do so, specifically as it relates to ongoing data feeds.
10. Describe your disease management process from data collection and referral to “graduation” from your program.
 - Identify specific milestones and responses to setbacks along the way.
 - Is the physician part of the process? Why or why not?

11. Would you consider your program patient-centered, care-centered, physician-centered, or health-plan centered? Please explain. Have you integrated your program with other models?
12. What policies and communication channels are in place to ensure that the participant's health care team (i.e., providers, registered nurses, health educators, social services, dietitians, pharmacists, physical therapist, occupational therapist, respiratory therapist, etc.) are continually updated regarding participant status?
13. How frequently does your organization contact providers and other members of the health care team to provide updates on participants?
14. If the care program outlined by the practicing physician is not in compliance with current practices and may not be the best appropriate (or most appropriate) care for that individual patient, how is the issue addressed with the attending physician? Do you have physicians on staff that conduct physician-to-physician discussions? Please describe your success in these situations.
15. Are providers involved in developing and defining best practice clinical guidelines?
16. Please identify the creative ways in which you have partnered with employers and their group plans. Have you implemented processes for maximizing participation and the successful completion of these programs by employees and their dependents?
17. Explain how disease management interventions are targeted to individual participants' needs and their motivation to change. Please explain any tools available to case managers that make your organization's approach more "scientific" versus "personal experience" based.
18. Which of the following variables are included in your disease management models:
 - Quality of life
 - Medical utilization
 - Cost
 - Disease-specific clinical indicators
 - Readmission rates
 - Admission rates
 - Length of stay
 - Emergency room usage
 - Office visit rate
 - Medication compliance
 - Other
19. Do you typically coordinate your disease management services with other services available in the community and/or other employer-sponsored programs?
20. Please describe in detail your ability and approach to managing behavioral health (mental health and substance abuse) cases as a stand-alone diagnosis and as co-morbidities.
21. Please describe your ability to manage co-morbidities and indicate specifically how your approach and processes may change based on their existence. For example, would a member be contacted more frequently? By different case managers?

22. Please describe your ability to manage members with soft tissue and self-diagnosed claims. Please explain your approach with these issues.
23. Please describe how case managers are assigned to a particular member. Describe the specialties available within your organization and if their background is matched with a particular diagnosis class for case management purposes.
24. Describe the roles and qualifications of your disease management staff (i.e., Medical Director, RNs, Health Educators, etc.) including program development, supervision, delivery and evaluation.
 - a) What clinical practice guidelines are used in the program?
 - b) How often are these guidelines updated?
25. Please describe the orientation process once a member has been identified to participate in the program and has agreed to participate. Please indicate any sign-offs, waivers, release forms, etc. that the member may need to sign in order to start the process. Please provide a sample orientation package in your response.
26. What type of initial and ongoing education and support do providers receive to understand clinical guidelines, program content, and impact monitoring?

PARTICIPANT IDENTIFICATION AND RECRUITMENT

27. Please explain how your “target” group is identified. Are members of the employee population stratified according to the severity of the condition and how does this get accomplished?
28. Indicate the data sources and any other methods you use to identify potential candidates for each disease management program.
29. Please describe your ability to identify specific risk factors by the existence of claims data and the lack of claims data (i.e., a member with diabetes not having annual eye exams).
30. Please describe the way you utilize and integrate prescription drug data to identify the “at risk” or chronically ill population. Please provide the list of pharmacy vendors from whom you currently receive data.
31. Please describe the tools and models used to identify potential participants, assess their current health state and structure treatment plans on an automated basis. Does your system have the ability to “track” participants until they reach a state of compliance?
32. Please describe how your organization uses technology to segment the employee population and identify employees with chronic illnesses.
33. Describe your ability to identify the at-risk population. Please be specific as to situations when you can receive detailed, electronic information and when other methods of outreach are needed.

34. Once you have identified potential participants, how do you engage the individual and what is your enrollment process?
35. Can a participant make a self-referral?
36. Please describe your approach if there is “no answer” or “no response” upon outreach.
37. Please describe your approach if a member chooses not to participate. Please describe triggers for additional follow up and closure.
38. Define what member engagement means in your organization. What is your engagement percentage as a book of business?
39. After individuals are engaged and enrolled, what is your methodology to stratify participants by risk level based on health care utilization, health care costs, risk factors, and clinical indicators in order to match participants to the appropriate intensity of intervention?
40. How does your organization segment an employee population by health risk? How is this information used?
41. Indicate how your organization protects patient confidentiality and privacy.

COMMUNICATION

42. Communication is a very important component of successful disease management programs. Please describe your communication capabilities. Please provide a sample communications package.
43. Please confirm what communication materials are included in your base fee and what items are offered at an additional charge. Please provide samples and pricing of each offering. Can the communication materials be customized with ATU’s logo?
44. Describe how your firm maximizes technology to reach members with education, resource tools, and other communication materials. Identify the utilization rate of each resource tool.
45. Please describe available educational resources related to preventive health care topics. Clarify if this information is available online, with a mobile app, etc.
46. Please provide a sample of your management reporting package for this product. Provide the frequency that these reports are distributed. Can the report be customized?
47. Do you conduct annual participant, provider, and health plan surveys to gauge satisfaction levels? If yes, please report your results from the most recent surveys.
48. Are you willing to perform a satisfaction survey specific to ATU participants and network providers?

INFORMATION SYSTEMS

49. Do you have an automated system that develops tailored treatment plans? Is the model used as a tool to track progress, document member interaction and activity, and determine compliance? Please describe.
50. Do you have an automated assessment tool that your staff utilizes to monitor and work with patients? Please explain.
51. Please describe the specific systems enhancement planned to perfect the population assessment process.
52. List the measurement and evaluation studies your organization has completed or are in the process of conducting which indicate the impact of your programs.
53. Please describe your call tracking and member progress tracking software.
54. Indicate what types of aggregate reports can be generated and provide examples of reports included in the contract fees.
55. Can these reports be customized further and is there an additional charge for these reports?

OUTCOMES/RETURN ON INVESTMENT

56. Please confirm your ability to measure savings. If you are only able to do so for specific diseases, please identify which disease can be measured. Please describe your methodology in detail.
57. Please describe how you measure program effectiveness and cost savings? How do you assess adherence/progress?
58. What is your typical return on investment (ROI) for your complete disease management package?
59. Outline the methodology used to evaluate the financial outcomes of the disease management intervention.

COST

60. Please provide the costs associated with your proposed disease management program. Be sure to include a detailed list of all covered services.
61. What is the length of your proposed fees guarantee?
62. What level of ROI are you willing to guarantee?

VI. MISCELLANEOUS

PPO NETWORKS

1. What networks do you primarily work with on a regional basis? Will your selected network allow a narrower network selected by ATU to be an additional option?
2. Is repricing done online or are claims sent off? If sent off, what is the turnaround time for claim repricing? What procedures are in place to verify that all claims sent to the PPO for repricing are returned for processing?
3. Please describe each recommended PPO's willingness to negotiate contracts with providers identified in areas in which the network does not have sufficient coverage.
4. Describe any network changes that are being planned or implemented that would impact current network access.
5. ATU may elect to pay claims for their facility as domestic at a discounted price outside the selected PPO network's pricing structure. Confirm your willingness to comply. Will you charge a process fee for these claims? If so, disclose the fee.

PHARMACY

6. Can the OOP Maximum be integrated with a PBM selected through a separate RFP process? Please include fees associated with the management and transfer for sending/receiving feeds to/from the PBM and all other fees.

BANKING

7. Explain banking options for claims payment.
8. If payments are made from the TPA's own bank account, how often will you request funds? Is the account set up individually for each employer?
9. What is the turnaround time in requesting funds from the client? For example, funds are requested daily based on checks that cleared the prior day.
10. Do you require a deposit of any funds? Please describe the amount of deposit, when it is made, when it is replenished, and what (if any) method and rate you will use for crediting interest on the deposit. If the deposit is reduced by paid claims, is it reduced as checks are issued or cleared?

IMPLEMENTATION

11. Provide an implementation plan that identifies your responsibilities and the assistance/activities that will be required from the employer.
12. What notifications, if any, do you send to participants regarding the change?

13. Provide a timetable for a January 1, 2027 change with specific tasks for converting an employer's current medical plan to your system.
14. Explain your willingness to create and maintain the Plan Documents and SPD? What is the process for updating/amending? If additional fee required, please explain.

AFFORDABLE CARE ACT REQUIREMENTS

15. Describe the support your firm will provide to the employer regarding ACA reporting requirements for self-funded groups, i.e., 1094-C, 1095-C and 1094-B, etc. reporting.

EXHIBIT A

PREFERRED CONTRACTUAL PROVISIONS

SERVICES

During the term of this Agreement, the Firm shall provide for ATU the goods and services offered to ATU by the Firm in its proposal and/or any addenda to its proposal and as specified by ATU when it selected the Firm.

CLIENT AUTHORIZED REPRESENTATIVE

The only persons who are or shall be authorized to speak or act for ATU in any way with respect to this Agreement are those whose positions or names have been specifically designated in writing to the Selected Firm by ATU. Final authority for purchasing decisions rests with ATU.

WAIVER

No waiver of any right hereunder shall be deemed a continuing waiver, and no failure on the part of either party to exercise wholly or in part any right hereunder shall prevent a later exercise of such or any other right.

INDEMNIFICATION

The selected Firm shall indemnify and hold harmless ATU and the employees and agents of each, from all property damage or loss, claims, liability, damages, expenses (including, without limitation, attorneys' fees and expenses) and any other amounts arising out of the performance of the Agreement by the Selected Firm.

GOVERNING LAW

This Agreement is subject to the laws of the State of Arkansas.

TERMINATION

If the Selected Firm fails to provide quality goods and services in a professional manner solely as determined by ATU and, upon receipt of notice from ATU, does not correct the deficiency within a reasonable period of time not to exceed thirty calendar days, unless otherwise agreed to by both parties, ATU reserves the right to terminate this Agreement by giving written notice to the Selected Firm.

TAXES

ATU is exempt from Federal excise and all state and local taxes. Such taxes shall not be included in contract prices. Tax-exempt certificates will be furnished on request by the issuing office.

INSURANCE

The Selected Firm shall provide to ATU within 10 days after the contract is awarded a valid certificate of insurance listing the insurance coverage maintained. The liability insurance coverage maintained by the Selected Firm shall include, but is not limited to, the following coverage:

- Premises - Operations
- Contractual
- Personal Injury
- Cyber Liability
- Commercial General Liability Insurance (CGL):
 - Vendor is responsible for carrying Commercial General Liability insurance including Contractual Liability per CG0001 (12/07 or equivalent), with limits not less than \$1,000,000 Each Occurrence and \$2,000,000 in the aggregate for bodily injury and third party property damage including products and completed operations.
 - Such coverage shall name ATU and all subsidiaries as additional insured. Such coverage will be on a primary and non-contributory basis for both ongoing and completed operations and shall include a waiver of subrogation in favor of ATU and all subsidiaries.
 - Vendor will provide the Company with certificates of insurance evidencing CGL written by insurance companies with A-VII or better AM Best rating.
- Professional Liability/ Errors and Omissions, including coverage for claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security with limits not less than \$1,000,000.