STATE OF TENNESSEE
Benefits Administration

REQUEST FOR PROPOSALS # 31786-00133
AMENDMENT # Three
FOR EAP/BHO Services

DATE: April 14, 2016

RFP # 31786-00133 IS AMENDED AS FOLLOWS:

1. **This RFP Schedule of Events updates and confirms scheduled RFP dates.** Any event, time, or date containing revised or new text is highlighted.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		February 22, 2016
2. Disability Accommodation Request Deadline	2:00 p.m.	February 25, 2016
3. Pre-response Conference	1 p.m.	February 26, 2016
4. Notice of Intent to Respond Deadline	2:00 p.m.	February 29, 2016
5. Written "Questions & Comments" Deadline	2:00 p.m.	March 4, 2016
6. State Response to Written "Questions & Comments"		March 24, 2016
7. 2nd Written "Questions & Comments" Deadline	2:00 p.m.	March 30, 2016
8. State Response to 2nd round of Written "Questions & Comments"		April 14, 2016
9. Deadline to Submit Network and Claims Information to Aon Hewitt	5:00 p.m.	April 20, 2016
10. Response Deadline	2:00 p.m.	April 25, 2016
11. State Completion of Technical Response Evaluations		May 13, 2016
12. State Opening & Scoring of Cost Proposals	2:00 p.m.	May 16, 2016
13. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	1 Day after Insurance Committee Award of Contract
14. End of Open File Period		7 CALENDAR DAYS LATER
15. State sends contract to Contractor for signature		1 BUSINESS DAY LATER

16. Contractor Signature Deadline	2:00 p.m.	1 – 5 BUSINESS DAYS LATER

2. State responses to questions and comments in the table below amend and clarify this RFP.

Any restatement of RFP text in the Question/Comment column shall NOT be construed as a change in the actual wording of the RFP document.

	QUESTION / COMMENT	STATE RESPONSE
1	For response #30 in the Vendor QA document regarding Work Life Utilization, please confirm if the Child/Elder Services includes fully verified referrals.	Yes, the vast majority of the Child/Elder Care Services include fully verified referrals, customized to each member request.
2	Per the RFP we are to bid on a total of 152,000 employees and 272,000 members (average contract size of 1.79); however, Appendix 7.4 indicates 136,913 employees and 272,435 members (average contract size of 1.99). As average contract size is a variable in determining rates, will the state please clarify the exact number of employees and members so we can provide accurate pricing.	As of March 2016 there are approximately: • 138,062 enrolled employees • 277,000 total enrolled members (which includes both employees and dependents.) • 8,543 State and Higher Education employees, who have EAP services, yet are not enrolled in the medical plan. Throughout the year, enrollment in the State Group Health Insurance Program has slight fluctuations. See Amendment Section #13 and #15 below.
3	In Appendix 7.13 the EAP utilization shows declining utilization from 2012-2015. What is driving the decline in utilization?	Many factors may be involved in the declining utilization including limited communication, stigma associated with accessing services, and provider access. In January of 2012, a new contract was implemented which involved a significant amount of communications. This implementation communication campaign may have accounted for the increased utilization in 2012.
4	RFP Attachment 6.2 – C.14 This section says to "Describe your member services unit for this Contract – at a minimum, address or provide each of the following…" then the section goes on to describe "Member Services Group" and "Member Services Representative." One other variation of the member services representative descriptor is found on pg.79 A.14 m. (4) and it says, "Customer Service Representative" can you confirm that all these references are indicating a licensed master's level or above staff	The State's expectation is that all callers will first speak with a licensed clinician to assess need and assist. A caller may be redirected, after speaking with the licensed clinician, to a trained customer service representative to provide an administrative task or claims inquiry.

	QUESTION / COMMENT	STATE RESPONSE
	member?	
5	RFP Attachment 6.2 C.14 a. b. c. d. e. f. g. h. i. j. k.: Is it the expectation that all responses to each letter in this section are to apply only to clinical representatives, those that are licensed master's level or above?	Each of the responses may apply to the dedicated service unit composed of both licensed clinicians and trained customer service representatives.
6	Attachment 6.3 What is the EAP utilization target/goal that would trigger the state to change to a fully insured rate for all members?	The State would consider moving to a fully insured EAP rate if EAP utilization were to reach an average utilization as compared to peer employer groups and there was a cost advantage to the State.
7	RFP Section C.6.b: are the "details that quantify success metrics" requested here in reference to the example requested in C.6a or for the vendor's overall use of technology to engage members?	C.6.b. applies to either the example cited in C.6.a. or the proposer's overall use of technology to engage members.
8	RFP Section C.17.2 (d) Is this question inquiring about where paid claims data is stored?	Yes, C.17.2. (d) is referencing where duplicate claims payment records are maintained for business continuity/disaster recovery practices as referenced in A.20.h.8.
9	#40 in the Vendor QA document asks "B.17 requests references from three "completed projects". May the Respondent include contracts that have been fulfilled and have been renewed?" and the State's response was: "Yes, you may include both fulfilled and renewed contracts." Please confirm that for "completed projects" we may use clients that have renewed with us, so technically we could have all active clients and no terminated clients as references.	Yes, the respondent may include contracts that have been fulfilled and renewed. Yes, completed projects may include clients that have renewed.
10	• Please provide the total number of claims submitted and processed per year for MHSUD services. • Please provide the annual call volume for the current program. • Please provide the annual number of appeals for the current program.	176,504 claims were paid for January 1, 2015 – December 31, 2015. **Annual Call Volume;** CY 2014 – 42,491 CY 2015 – 38,663 **Annual number of appeals;** **2014** Administrative 10 Claims 152

	QUESTION / COMMENT	STATE RESPONSE
		Clinical 78 **2015** Administrative 14 Claims 173 Clinical 83
11	Should the network and claims information submitted to Aon Hewitt be in a hard copy or electronic format?	An electronic format submission would be preferred.
12	Attachment 6.2, Section D Please confirm that respondents may only include in-network providers with a behavioral health specialty and that medical providers will not be considered in the Network Analysis score.	Yes, only behavioral health providers and not medical providers.
13	D.1.3 and D.1.4 Which value do we use to rerun the geo, since there are 7 values per line of data?	Please follow instructions found in Appendix 7.7. D.1.3 and D.1.4 raw score calculations are completed by the State Procurement Manager.
14	D.1.3 and D.1.4 Can we get zip codes for the lines which have (blank) as the zip? Or is it acceptable running a geo with the values as provided to us? There are only 91,951 members with zip codes. We want the results to show a true picture of accessibility and it appears the file is missing many member zip codes.	Please use Appendix 7.2 for running GeoAcces reports. Do not include blank zip code enrollment. Total zip code enrollment, not including blanks, in Appendix 7.2 is 220,267.
15	Appendix 7.6 • Please provide the total covered membership by year for the revised utilization data in Appendix 7.6. • For each of the spreadsheet tabs, please provide the total number of units utilized by level of care per year. • The acute inpatient MHSUD utilization data for the current program was not included with the revised Appendix 7.6. Please provide the annual utilization data for acute inpatient services to include the total covered membership, total acute inpatient units utilized per year, and the average length of stay. • It appears the “Days LOS Admit Acute”, “Patient Admit”, and “Admits” are the same on the “Residential Inpatient” spreadsheet tab	See Amendment Section #3 below. Contract Amendment Appendix 7.6 has been revised to include the data currently available. The data was run based on a subset of members with the specified service categories, revenue codes, and/or facilities (not claims or admits) within the subsets (which both include the same service subcategory codes), so the two subsets (or levels of care) can absolutely overlap in that respect. Also, the measures that do have the same numbers for each level of care are based on general admissions (i.e. not specific to MHSA) for people who had these types of admissions, which may or may not be inclusive of only MHSA.

	QUESTION / COMMENT	STATE RESPONSE
	and the “Partial Inpatient” spreadsheet tab, is this an error? • Please provide the allowed and paid amount per unit by level of care.	
16	B.17 Can a completed contract period serve as one of the completed project references even though respondent has subsequently renewed again with the same customer and has a current contract active for a new contract period?	Yes, a completed contract that has renewed can serve as a reference.
17	A.3.i Please describe ‘optional telephonic EAP services’ not already specified in the RFP.	The State expects all potential vendors to have the ability to offer employees the option of obtaining EAP services telephonically. Table C within the Cost Proposal references optional TeleBehavioral health services as opposed to EAP services.
18	A.5 Please confirm if the access standards as outlined below are for both the EAP and behavioral health networks. 1) Emergency/crisis service: four (4) hours 2) Urgent visit: twenty-four (24) hours 3) Routine/Initial visit: seventy two (72) hours	Yes, the access standards apply to both the Employee Assistance and the Behavioral Health network.
19	A.5.b Can you help us understand why the State requires 70% of psychiatrists to be board-certified? Would the State accept 60% board certified with over 95% board eligible? If we narrow our network to board-certified psychiatrists only, members will lose access.	The State has amended the contract language. Refer to Amendment Section #4 and 5 below.
20	A.8.f. This section starts by saying the following: “Unless otherwise directed by the State, the Contractor shall implement a project to monitor and identify areas of potential risks with our members’ opioid prescription activity. However, later it states “This program shall provide medical providers with prescription, behavioral health, and substance abuse information as applicable for their patients who are prescribed opioids	The program may cover both opioid and benzodiazepines.

	QUESTION / COMMENT	STATE RESPONSE
	and/or benzodiazepines….." Please clarify if this program is targeting only opioid prescription activity or both opioid and benzodiazepines.	
21	A.8.l Can you please provide the specific populations that are potential members for this program? For example, is this for employees only or all covered lives? What divisions are included? How many total in potential population?	This program would be available to any adult (18 and above) member enrolled in the State Group Insurance Program. As of February 2016, there are approximately 223,583 members, 18 or above, enrolled in the plan.
22	A.11.a Will the State consider removing "subcontractors" from this requirement. We currently do not audit our subcontractors: "Upon thirty (30) days' written notice and the execution of any applicable third party confidentiality agreement(s), the State and/or its authorized representative has the right to examine and audit the Contractor services and pricing to ensure compliance with all applicable requirements. For the purpose of this requirement, the term, 'Contractor,' shall include its parent organization, affiliates, subsidiaries, subcontractors, and providers."	No, the State does not agree.
23	A.12.k. states that "Unless otherwise directed by the State, the Contractor shall conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey." However, it is our understanding that CAHPS is a health plan survey, geared to medical plans and is not applicable to MBHOs. Can the State please explain its intent in requiring the behavioral health vendor to implement this survey?	Contract language specifies "unless otherwise directed by the State." Further agreement on an appropriate member satisfaction survey to be discussed during implementation.
24	A.19.m Content received by of our subcontractors may be subject to non-disclosure agreements; therefore, we are legally bound to keep this information confidential and cannot release it to the State. Will the State consider adding "as legally allowable" to the end of this requirement: "The decision of the State on these matters shall not be subject to appeal as legally allowable."	No, the State does not agree.
25	A.20.h (4) Will the State accept a copy of our	A summary of Business Continuity Results are

	QUESTION / COMMENT	STATE RESPONSE
	DR summary results for this requirement? For purposes of security we do not currently release our BC results externally.	required. Details on system weakness do not have to be shared but must be acknowledged. Results are confidential and will not be shared except in the case of an incident or audit. In those situations it is only shared on a need to know basis with the State Office of Information Resources, State Audit, and/or Legal.
26	A.20.h(5) Currently, our Disaster Recovery department simulates disasters; therefore, will the State consider striking "and low level failures" from this language: “The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions. The Contractor shall submit an annual BC-DR Results Report to the State (see Contract Attachment C, Report #25).”	No, the State does not agree. This Contract requires both simulated disasters and low level failure testing.
27	A.20.h (7) Due to the intricate development of the systems used in our BH/EAP solutions, we established an RPO of 48 hours. Is the State willing to negotiate this timeframe from the 8 hours in the Pro Forma contract?	The State will agree to 24 hours. See Amendment Section #12.
28	A.20.h (8) Our data resides in a shared environment with logical separation by customer, not physical separation of data. Backups are performed by database/server, not by customer; therefore, it would be a HIPAA violation to provide backup data and impossible to extract archival data for a specific customer (without costing the State vast amounts of money). “The Contractor shall maintain a ~~duplicate set~~ **backup** of all records relating to this Program in electronic medium, usable by the State and the Contractor for the purpose of disaster recovery or data restoration. Such ~~duplicate records~~ **backups** are **electronically vaulted to a geographically separated Date Center** ~~to be stored at a secure fire, flood, and theft-protected facility located away from the storage location of the originals~~. The Contractor shall **perform backups per the established data protection schedule which includes daily, incremental, and full backups** ~~update duplicate records, at a~~	No, the State does not agree. How the contractor stores the data backup is not a required safeguard but the contractor’s data backup plan must have the capability of retrieving exact copies of ePHI for each member.

	QUESTION / COMMENT	STATE RESPONSE
	~~minimum, on a daily basis~~ and shall retain **backups** ~~said records~~ for a period of sixty (60) days from the date of creation. ~~At the termination of this Contract, the Contractor shall convey the original and the duplicate records medium and the information they contain to the State on or before the date of termination.~~"	
29	A.20.j (6) Will the State consider amending the language to state "provide the State access once annually" instead of "upon request"? "The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities provide the State access once annually ~~upon request~~. The physical security provisions shall be in effect for the life of this Contract."	No, the State does not agree. "Upon request" is not intended to be anytime access on a regular basis. Typically this request would occur due to an audit or legal matter. Prior notification of the need to access would be provided.
30	A.20.j (11) Is there a specific audit format required for the annual security risk assessment or is the format up to the Contractor to determine?	No, there is not a specific audit format required, as long as the audit and report meet the standards provided in the Contract Section A.20.j (11).
31	A.21.c. Please clarify the expected award date of the contract?	The contract is expected to be awarded in June, with contract start date of July 1, 2016 and all systems fully operational by January 1, 2017.
32	A.21.i. • Will the Contractor be required to use the historical data for reporting or other operational needs (e.g., incumbent claims run-off)?	No, the Contractor is not required to use the data provided to the DSS vendor.
33	A.23.a • Allowing State employees this level of access presents the Contractor with a risk as users may make changes which would be beyond our control. As a result, will the State consider these impacts and be open to negotiating the performance guarantees and potential penalties?	Access to the eligibility system for view only access is permissible. Alternative, real time updates to the eligibility system will be permitted as agreed upon during implementation. See Amendment Section #6 below.
34	A.21.e.(3) • Please clarify the errors noted are related to eligibility records the Contractor is unable to load as a result of missing data elements otherwise noted as required data and are returned to the State for correction. • How will the State supply the corrected	Benefits Administration has a dedicated staff member that works with State vendors via email to update identified errors as reported by the vendor. Errors identified during the loading of the eligibility file have a four business day time frame. Errors identified during normal business operations,

	QUESTION / COMMENT	STATE RESPONSE
	records back to the Contractor? Will there be an indicator to denote these in the file in order to track the four-day turnaround time? • Please clarify, does Contractor have four business days or one business day to resolve errors or is the timeframe one which can be agreed upon with the State during the collection of file requirements?	typically at point of service for a member, are to be updated within one business day.
35	A.21.i (5) What is the average amount the Contractor should expect to budget for developing and testing the file exchange with the DSS vendor? What is the average monthly/annual amount the Contractor should expect to budget for ongoing interface with the DSS vendor?	The prevailing vendor will incur a $15,000 charge to implement a file exchange with the State's DSS vendor. The State recommends an annual budget of approximately $2,000 for problems related to the behavioral health vendor's transmission of the data and any performance guarantees. This is an approximation based on historical vendor experience.
36	A.22.d Will the State consider changing "immediately" to "promptly" in this requirement: "The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. The Contractor shall immediately promptly report to the State any unauthorized use or disclosure of the PHI. Contractor shall comply with the HIPAA Breach Notification Rules found in 45 CFR §, Section 164.400 et al, and shall cooperate with the State in responding to any unauthorized use or disclosure of PHI related to this contract."	The State does not agree to add the proposed language but will insert promptly (within 48 hours). See Amendment Section #11 below.
37	E.9 Will the State consider changing "immediately" to "promptly" in the following requirement: "Contractor shall immediately promptly notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives."?	No, the State does not agree.

	QUESTION / COMMENT	STATE RESPONSE
38	E.9 Will the State consider including the following language to the end of this requirement: " Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII unless vendor determines that return or destruction is not feasible. Vendor will for the period specified in the records retention schedule and shall extend any and all protections, limitations and restrictions contained in this agreement."	No, the State does not agree.
39	E.9 Will the State consider including the following language to the end of this requirement: " Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII unless vendor determines that return or destruction is not feasible. Vendor will for the period specified in the records retention schedule and shall extend any and all protections, limitations and restrictions contained in this agreement."	No, the State does not agree.
40	C.14.j Can you please clarify where in the contract this expectation is stated? Can you also clarify if ALL calls, even administrative type questions (e.g. claims questions) are to be answered by a clinician, or whether it is permissible to have clinical calls answered by a clinician and administrative calls answered by a Customer Service representative?	A.14.c. states "The Contractor's call center shall be open and staffed with trained and qualified member service representatives, who are, at minimum, licensed behavioral health professionals (master's level or higher), preferably Certified Employee Assistance Professionals…" A caller may be redirected, after speaking with a licensed clinician, to a trained customer service representative to provide an administrative task or claims inquiry.
41	Attachment D Please clarify if the expectation is to have geriatric care managers handle all child care related calls. Typically GCM's are designed to handle elder care case management issues, not intake calls related to child care.	Contract Attachment D requires that child and elder care assistance be provided by **either** a Certified geriatric case manager **or** a licensed behavioral health professional.
42	E.9 Will the State consider changing "within	No, the State does not agree.

	QUESTION / COMMENT	STATE RESPONSE
	twenty-four (24) hours" to " as soon as practicable" in the following requirement: "The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor, as soon as practicable, ~~within twenty four (24) hours~~ after the Unauthorized Disclosure has come to the attention of the Contractor."	
43	Attachment B, #8 Will the State please provide facility access standards for our GeoAccess report? They do not appear to be in Appendix 7.7 or the PGs. What is in each of those sections are provider standards. Can we use our facility access standards of urban: 1 in 15, suburban: 1 in 30, and rural: 1 in 60.	No, the State does not agree with the suggested access standards and requires the standards below. Facility access standards are; Urban - 2 providers within 20 miles Suburban- 2 providers within 30 miles Rural - 2 providers within 40 miles The State has updated the language in Pro Forma Contract Attachment B #8. See Amendment Section #5 below.
44	HIPAA BAA Will the State consider the following language: "3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within **ten (10)** business days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware **and is applicable to the State's data**. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine	The State agrees to the ten (10) business days. The State does not agree to the addition of 'and is applicable to the State's data' language. See Amendment Section #9 below.

	QUESTION / COMMENT	STATE RESPONSE
	incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events."	
45	HIPAA BAA Will the State consider changing "immediately" to "promptly" in the following requirement: "4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached ~~immediately~~ **promptly** upon becoming aware."	The State does not agree to add the proposed language but will insert promptly (within 48 hours). See Amendment Section #10 below.
46	A.15.e(8) Is the welcome packet required to be sent via first class postage? If so, can you elaborate on the contents and size of the welcome packet to ensure we include accurate pricing as the USPS costs can vary greatly from a postage stamp to a larger mailing?	Yes, the welcome packet is required to be sent via first class postage. The prevailing vendor will work collaboratively with Benefits Administration to determine the contents and size based on contract requirements and State approval. A recent welcome packet by another vendor cost approximately $58,000 to produce in addition to approximately $96,000 in postal costs.
47	What is the current work life utilization by legal, financial, child and elder care?	There were 1,110 Legal/Financial services provided and 290 Child/Elder Care services in FY 2014.
48	Performance Guarantee #4 • How does the assessment of $100 per occurrence apply to the claims processing standards outlined in pro forma contract section A.9b1 (pg. 69)? • What is the State's out-of-network usage?	The $100 Assessment noted in PG # 3 is explained in Contract Section A.9.i. In calendar year 2015, approximately 93% of claims paid were for in network care.
49	Performance Guarantee #4 This performance guarantee states that Contractor shall process, including reimbursement of network	Performance Guarantees # 3 and # 4 have been amended to provide contract references that clarify the difference between the two. See Amendment

QUESTION / COMMENT	STATE RESPONSE
providers for paid claims, within twenty-one (21) calendar days for ninety-eight percent (98%) or higher of all clean claims; however, the Claims Processing Turnaround performance guarantee does not distinguish the claims as paid claims. Can the State please clarify the difference between these two performance guarantees? a) A.9b3 states that "The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days" From what date is the 7 days measured from? b) Please confirm that the term "shall correctly implement any plan design changes within 60 days" may mean implementing one change to one plan and/or implementing multiple changes to one plan c) Please confirm that this performance guarantee only includes plan changes made after the implementation period. d) If multiple plans and multiple changes are required, does the Contractor have 60 days per plan to implement the changes? e) What is the current volume of benefit plans? f) During an implementation, we work directly with the plan subject matter experts and stakeholders to obtain benefit information and clarification. This would include having all benefit documentation business rules by line of business (i.e., covered levels of care and how they are administered, cost share, authorization business rules, covered procedure codes, diagnosis codes or any component required for benefit configuration, etc.) finalized and approved by all relevant stakeholders internally as well as the client. Can the State confirm that Contractors will have this partnership for plan changes and that the 60 day plan change timeline will start once all documentation has been approved? g) If during configuration there are areas which require additional clarification that results in the requirement for updated documentation and approvals, can the State confirm that the 60-day timeline would re-start with the new approved final information? h) What is the reporting mechanism for	Section #7 below. a) The 7 business days are measured from the date the vendor receives the adjusted claim. b) Plan changes are typically implemented on an annual basis. Benefits Administration offers multiple plans with varied benefits. Changes may be additions or deletions of plans offered or changes to the benefits within the plans. c) Performance Guarantee #4 applies at any time in which Benefits Administration directs the prevailing contractor to implement a plan design change. d) The prevailing vendor shall have up to 60 days, to execute all plan changes for all plans. e) Benefits Administration currently offers five benefit plans: Partnership PPO, Standard PPO, Limited PPO, Wellness HealthSavings CDHP, and HealthSavings CDHP. Administering benefits for over 300,000 individuals, the plan spent $1.4 Billion in claims during CY 2015. f) Typically, during implementation vendors are given greater than sixty days to implement plan changes. The sixty day time period does not began until the vendor is provided information required to execute the plan change, however it includes vendor understanding and documentation approval. g) No, the sixty day timeline does not re-start. h) The Contractor shall include claim adjustment processing in the monthly paid claims report. i) No, Performance Guarantee #18 does not include 80% auto adjudication rate however vendor shall include the auto adjudication rate in the monthly paid claims report

QUESTION / COMMENT	STATE RESPONSE
adjustments? i) Does the assessment and measurement apply to all of the claims processing standards, including the 80% auto-adjudication rate?	
50. Performance Guarantee #7 • This performance guarantee references contract requirement A.5m; however, A.5m describes a report to be submitted to the State whereas the performance guarantee states the Contractor's requirement to provide notice to members. Please clarify if both the report and notice to member is required to fulfill this guarantee. • Please provide the requirements of the notice to members such as specific information required to be included in the notice, the timeframe for notifying members, is the notice required for all members who ever saw the terminated provider or those who saw them recently (e.g., within the last year), etc.	Performance Guarantee #7 applies to the prevailing contractor notifying members of provider terminations, details specified in Contract Section A.5.o. See Amendment Section #8 below.
51. Performance Guarantee #16 • Please confirm that the State will use the following formula to define Claims Payment Accuracy: Total number of claims audited without financial error / (divided by) the total number of claims audited = Payment Accuracy.	The prevailing contractor shall perform the calculations based on a sample of claims. Claims Payment Accuracy: The measurement of claims processed with an accurate payment of benefits divided by the total number of claims with payments in the audited population
52. Performance Guarantee #17 • Please confirm that the State will use the following formula to define Overall Claims Processing Accuracy Total Number of Claims without an error / (divided by) Total Number of Claims audited = Overall Accuracy Percentage	The prevailing contractor shall perform the calculations based on a sample of claims. Claims Processing Accuracy: The measurement of claims processed without any type of error divided by the total number of claims in the audited population.
53. Performance Guarantee #22 • What are the specifics of the penalty? • How does the State intend for the Contractor to report on this measure? • Does "per violation" mean per impacted person, or the overall occurrence?	Please see details specified in Contract Section A.22. The Contractor shall report breaches in compliance with A.22.d. and A.22.h. Per violation means the assessment will be imposed on a per incident basis meaning regardless of how many members are impacted.
54. Performance Guarantee #24 • Can the State please outline the scenarios in which the	The noted situations are some examples, others include significant file feed data issues, systemic

QUESTION / COMMENT	STATE RESPONSE
vendor would be required to immediately contact the State? Generally, XXX (redacted name) would immediately contact a client regarding the following situations that have the potential to negatively impact the administration or delivery of the behavioral health program, plan or benefits: severe weather, telephony/internet issues, natural disasters which may impact service access, and discovery of provider fraud and abuse.	program administration issues, etc. The State's intent is to prevent a vendor from performing internal investigations of a suspected issue over an extended period of time without notifying the State causing continued impact to members, the plan, or the State.

3. **Delete RFP Appendix 7.6 in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

   Appendix 7.6 MHSA Claims Data

4. **Delete language in Pro Forma Contract section A.5.b. and add the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

   Delete:
   The Contractor's behavioral health provider network shall include appropriately licensed and credentialed behavioral health practitioners, including, but not limited to, psychiatrists, including addiction psychiatrists (70% of the Contractor's network psychiatrists shall be board certified), Advanced Practice Psychiatric Nurses -Board Certified (70% of the Contractor's network Advanced Practice Psychiatric Nurses shall be board certified), licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), Substance Abuse Professionals (SAPs), and drug and alcohol counselors representative of the culture, race, sex and age of the population to be served. The Contractor's network shall also include a sufficient selection of licensed and credentialed programs and facilities (acute, residential, intensive outpatient, detoxification facilities and other necessary programs and services) in the network to provide access to behavioral health services. The Contractor's network shall include providers with expertise related to domestic violence, sex addiction, eating disorders/body image disorders, and gambling addiction, as well as substance abuse providers that provide detoxification for adolescents.

   Add:
   A combined 65% of all the Contractor's psychiatrist and advanced practice psychiatric nurses shall be board certified. 98% of all network psychiatrists and advanced practice psychiatric nurses shall be board eligible.

5. **Add language in Pro Forma Contract Attachment B #8 and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

   Delete:

1. **Provider Network Accessibility**		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider network shall assure that 95% of all members shall have the Access Standard indicated.	
Definition	**Provider Type**	**Access Standard (Urban, Suburban, and Rural)**
	Outpatient Behavioral Health Network Providers	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
	Inpatient Behavioral Health Network Providers	2 providers within 20 miles 2 providers within 30 miles 2 providers within 40 miles
	Psychiatrists (board certified and non-board certified) and Advanced Practice Psychiatric Nurses (board certified and non-board certified). Note: 70% of the Contractor's network psychiatrists shall be board certified and 70% of the Contractor's network Advanced Practice Psychiatric Nurses shall be certified per Contract Section A.5.b.	2 psychiatrists or Advanced Practice Psychiatric Nurses within 10 miles 2 psychiatrists or Advanced Practice Psychiatric Nurses within 15 miles 2 psychiatrists or Advanced Practice Psychiatric Nurses within 30 miles

Add:

2. **Provider Network Accessibility**		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider network shall assure that 95% of all members shall have the Access Standard indicated.	
Definition	**Provider Type**	**Access Standard (Urban, Suburban, and Rural)**
	Outpatient Behavioral Health Network Providers	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
	Inpatient Behavioral Health Network Facilities	2 facilities within 20 miles 2 facilities within 30 miles 2 facilities within 40 miles
	Psychiatrists (board certified and non-board certified) and Advanced Practice Psychiatric Nurses (board certified and non-board certified). Note: A combined 65% of all the Contractor's psychiatrist and advanced practice psychiatric nurses shall be board certified. 98% of all network psychiatrists and advanced practice psychiatric nurses shall be board eligible per Contract Section A.5.b.	2 psychiatrists or Advanced Practice Psychiatric Nurses within 10 miles 2 psychiatrists or Advanced Practice Psychiatric Nurses within 15 miles 2 psychiatrists or Advanced Practice Psychiatric Nurses within 30 miles

6. **Add language in Pro Forma Contract section A.23.a. and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

Unless otherwise agreed upon by the State, the Contractor shall provide a minimum of five (5) State employees with access to the Contractor's eligibility system no later than nine (9) days prior to the go-live date. Additional or replacement users may be added at any time at the State's request. Access shall include the ability to do real-time updates to the Contractor's eligibility records. State access is limited to only eligibility data.

7. **Add language in Pro Forma Contract Attachment B #3 and 4 and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

3. **Plan Design**	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design per Contract Section A.9.i.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) plus the actual costs incurred of the incorrectly-processed claim.
Measurement	Measured, reported, reconciled and paid after each occurrence.
4. **Plan Changes**	
Guarantee	The Contractor shall correctly implement any plan design changes within sixty (60) days of written notification from the State as required in Contract Section A.9.j.
Assessment	One thousand dollars ($1,000) per day if the standard is not met. The State will not assess liquidated damages pursuant to both this guarantee and the guarantee related to Plan Design for the same deficiency.
Measurement	Measured, reported, and paid after each occurrence.

8. **Delete language in Pro Forma Contract Attachment B #7 replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:

7. **Member Notice of Provider Termination**	
Guarantee	The Contractor shall provide written notice to members regarding terminated providers, as specified in Contract Section A.5.m.
Assessment	Three thousand dollars ($3,000) per occurrence (defined as each provider termination) if the standard is not met.
Measurement	Measured, reported, and paid after each occurrence.

Add:

7. **Member Notice of Provider Termination**	
Guarantee	The Contractor shall provide written notice to members regarding terminated providers, as specified in Contract Section A.5.o.
Assessment	Three thousand dollars ($3,000) per occurrence (defined as each provider termination) if the standard is not met.
Measurement	Measured, reported, and paid after each occurrence.

9. Delete language in Pro Forma Contract Attachment E Section 3.4 and replace with the following (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:
Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) business days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

Add:
Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within ten (10) business days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

10. Delete language in Pro Forma Contract Attachment E Section 4.3 and replace with the following (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:
Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached immediately upon becoming aware.

Add:
Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required

By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached promptly (within 48 hours) upon becoming aware.

11. **Delete language in Pro Forma Contract A.22.d. and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:
The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. The Contractor shall immediately report to the State any unauthorized use or disclosure of the PHI. Contractor shall comply with the HIPAA Breach Notification Rules found in 45 CFR §, Section 164.400 et al, and shall cooperate with the State in responding to any unauthorized use or disclosure of PHI related to this contract.

Add:
The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. The Contractor shall promptly (within 48 hours) report to the State any unauthorized use or disclosure of the PHI. Contractor shall comply with the HIPAA Breach Notification Rules found in 45 CFR §, Section 164.400 et al, and shall cooperate with the State in responding to any unauthorized use or disclosure of PHI related to this contract.

12. **Delete language in Pro Forma Contract A.20.h(7) and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete: In the event of a declared major failure or disaster, as defined in the Contractor's BC-DR plan, the Contractor's critical functionality shall be restored within seventy-two (72) hours of the failure's or disaster's occurrence. The Contractor shall also ensure a Recovery Point Objective (RPO) of eight (8) hours in the event of any data loss.

Add: In the event of a declared major failure or disaster, as defined in the Contractor's BC-DR plan, the Contractor's critical functionality shall be restored within seventy-two (72) hours of the failure's or disaster's occurrence. The Contractor shall also ensure a Recovery Point Objective (RPO) of twenty-four (24) hours in the event of any data loss.

13. **Delete language in RFP Attachment 6.3 Cost Proposal and replace with the following** (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:

	TABLE A – Administrative Fees for Self-Funded BHO/EAP Model					
Fee Per Employee Per Month (PEPM) – NO Medical	**Rates for services/benefits for employees that do not participate in the medical program (Fully Insured Active Employees and their dependents), but are only covered in the EAP 5-visit model. (Currently approximately 7,000 employees)***					**State Use Only**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	**Evaluation Cost (sum*12)**

Administrative Fee per employee per month	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
Fee Per Employee Per Month (PEPM) – WITH Medical	**Rates for BHO/EAP services/benefits for members that participate in the medical program (Self-funded Active Employees, Retirees, COBRAs, and their dependents (currently approximately 145,000 contracts) ****					**Evaluation Cost (sum*12)**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	

PEPM fees should include all costs to deliver the services outlined in the Scope of Services of the RFP Attachment 6.6., Pro Forma Contract, except actual claim payments to covered persons.

*This rate includes both members enrolled in the medical plan (approximately 145,000) and employees eligible, yet not enrolled in the medical plan who are covered by the EAP (approximately 7,000) for a total of approximately 152,000.

** Services include: BHO and EAP claims processing/member services, claims fiduciary, administration/banking, account management/reporting (standard and ad hoc), member communication materials, quality assurance management, and the five (5) session EAP model. Employee education sessions/topical seminars, manager/supervisor training, critical incident debriefing and employee orientation. These services are to be provided via an annual "bank" of six hundred (600) hours that is available at the discretion of the State. Any unused hours at the end of each year will roll forward to the next year's bank, up to a maximum of three hundred (300) hours that do not expire until twelve (12) months prior to contract termination. These services are to be provided on an Administrative Services Only (ASO) basis.

	EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.			
lowest evaluation cost amount from all proposals		**x 8 (Table A score)**	**= SCORE:**	
evaluation cost amount being evaluated				

	TABLE B – Administrative Fees for Optional Fully Insured EAP Model					
Fee Per Employee Per Month (PEPM) – EAP Services	**Rates for EAP services/benefits for all employees, covered in the EAP 5-visit model.* Fully Insured Active Employees, Retirees, COBRAs, and their dependents (currently approximately 152,000 contracts)**					**State Use Only**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	**Evaluation Cost (sum*12)**
Administrative Fee per employee per month	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	

Fee Per Employee Per Month (PEPM) – BHO Services	Rates for BHO services/benefits for members** (Self-funded Active Employees, Retirees, COBRAs, and their dependents (currently approximately 145,000 contracts) **					
	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	1/1/2021 – 12/31/2021	
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
	PEPM fees should include all costs to deliver the services outlined in the Scope of Services of the RFP Attachment 6.6., Pro Forma Contract, except actual claim payments to covered persons. *This rate includes both members enrolled in the medical plan (approximately 145,000) and employees eligible, yet not enrolled in the medical plan who are covered by the EAP (approximately 7,000) for a total of approximately 152,000. ** Services include: BHO claims processing/member services, claims fiduciary, administration/banking, account management/reporting (standard and ad hoc), member communication materials, and quality assurance management. These services are to be provided on an Administrative Services Only (ASO) basis.					
	EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.					
lowest evaluation cost amount from all proposals		**x 1 (Table B score)**		**= SCORE:**		
evaluation cost amount being evaluated						

	TABLE C – Administrative Fees for Optional TeleBehavioral Health Services					
	Rates for services/benefits for the members that participate in the medical program (Self-Funded Active Employees, Retirees, COBRAs, and their dependents) (currently approximately 145,000 contracts).**					State Use Only
	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	1/1/2021 – 12/31/2021	Evaluation Cost (sum*12)
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
	EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.					
lowest evaluation cost amount from all proposals		**x 1 (Table C score)**		**= SCORE:**		
evaluation cost amount being evaluated						

Add:

TABLE A – Administrative Fees for Self-Funded BHO/EAP Model						
Fee Per Employee Per Month (PEPM) – WITH Medical	**Rates*** for BHO/EAP services/benefits for members that participate in the medical program (Self-funded Active Employees, Retirees, COBRAs, and their dependents (currently approximately 139,000 contracts) ******					**Evaluation Cost (sum*12)**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	
BHO Administrative Fee***	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
EAP Administrative Fee***	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
Administrative Fees for Limited Fully Insured EAP Model						
Fee Per Employee Per Month (PEPM) – NO Medical	**Rates for services/benefits for employees that do not participate in the medical program (Fully Insured Active Employees and their dependents), but are only covered in the EAP 5-visit model. (Currently approximately 8,500 employees)***					**State Use Only**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	**Evaluation Cost (sum*12)**
Administrative Fee per employee per month	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
	PEPM fees should include all costs to deliver the services outlined in the Scope of Services of the RFP Attachment 6.6., Pro Forma Contract, except actual claim payments to covered persons. * There are currently approximately 8,500 State and Higher Education employees that waive medical coverage and therefore would be provided EAP services, which includes both the five (5) visit model and Work-Life Program, on a fully insured basis. Non enrolled dependents of an enrolled Head of Contract (HOC) for Local Education and Local Government are also eligible for five (5) EAP/Work-Life sessions on a fully insured basis. ** Services include: BHO and EAP claims processing/member services, claims fiduciary, administration/banking, account management/reporting (standard and ad hoc), member communication materials, quality assurance management, and the five (5) session EAP model. Employee education sessions/topical seminars, manager/supervisor training, critical incident debriefing and employee orientation. These services are to be provided via an annual "bank" of six hundred (600) hours that is available at the discretion of the State. Any unused hours at the end of each year will roll forward to the next year's bank, up to a maximum of three hundred (300) hours that do not expire until twelve (12) months prior to contract termination. These services are to be provided on an Administrative Services Only (ASO) basis. ***Rates: Administrative fees for BHO and EAP are separate to allow flexibility for future carve in/carve out opportunities.					
EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.						

(lowest evaluation cost amount from all proposals divided by evaluation cost amount being evaluated)	**x 8 (Table A score)**	**= SCORE:**	

	TABLE B – Administrative Fees for Optional Fully Insured EAP Model					
Fee Per Employee Per Month (PEPM) – EAP Services	**Rates for EAP services/benefits for all employees, covered in the EAP 5-visit model.* Fully Insured Active Employees, Retirees, COBRAs, and their dependents (currently approximately 147,500 contracts)**					**State Use Only**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	**Evaluation Cost (sum*12)**
Administrative Fee per employee per month	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
Administrative Fees for Self-Funded BHO Model will be reimbursed at the same rate listed in Table A. PEPM fees should include all costs to deliver the services outlined in the Scope of Services of the RFP Attachment 6.6., Pro Forma Contract, except actual claim payments to covered persons. *This rate includes both members enrolled in the medical plan (approximately 139,000) and employees eligible, yet not enrolled in the medical plan who are covered by the EAP (approximately 8,500) for a total of approximately 147,500.						
EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.						
(lowest evaluation cost amount from all proposals divided by evaluation cost amount being evaluated)	**x 1 (Table B score)**	**= SCORE:**				

TABLE C – Administrative Fees for Optional TeleBehavioral Health Services						
Rates for services/benefits for the members that participate in the medical program (Self-Funded Active Employees, Retirees, COBRAs, and their dependents) (currently approximately 139,000 contracts).**						**State Use Only**
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**	**Evaluation Cost (sum*12)**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	
	EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.					

(lowest evaluation cost amount from all proposals divided by evaluation cost amount being evaluated)	**x 1 (Table C score)**	**= SCORE:**	

14. Delete language in Pro Forma Contract C.3 Table A and replace with the following (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:

Fee Per Employee Per Month (PEPM) – NO Medical	**Rates for services/benefits for employees that do not participate in the medical program**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM
Fee Per Employee Per Month (PEPM) – WITH Medical	**Rates for BHO/EAP services/benefits for members that participate in the medical program**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM

Add:

Fee Per Employee Per Month (PEPM) – WITH Medical	**Rates for services/benefits for employees that do not participate in the medical program**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
BHO Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM
EAP Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM
Fee Per Employee Per Month (PEPM) – NO Medical	**Rates for BHO/EAP services/benefits for members that participate in the medical program**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM

15. Delete RFP Appendix 7.1.b in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Appendix 7.1.b Analytic Model Information

16. **Delete Pro Forma Contract C.3. Table B in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

Delete:

Fully Insured Active Employees, Retirees, COBRAs, and dependents (currently approximately 152,000 contracts)	**Rates for EAP services/benefits for all employees, covered in the EAP 5-visit model.***				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM
Self-funded Active Employees, Retirees, COBRAs, and dependents (currently approximately 145,000 contracts)	**Rates for BHO only services/benefits for members that participate in the medical program****				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM
*This rate includes both members enrolled in the medical plan (approximately 145,000) and employees eligible, yet not enrolled in the medical plan who are covered by the EAP (approximately 7,000) for a total of approximately 152,000. If the prevailing vendor is able to achieve the State's goal of increased EAP utilization, the State has the ability to switch from a self-funded model (Table A) to a fully insured payment model (Table B) for future EA services. The State will decide which payment method to utilize prior to each calendar year. Within Table B, the Proposer is asked to provide a fully insured EAP rate based on employees currently eligible for EA benefits (approximately 152,000 contracts).					
**Services include: BHO claims processing/member services, claims fiduciary, administration/banking, account management/reporting (standard and ad hoc), member communication materials, and quality assurance management. These services are to be provided on an Administrative Services Only (ASO) basis.					

Add:

Fee Per Employee Per Month (PEPM) – EAP Services	**Rates for EAP services/benefits for all employees, covered in the EAP 5-visit model. Fully Insured Active Employees, Retirees, COBRAs, and their dependents.**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM

17. **Add the following language to Pro Forma Contract C.3. Table C** (any sentence or paragraph containing revised or new text is highlighted)**:**

Fee Per Employee Per Month (PEPM)	**Rates for Optional Tele-Behavioral Health Services**				
	1/1/2017 – 12/31/2017	**1/1/2018 – 12/31/2018**	**1/1/2019 – 12/31/2019**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
Administrative Fee	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM	$ /PEPM

18. **RFP Amendment Effective Date.** The revisions set forth herein shall be effective upon release. All other terms and conditions of this RFP not expressly amended herein shall remain in full force and effect.