STATE OF TENNESSEE
FINANCE AND ADMINISTRATION, DIVISION OF BENEFITS ADMINISTRATION

REQUEST FOR PROPOSALS # 31786-00125 AMENDMENT # 2 (TWO) FOR REGIONAL THIRD PARTY ADMINISTRATOR SERVICES FOR THE STATE'S PUBLIC SECTOR HEALTH PLANS

DATE: April 28, 2015

RFP # 31786-00125 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 (all dates are state business days)
1. RFP Issued		March 24, 2015
2. Disability Accommodation Request Deadline	2:00 p.m.	March 27, 2015
3. Pre-response Conference	11:00 a.m.	March 30, 2015
4. Notice of Intent to Respond Deadline	2:00 p.m.	April 1, 2015
5. Written "Questions & Comments" Deadline	2:00 p.m.	April 10, 2015
6. State Response to Written "Questions & Comments"		April 28, 2015
7. 2nd Written "Questions & Comments" Deadline	2:00 p.m.	May 4, 2015
8. Deadline to Submit Network and Claims Information to Aon Hewitt	5:00 p.m.	May 1, 2015
9. State Response to 2nd round of Written "Questions & Comments"		May 8, 2015
10. Response Deadline	2:00 p.m.	May 15, 2015
11. State Completion of Technical Response Evaluations		June 15, 2015
12. State Opening & Scoring of Cost Proposals	2:00 p.m.	June 16, 2015
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. State sends contract to Contractor for signature		8 BUSINESS DAYS LATER

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

NOTE: Vendors may submit no more than 5 questions to the State in the 2nd round of Written Questions and Comments.

*****Please also note that Section C of the Cost Proposal should be submitted to the State by the Deadline of May 1st – as this is information the State will need to provide to Aon Hewitt along with the claims information supplied by the Respondent.*****

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	**C. Payment Terms and Conditions p. 98** d. The State shall reimburse the Contractor for the actual cost of the following in the performance of this Contract, provided that the Contractor provides documentation of actual costs incurred as required by the State. (1) Value Oriented Payments. The State shall reimburse the Contractor an amount equal to the actual cost of payments resulting from any State approved value oriented initiatives. **Value Oriented.** C.3.d.(1) Do the incentives in this section apply for programs approved by the State during this contract such as a PCMH?	**Yes. This applies to any program, such as a PCMH, requiring additional provider incentive or reward payments as a result of improved performance and outcomes. All such initiatives must be prior approved by the state before payments are authorized. The State expects, and will require documentation of the value of, and additional cost savings or quality improvements attributable to, the program prior to approval. Please see Amendment Section 22 below.**
2	**Section A, Mandatory Requirement Items, Question A.4 (p. 22)** – Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months. In lieu of two positive credit references from vendors, will a report from Dun & Bradstreet or Standard and Poor's be considered sufficient enough to give us a passing score?	**No, a Dun & Bradstreet or Standard and Poor's report will not be sufficient. The State requires two positive credit references from Vendors with which the Respondent has done business.**
3	**Section A, Mandatory Requirement Items, Question A.5 (p. 22) –** Provide an official **document or letter from an accredited credit bureau, verified and**	**Yes, a Dun & Bradstreet report or Standard and Poor's report verified and dated within the last three (3) months and indicating a satisfactory**

	QUESTION / COMMENT	STATE RESPONSE
	dated within the last three (3) months and indicating a satisfactory credit rating for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.) In lieu of an official document or letter from an accredited credit bureau, would a report from Dun & Bradstreet or Standard and Poor's be considered sufficient enough to give us a passing score?	**credit rating for the Respondent will be sufficient to fulfill this requirement.**
4	**Section A, Mandatory Requirement Items, Question A.15 (p. 24) –** Provide a valid, Certificate of Insurance that is verified and dated within the last six (6) months and which details all of the following: Can you please provide the address that should be listed on the Certificates of Insurance (COI) for this RFP and where they should be sent?	**These Certificates should be sent along with your technical proposal to the State in your response to be delivered to the State on May 15, 2015. They should not arrive separately from your proposal response.**
5	**RFP Attachment 6.3 – Cost Proposal (p. 48)** - Table D- Trend Guarantee – The State's consulting actuary will normalize claims to account for differences in population demographics. Would you provide information that explains what the adjustments will be and how they will be done? Specifically with respect to demographics, plan design selection changes and membership shifts in and out of contractor plans?	**Exact methodology and terms of the calculation of this trend guarantee will be worked out by the Respondent and the State's consulting actuary prior to the measurement of the experience period trend. The State retains the right to utilize their consulting actuary on its behalf during all conversations related to methodology and results.** **The trend will be calculated using allowed amounts for in-network claims incurred during each plan year. The calculation shall include any Member cost share amounts.**

	QUESTION / COMMENT	STATE RESPONSE
6	**3.2.2.2 under Response Delivery states (p. 12):** One (1) original Cost Proposal paper document for each region the Respondent is proposing to offer services in labeled: **"RFP # 31786-00125 COST PROPOSAL ORIGINAL - (APPLICABLE REGION, I.E. EAST, WEST, MIDDLE, STATEWIDE)** Table A – Administrative Services Only p. 46: **When bidding on multiple regions, bidders are required to submit administrative fee bids that are uniform across all regions.** Question 1: Under Response Delivery, Page 12, 3.2.2.2, is the correct interpretation of this section mean: if a contractor is proposing on each region and statewide, there would be four (4) separate cost proposals? And each cost proposal would include the following: (1) Table A, ASO fees; (2) Table B, Telemedicine; (3) Table C Network; and (4) Table D Trend Guarantee (except on the statewide cost proposal)? Question 2: If this is correct that there are separate cost proposals, for Table C – Network would only the applicable region or statewide network be completed and the other regions would be blank? Question 3: If the interpretation in Question 1 is correct, can the percentage fees in Table D – Trend Guarantee – be different for each region?	**Question 1: If a respondent is proposing on all three regions and statewide there would be two copies of Table A; one copy of Table B, two copies of Table C and four (4) copies of Table D.** **Question 2: There will not be four (4) separate cost proposals; please see the response above. Any regions not proposed should be left blank on Table C.** **Question 3: Yes** **The Cost Proposal in RFP Attachment 6.3 has been revised; please see Amendment Sections 6, 7, 8, 9, and 10.** *****Note – Fees listed in Tables A and B must be the same for both regional and statewide submissions, if the fees in these tables differ – the State will consider the Respondents' cost proposal non-responsive and it will not be evaluated.**
7	**3.6. Additional Services** If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information. **NOTICE: If a Respondent fails to submit a**	**Any fees the Contractor wishes to charge the State for services provided should be contained within the costs proposed in the Cost Proposal attached to the RFP in Attachment 6.3. No lines for additional fees should be added.** **Given that the program has not yet been requested, there should be no associated costs included in your proposal. Should the State decide to implement programs such as the pre-diabetes program at a later time, program specifics, fees, and duration will be mutually agreed upon by the State and the Contractor, and effected in a contract amendment if necessary.**

	QUESTION / COMMENT	STATE RESPONSE
	Cost Proposal exactly as required, the State may deem the response non-responsive and reject it. Question: If we are not doing the program currently but the RFP mentions it (i.e. Pre-diabetes program) how do you want us to show any associated cost for programs like this? (p.79 item p)	
8	**<u>GeoAccess:</u>** **Please confirm the following zip codes should be excluded or will you send replacement, valid zip codes for inclusion in the GeoAccess reports since they are not valid zip codes.** Zip ZipCount 37004 1 37021 1 37038 1 37648 2 37796 4 37894 4 37961 1 38307 1 38527 1 Undef 51	**Please exclude the zip codes listed in the table attached to the question.**
9	**<u>A.4. Utilization Management, page 61</u>** **o. The Contractor shall identify, no less than every six (6) months, members using emergency department services inappropriately or excessively. The Contractor shall outreach to those members not currently engaged in health coaching with the State's wellness vendor for the purpose of educating the member on appropriate emergency department use, enrolling the member in case management, if appropriate, or referring the member to other State vendor's for assistance.** In order the comply with the requirements of this section, will the State's wellness vendor send reports to the contractor identifying the	**The wellness vendor will not establish the criteria for excessive or inappropriate use of the emergency department. That is up to the Contractor. The Contractor will work with the wellness vendor to identify members not engaged in coaching, share reports and coordinate care.**

	QUESTION / COMMENT	STATE RESPONSE
	circumstances of why the Contractor should reach out to the member? How will the Contractor be notified from the wellness vendor that the member is not actively engaged in health coaching?	
10	**A.5 Quality Assurance Program, page 62** **The Contractor shall adopt and implement evidence-based clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. Any provision of the Public Sector Plan Documents and any guideline, protocol, or pathway adopted by the Benefits Administration Division shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.16.) shall contain all such guidelines, protocols, or pathways that are applicable to the Public Sector Plans.** Is it acceptable with the State based on this provision that the Contractor will provide all information as stated except any provisions that are proprietary based on contracts with external vendors. However, if there is a denial based on a provision that is proprietary, the information can be shared based on processes in place for appeals.	**Yes. In some cases, the proprietary information may also be required in a summary format for the basis of determining equal coverage or in the development of an overarching Benefits Administration guideline.**
11	**A.9 Claims Processing, Payment and Reconciliation, page 65** **b. The Contractor shall operate a claims management system that tracks accumulations toward deductibles and out-of-pocket maximums, tracks co-payments and co-insurance amounts and appropriately links claim history, enrollment information, member services, provider network, and utilization management information. This shall include the daily electronic exchange of member-level deductible and maximum out-of-pocket accumulator data with the Pharmacy vendor, EAP/BHO vendor, Health Savings Account (HSA) fiduciary, and any other State contracted vendor as**	**Yes, the State requires that accumulator data be shared with the HSA vendor; please refer to new language Amendment Sections 14 and 19.**

	QUESTION / COMMENT	STATE RESPONSE
	needed. **Please clarify that the State of Tennessee wants carriers to share accumulators with the HSA vendor. Normally, true claims data is sent to the HSA vendor and true claims data is also not asked for in A.29.h.**	
12	**A.9. Claims Processing, Payment and Reconciliation, page 66** **i. Claim Processing Standards** **3. The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days.** Please clarify what is being considered as an adjustment. For example: If a provider submits a corrected billing is this classified as an adjustment or will it only be claims adjustments due to original incorrect payments generated from the member?	**Adjustments are corrected claims that are identified as a resubmission.** **Section A.9.i is referencing claims processing as submitted by the provider. If a provider submits a corrected billing it is classified as an adjustment.**
13	**A.9 Claims Processing, Payment and Reconciliation, page 67** **w. The Contractor shall remit to the State no less frequently than quarterly a check for all rebates accrued during the claim period ending six (6) months prior to the rebate payment date which were obtained on behalf of the State due to the use of medical services, devices and pharmaceuticals by members of the Public Sector Plans.** Would it be acceptable to the State that the Contractor agree to pay specialty pharmacy rebates within three months of receipt of payment by the manufacturer.	**Yes, that is acceptable; please see revised language in Amendment Section 15.**
14	**A.16. Website, page 77** **n. The Contractor's website shall contain consumer cost transparency and quality tools which allow members to research the price and quality of health care services. Such tools shall be enabled for mobile devices. At a minimum, the tools must:** **3) Present price information based on how a current claim would process, not historical claims data**	**The costs presented to a member for a service should mirror current contracted rates. Given that contracts do change, the carrier should ensure that transparency tools are updated quarterly to reflect your most recent pricing agreements. A.16.n.3. has been updated to reflect this requirement, please see Amendment Section 16.**

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	What types of pricing scenarios/data sources would not be considered acceptable? In other words, please advise more specifically what is being sought with regard to claims processing and the non-use of historical claims data? Would you accept 12 months of procedure utilization adjusted to current contracted reimbursement arrangements that would include adjusting costs to represent present pricing information should a facility contract be updated?	**Yes, this is acceptable.**
	Would you accept bundled procedures and services commonly performed together into "episodes of care?" This type of bundling is designed to help members get a better understanding of total procedure costs and to provide realistic estimates on how much an actual procedure might cost. Additionally, estimates will be provided using the subscriber's benefit plan design and their current out-of-pocket accumulators to show them what they might have to pay and what their health plan will pay.	**It is acceptable to provide a total episode cost if the procedures that make up the episode are broken out so that the member may see the line items that comprise the total episode cost. See Pro Forma Contract Section A.16.n.4.**
	8) Include up-to-date information on a member's HSA balance (if applicable); Please confirm that the requirement will be to display the member's HSA only versus typical FSA/HRA integration. Would you accept a link on the Contractor's web site that will launch a member directly to the HSA vendor's web site so that they may view their HSA balances?	**A.16.n.8. has been amended to include the FSA balance as well, please see Amendment Section 17. The state currently has no plans to implement an HRA; therefore this requirement is limited to the HSA and FSA only.** **Understanding that the HSA and FSA balances presented on your website would not be real time, a link to the HSA/FSA website is acceptable.**
15	**A.16. Website, page 78** **p. Video/Multi-media content: If the Contractor posts any video content it shall include closed captioning option in English for these products.**	**Yes, it would apply to videos requiring closed captioning related to the product design purchased by the State of Tennessee i.e. network specific, plan specific videos. This is a Section 508 compliance issue.**

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	With more than 400 hundred educational videos in our library we would like to better clarify which videos should have closed captioning. Would videos requiring closed captioning be related to the product design purchased by the State of Tennessee i.e. network specific, plan specific videos or would this apply to all videos hosted both on site and with external partners that may provide educational content?	**This would not apply to all videos hosted both on site and with external partners that may provide educational content.**
16	**A.20.Data Integration and Technical Requirements, page 84** **a. The Contractor shall maintain an electronic data interface with the State's Edison System for the purpose of processing State member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of PHI with the State of Tennessee, the State requires the use of second level authentication. This is accomplished using the State's standard software product, which supports Public Key Infrastructure (PKI). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption**	**Yes. If any changes occur, the Contractor will be notified and allowed time to comply.**

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	standard or tool in the future, the Contractor shall, with adequate notice, cooperate with the State to maintain the security of protected information according to all applicable State and Federal standards. As a current contractor, will the process remain the same as what is currently in place today?	
17	**A.20.Data Integration and Technical Requirements, pages 84-85** **The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Public Sector Plans.** **The Contractor and/or its subcontractors, shall electronically process one hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, within four (4) business days of receipt of the weekly file. The State and the Contractor shall work to develop a process for responding to invalid or non-processed records.** **The Contractor and/or its subcontractors shall resolve all enrollment discrepancies as identified by the State or Contractor within one (1) business day of identification.** Aside from the timeframe, please provide clarification on how these two requirements are different.	**A.20.e (3) refers to processing the enrollment file and resolving any errors identified with the processing of the file.** **A.20.e (4) refers to resolving enrollment discrepancies within ongoing operations as identified by either the Contractor or Benefits Administration. These discrepancies are usually identified through a member complaint as an incoming call through either the Contractor or the State's call center.**
18	**A.20.Data Integration and Technical Requirements, page 85** **The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Public Sector Plans.** **The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe**	**No. This is not referencing the State of Tennessee's EDI Eligibility processing platform. This is referencing the Contractor's system and logic for processing and loading Benefits Administration's Eligibility/Enrollment file.** **For example, The Contractor's system is assigning an incorrect termination date for a member's dependent when switching from Employee/Retiree plus dependent to Dependent**

	QUESTION / COMMENT	STATE RESPONSE
	mutually agreed upon with the State. The Contractor shall document in an eligibility system modification log, the system error details, the proposed solution, and the final solution as agreed upon by the State. The Contractor shall update and submit this log quarterly (refer also to Contract Attachment C, Reporting Requirements). Subsequent errors identical in nature may be subject to Liquidated Damages as specified in Attachment B. Is an entry for the eligibility system modification log made only when a modification has been made to the State of Tennessee EDI Eligibility processing platform due to resolution of a system error? Please provide additional clarification regarding this request. Also, provide clarity on the definition of a System Error. Please provide examples as needed.	**only coverage due to the Contractor's incorrect system logic. The Contractor would need to identify a solution with agreement from the State, log the issue/error and the solution, and fix the error. Any future issues with assigning an incorrect termination date for a member's dependent when switching from Employee/Retiree plus dependent to Dependent only coverage would be considered a subsequent error, identical in nature.**
19	**C. PAYMENT TERMS AND CONDITIONS, pages 98-99** **C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.** **The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than 5% of the gross recoveries received. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.** The wording in this portion of the RFP for the contract language surrounding subrogation is wording used in previous contracts with the	**Confirmed. The language as presented in C.3.e. is accurate.**

	QUESTION / COMMENT	STATE RESPONSE
	State Plan, but not the most current contract. Please confirm the contract language and requirements are changing to the wording as stated in C.3.e. We understand about the fee arrangement, but would like clarification on who will be responsible for paying legal expenses.	**While very rare, legal expenses are deducted from the recovery amount when legal counsel is retained for a case.**
20	**<u>Contract Attachment B: Performance Guarantees and Liquidated Damages, p. 111</u>** **Section 3: Maximum Assessment: The maximum amount of Liquidated Damages payable over any twelve (12) month period shall not exceed twenty percent (20%) of the annual fixed price billings. In the event that a single occurrence subjects the Contractor to Liquidated Damages in multiple subsections of this provision, the State is entitled to assess a single Liquidated Damage selected at the discretion of the State.** This requirement states the maximum amount of Liquidated Damages will not exceed 20% of the annual fixed price billings. Does "annual fixed price billings" mean the ASO Fees from TABLE A of the Cost Proposal?	**Yes, the annual fixed price billing amount is the amount of ASO fees (as proposed in table A) that the contractor will receive annually.**
21	**<u>Contract Attachment B: Performance Guarantees and Liquidated Damages, page 117</u>** **Number 33 Performance Guarantee: Contractor shall maintain fifty percent (50%) or greater performance of the State Group plan(s) HEDIS measurements against the Contractor's Tennessee Book of Business as demonstrated in the annual HEDIS report.** Please clarify which HEDIS measures - the accreditation measures or all HEDIS measures? What is meant by 50% or greater performance? Please explain how this will be measured? Are they 50th percentiles per NCQA?	**Benefits Administration reviews the NCQA list of HEDIS measures annually and identifies particular HEDIS measures of importance for the State Group Plan(s). The updated list will be provided to the Contractor annually.** **We will review the overall State Group Plan performance against the Contractor's Tennessee Book of Business performance. The number of measures where the State Group Plan meets or exceeds the Contractor's Tennessee Book of Business performance should be 50% or more of the total number of HEDIS measures reported.**

	QUESTION / COMMENT	STATE RESPONSE
22	**Contract Attachment B: Performance Guarantees and Liquidated Damages, page 117 – 118** **B #34 Eligibility System Errors and Attachment C - Reporting Requirements C #24 Eligibility System Modifications Log** Please clarify the differences in the two reports.	**Attachment C is the list of reports (log) that must be delivered.** **If the reports in Attachment C are not delivered timely penalties may be assessed in association with Attachment B #28.** **Attachment B is the list of performance guarantees.** **If the Eligibility System Modifications Log (report due as listed in Attachment C) has errors that are identical in nature, the Contractor will be required to pay penalties as listed in Attachment B #34 for the outcome of the log.**
23	**Contract Attachment C, Reporting Requirements, page 118** **Report 20. Transparency Tool Report and A. 16 Website. n. (12) on page 77.** Please confirm the information, reports and data required in these sections will be based on adherence to PHI and other regulatory protocols.	**Confirmed. The State will never request reports with personally identifiable member information. All reports are aggregated but may be requested at the plan level (Partnership State, Local Education Limited, etc.).**
24	**Contract Attachment C, Reporting Requirements, page 118** **CMS/Medicare Employees:** Will a file be supplied to the Contractor providing the data that will aid in determining when local government retirees will become eligible for Medicare in the subsequent month?	**No. Per contract section A.20.f. the vendor must establish a regular data match with CMS in order to identify Medicare enrollees and report this information to the state.** **Note: A.20.f. has been amended to change the frequency of this report from quarterly to monthly and to better explain information that should be included in the report. Please see Amendment Section 18.**
25	RFP Page 113 & 114 – RFP Attachment 6.6 Pro Forma Contract Attachment B #15 (Statewide Provider/Facility Network Accessibility): Please confirm the Provider Group – Suburban access standard for Cardiologists and Endocrinologists are “2” physicians within 20 miles since the “Urban” access standards for Cardiologists and Endocrinologists are “1” physician within 15 miles.	**Confirmed. These access standards are accurate.** **Also, note the addition of Acute Care Hospitals to the rural section of LD #15 table requiring 1 hospital within 30 miles. Appendix 7.8 has also been updated to reflect this change. Refer to Amendment Section 27.**

	QUESTION / COMMENT	STATE RESPONSE
26	RFP Page 113 & 114 – RFP Attachment 6.6 Pro Forma Contract Attachment B #15 (Statewide Provider/Facility Network Accessibility): Why are the Access Standards different in #15 for a statewide contract compared to #16 regional contract?	**The different access standards for the statewide contract versus the regional contracts are intended to create different choices and meet the needs/wants of members. The statewide network is intended to offer a broader network to members while the regional networks can be somewhat narrower. The State feels it is important to offer member choice which is why the broader statewide network is being introduced.**
27	RFP Page 113 & 114 – RFP Attachment 6.6 Pro Forma Contract Attachment B #15 (Statewide Provider/Facility Network Accessibility) & RFP Page 508 – Appendix 7.8 GeoNetworks Analysis Instructions: The Access Standards listed under #16 for regional contracts do not match the Required Access Standards listed on page 508 of the RFP under section C, Report Specifications. Is this correct?	**This is not correct, and was an oversight – Appendix 7.8 has been revised, please see Amendment Section 27 below.**
28	Appendix 7.3 – PCP Disruption Analysis Template: Can the provider Tax ID be provided for respondents to use when completing the disruption analysis?	**The State is still working to gather this information and will post this document with a subsequent amendment to the RFP.**
29	RFP Page 41 – RFP Attachment 6.2 – Section D, Part 2: Sections D.2.1. and D.2.2 state that the GeoAccessGeoNetworks Provider Accessibility Analysis shall be created as required in Appendix 7.8 and 7.9 and "using the State's total participant population data provided in 7.2, TN Zip Code Counts". Appendix 7.8 states "Employee Group – The total number of State employees MUST MATCH EXACTLY the number contained in Appendix 7.3 (7.2?) – Zip Code Counts. This data includes locations outside Tennessee and invalid zip codes that cannot be Geocoded for the analysis reports. Please confirm the TN Zip Code Count expected to be viewed within the GeoAccessGeoNetworks Provider Accessibility Analysis reports.	**Please refer to the response to Question #8 above; the zip codes identified in that question should be excluded.**
30	Appendix 7.2: The State's participant population data by zip code provided to	**Yes. Appendix 12 provides an accurate**

	QUESTION / COMMENT	STATE RESPONSE
	generate the GeoAccessGeoNetworks Provider Accessibility Analysis has many counties assigned to multiple regions. This will skew the Provider Accessibility Analysis by region. Should the proposer respondents change the region assignments for each county to represent the counties and regions listed on Appendix 7.12 based on zip code?	**description of the counties in each region for the purposes of preparing the regional accessibility analysis.** **An excel file with zip codes by region is also attached; please see Excel file "30-Geolocation zip codes".**
31	RFP Page 10 – RFP Schedule of Events: Please clarify exactly what is required to be submitted to AON Hewitt by 5:00 pm Central on May 1, 2015.	**The required data is detailed in the Uniform Data Specifications found in Appendix 7.1, if the Respondent's proposed network claims information is not already on file with Aon Hewitt. If Aon Hewitt already has the information on file, nothing is required to be sent to them.**
32	Please provide complete copies of the duly executed contracts in place between the State and each of the current administrators (TPAs) with regard to the State Group, Local Education Group and Local Government Group, self-funded Preferred Provider Plans (PPOs) in all three grand divisions.	**Please see Attachment 1 to this amendment.**
33	Please provide the fee per employee per month (PEPM) being charged by each of the State's current TPA vendors for each year of the existing contracts.	**Please see Attachment 2 to this amendment.**
34	If the fee per employee per month (PEPM) in the above referenced contracts is broken out, please provide: the "total" fee per employee per month (PEPM) for all services; the fee per employee per month (PEPM) for administrative services; the fee per employee per month (PEPM) for Network services, and any other fees charged per employee per month (PEPM), for each of the State's current TPA vendors for each year of the existing contracts.	**Please see Attachment 2 to this amendment.**
35	Sections 4.4, B.14 and contract section A.25.aaa reference subcontractor requirements. Would it be appropriate to assume the State's intent is focused more on larger subcontractors performing core member or client facing services like customer service, claim processing, clinical program staff, etc. and not the office cleaning company, shredding company or supply vendors ?	**Yes. The state is interested in those subcontractors handling core services required in this contract. Core services include things such as implementation and account management, claims processing, provider networking, utilization management services, quality assurance, audits, fraud and abuse oversight, appeals, call center, communications, website development and maintenance, information systems, and reporting. Unless the subcontractor can have a direct impact on the**

	QUESTION / COMMENT	STATE RESPONSE
	The first group for most companies would be a relatively small group of subcontractors while the latter for a large company with offices across the country and world could be in the thousands.	**contracted service delivery they do not need to be identified in RFP Attachment 6.2 Section B.14. Beyond those subcontractors listed in your question you may want to consider others like auditors and mail fulfillment houses that may impact your service delivery to, or come into contact with, the state.**
36	Technical Qualification Section C.4. Clinical Care Transformation references "moving from traditional care to fully integrated care". By "fully integrated care" is the State referencing PCMHs, Collaborative Accountable Care (CACs) models, etc., or does the State define this differently? If so, please elaborate.	**The State considers fully integrated care to be medical and behavioral health care that is comprehensive, focused on prevention and closely coordinated at all levels (including primary, secondary, and hospital care). Integrated care typically includes use of electronic medical records as well. Models such as PCMH and CAC do offer an integrated care delivery system.**
37	Section C.11.c With regards to the video demonstration, please review the following and advise: • What is the preferred file type? .MP4, .Wav, web hosted video or perhaps some combination thereof? • Is there a limit on length or a suggested length the State would like vendors to target? • Is the intent to use the videos merely for the scoring assessment or also for ongoing member education?	**Windows media, .MOV, or Captivate type web demonstrations are the preferred files and may be provided on either a CD-ROM or a jump drive.** **The demonstration should assume the member is already a registered user and is logged into the tool. Each search should be no more than 5 min for a total video maximum of 20 min.** **The video is for the sole purpose of the scoring assessment and will not be used for ongoing purposes.**
38	Cost proposal: Table A states "**When bidding on multiple regions, bidders are required to submit administrative fee bids that are uniform across all regions."** Please confirm that this applies to the statewide bid?	**Confirmed. The statewide contract should also offer uniform fees across all regions.**
39	Cost Proposal: Table A - Administrative Services Only (ASO) Fees includes the following: "**The <u>sum</u> of the PEPM and the number of employees (or heads of contract), not total enrollment levels; will generate the Contractor's total payment.**" Please confirm that the total payment will be the **<u>product</u>** of the PEPM multiplied by the number of employees and not the sum?	**This is confirmed, it should be the product, not the sum, please see Amendment Section 6.**

	QUESTION / COMMENT	STATE RESPONSE
40	Cost Proposal Table C - Network In the bottom of the grid for Table C, there appears to be a typo at the top of page 48 that says "= Table B Score:", please confirm that this should read "= Table C Score:"	**This is confirmed, the grid should read "Table C", please refer to Amendment Section 7.**
41	Total Cost Proposal Score grid – bottom of page 48 Total Score is defined as "**The Solicitation Coordinator will add the scores from Table A, Table B and Table C to determine the total Cost Proposal Score for the specific region**." Based on the matrix, it seems that this statement should include the Table D score. Instructions elsewhere in the RFP suggest table D should only be omitted for the statewide score since the trend guarantee is omitted from the statewide score. Please confirm.	**This is confirmed, Table D Score should be added, please refer to Amendment Section 8.**
42	If the statewide score omits the Trend Guarantee, how are each of the scoring section points reallocated to total for the cost proposal of 40 points for cost? What, if any, impact does that reallocation have on the statewide cost proposal maximum score of 40 as well as total maximum score of 100?	**Additional tables have been added and points reallocated for the statewide network since Table D does not apply. The cost proposal still accounts for 40 of the 100 points in the statewide network bid. Please refer to Amendment Sections 9 and 10.**
43	ProForma Contract A.9.ll. – 1099s - Does this apply to customer reimbursed travel expenses paid for transplant patients?	**Yes.**
44	ProForma Contract A.14.U. With this requirement, is the State wanting to have a bidder's systems/equipment available for access independently by trained/authorized state employees to perform remote monitoring or is the State merely wanting the bidder to forward recorded calls as requested for review by State employees?	**The latter. The State does not seek direct access into the vendor's phone system but instead requires the ability to listen to previously recorded calls with identifiable member information removed for the purposes of quality control.**

	QUESTION / COMMENT	STATE RESPONSE
45	**General Questions** Can you provide the process proposers should follow if we need to ask clarifying questions about the responses to these bidder questions?	**Yes, an additional questions and comment period has been added to the Schedule, please see the revised schedule in Section 1 of this amendment.**
46	Are any of the current plans you would like us to quote considered "grandfathered", in regards to PPACA/Health Care Reform?	**No. The State's current plan options are not "grandfathered" in regards to PPACA/Health Care Reform. We are not required to cover the essential health benefits, however, due to the self-insured status of the health plan.**
47	Please provide the current enrollment counts by either total employees or members enrolled in the Cigna plan in each region. Please break out the numbers for the middle region by the two different networks which Cigna offers. Please provide the same information for BCBS of TN.	**Please see the excel spreadsheet labeled "47-60 Medical Census" – tab 1.**
48	**Questions on Section A-Mandatory Requirements**. Would a copy of our Certificate of Authority be acceptable for Mandatory Requirement A.8 (page 23), regarding all State insurance filings? If not, what would be required?	**Yes, that would be acceptable.**
49	Can you provide information on what the State would require for documentation of executed provider agreements, as requested in Minimum Requirement A.11 (page 23)? Would meeting the required Geo-Access Results suffice?	**A summary of your GeoAccess reports and the current access are sufficient documentation for this requirement.**
50	Is a Respondent required to have the minimum insurance coverages in Mandatory Requirement A.15 (page 24) in effect as of the date the proposal is submitted or can these be provided before contract signing if the Respondent is one of the best evaluated Respondents? If the latter is acceptable, would a simple confirmation from the Respondent that they agree to these provisions be acceptable as meeting this requirement?	**This is a mandatory requirement, so the insurance coverage must exist and be in force at the time of the response submittal.**
51	**Questions on Section B-General Qualifications and Experience Items**	

	QUESTION / COMMENT	STATE RESPONSE
	Can you confirm there is no specific dollar and/or percent spend required for Minority and Women Enterprises (discussed in General Qualifications Item B.15 (page 27)), and that this a good-faith effort? Would the estimated percentage of the awarded contract amount be based on estimated annual administrative fees received from the State, and if not, what other measure?	**There is no specific dollar and/or percent spend required for Diversity businesses. However, B.15 is included with other questions in the B Section that does have an over-all point value. The diversity portion is assessed by the Governor's Office of Diversity Business Enterprise for the individuals assessing the RFP to use in their analysis of each proposal. The State has a diversity goal of 13%.**
52	Item B.14 (page 27) requires a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP. Can you confirm this statement needs to be made by the bidder, after consulting with the subcontractors, and that nothing is specifically required directly from the subcontrators? Can you also confirm that this would be for subcontractors specifically assigned to work on the State's account?	**Yes, the Statement should be made by the Respondent – no individual response is required from subcontractors.** **The statement would only apply to subcontractors assigned to work on the State's account.**
53	Can you confirm we do not need to list out our five largest client's names in the technical response, section B.19 (page 29), and just provide the required information for each (e.g. average number of members, annual claims volume, etc.), to prevent our largest client's information from becoming part of public record?	**Confirmed. Names are not required.**
54	In section B.17 (page 28) asking for customer references of the larger accounts currently serviced by and completed projected, is it acceptable for a proposer to use an employer that is a large healthcare system that may also be contracted with the proposers provider network and/or a subcontractor?	**No, as this poses a conflict of interest for the employer reference**.
55	Can you provide further specification around the video demonstration you request for Item C.11 (page 35) (Technical Qualifications). Would a power point showing screen shots work for this? If so, would you like a printed	**Please see the response to question 37. A power point may accompany the video but is not accepted as the only demonstration.**

	QUESTION / COMMENT	STATE RESPONSE
	copy, or just a copy on the CD-ROM?	
56	In one section of the RFP(6.2 C.12, page 35), it stipulates we must have a dedicated account management team but in another section (pro forma contract A.18 f, g, page 80) it says designated. Please clarify the exact request. For example, if we receive less than 10,000 lives (the first bracket in your requested fees chart), are we expected to still include the dedicated account team positions you have specifically requested, or may we provide a designated team?	**A designated team is acceptable. RFP Attachment 6.2. Section C.12 has been updated to reflect this, please refer to Amendment Section 5.**
57	**Questions on Section D- Network** Can you please re-issue the Disruption Report File (as required in Item D.2.3, page 41) to include Tax Identification Number (TIN), in addition to the provided National Provider Identifier (NPI)? The TIN is populated on all of our provider data for claim processing, whereas we do not always get the NPI. Including TIN will ensure our disruption results are the highest level of accuracy. This information is critical to the development of a competitive proposal and the incumbent has ready access to it. As a result, any proposers other than the incumbent would be placed at a substantial competitive disadvantage if this information were not made available to all bidders. We are bringing this level playing field concern to your attention in accordance with Section 1.6.3 (page 8) of the RFP.	**The State is still working to gather this information and will post this document with a subsequent amendment to the RFP.**
58	**Questions on Cost Proposal and Scoring Guide (6.3)** Where should proposers put any supplemental documents and clarifications to their pricing, as the States Cost Exhibit has no space for comments?	**Per RFP Section 3.3.2, the State does not accept qualifications on either the technical or cost proposal. RFP Section 3.1.2.1 states "A Respondent must only record the proposed cost exactly as required by the RFP Attachment 6.3., Cost Proposal & Scoring Guide and must NOT record any other rates, amounts, or information."**

<table>
<tr><th>QUESTION / COMMENT</th><th>STATE RESPONSE</th></tr>
<tr><td></td><td>If the proposer wishes to include supplemental documents not requested by the State that do not violate the provisions listed above, causing the Respondent to be declared non-responsive, they can be placed anywhere in the cost response, provided they are properly labeled for easy reference.</td></tr>
<tr><td>59 In order for proposers other than the incumbents to have adequate information to respond to the trend guarantee Attachment 6.3 Cost Proposal -Table D (page 48), please provide the State's medical trend for each of the three regions for each of the last five years.</td><td>Below is the medical allowed trend measured with 2 months of run-out and no adjustments. In 2010, the State revamped the plan designs and medical TPAs. Therefore, this plan year is excluded.

<table>
<tr><th>Medical PMPM Trend</th><th>East</th><th>Middle</th><th>West</th></tr>
<tr><td>2012 over 2011</td><td>1.4%</td><td>-1.6%</td><td>1.4%</td></tr>
<tr><td>2013 over 2012</td><td>1.7%</td><td>1.5%</td><td>0.9%</td></tr>
<tr><td>2014 over 2013</td><td>-1.8%</td><td>3.5%</td><td>3.5%</td></tr>
</table></td></tr>
<tr><td>60 Please provide a subscriber census that at least includes employee zip code, gender, medical tier, date of birth, region, current plan members are enrolled in. This information is critical to the development of a competitive proposal and the incumbent has ready access to it. As a result, any proposers other than the incumbent would be placed at a substantial competitive disadvantage if this information were not made available to all proposers.

We are bringing this level playing field concern to your attention in accordance with Section 1.6.3 (page 8) of the RFP.</td><td>Please see the excel spreadsheet labeled “47-60 Medical Census” – tab 2.</td></tr>
<tr><td>61 Please provide monthly paid claims with enrollment and large claim data for each region for the latest 48 months available. This information is critical to the development of a competitive proposal and the incumbent has ready access to it. As a result, any proposers other than the incumbent would be placed at a substantial competitive disadvantage if this information were not made available to all proposers.</td><td>Please see the excel spreadsheets labeled “61-Enrollment Net Claims” and “61- Large Claim Data”.</td></tr>
</table>

	QUESTION / COMMENT	STATE RESPONSE
	We are bringing this level playing field concern to your attention in accordance with Section 1.6.3 (page 8) of the RFP.	
62	Please provide a provider utilization file with 48 months of provider utilization that includes at least the Tax ID, Provider Name, Provider Zip Code, and amount of charges at each provider. This information is critical to the development of a competitive proposal and the incumbent has ready access to it. As a result, any proposers other than the incumbent would be placed at a substantial competitive disadvantage if this information were not made available to all proposers. We are bringing this level playing field concern to your attention in accordance with Section 1.6.3 (page 8) of the RFP.	**Please see the excel spreadsheet labeled "62-Provider Utilization".**
63	Regarding the requested fees for TeleHealth/TeleMedicine, please clearly outline exactly what programs/services you consider as TeleHealth/TeleMedicine (6.3, page 46)	**We do not have a clear definition of the program/services that will be considered TeleHealth/TeleMedicine at this time.** **If the State requests implementation of TeleHealth/TeleMedicine, the program/services will be based on TCA 56-7-1002.**
64	Due to the importance and high scoring level of the Trend Guarantee in Attachment 6.3 Cost Proposal -Table D (page 48), can you provide the methodology that the State would use to reconcile the trend guarantee? For example, how would the State's Actuaries normalize claims to account for differences in population demographics, would large claims over a particular threshold be removed, would you account for any benefit plan changes, etc.	**Exact methodology and terms of the calculation of this trend guarantee will be worked out by the Respondent and the State's consulting actuary prior to the measurement of the experience period trend. The State retains the right to utilize their consulting actuary on its behalf during all conversations related to methodology and results.** **The trend will be calculated using allowed amounts for in-network claims incurred during each plan year. The calculation shall include any Member cost share amounts.**
65	If a proposer has signed contracts for changes with specific providers in Tennessee, different from what is reflected in the Aon Hewitt database as described in the RFP, what specific information or processes is needed to get credit for these updates in the network discount analysis being conducted by Aon Hewitt and due May 1?	**The RFP process does not allow for the inclusion of additional data except under the Terms of the Uniform Data Specifications (under Projected Data) found in Appendix 7.1. You may submit a written explanation of the impact of these new contracts to the State of Tennessee.**

QUESTION / COMMENT	STATE RESPONSE
66 **Questions on Pro Forma Contract** Can you please provide additional details around the State's subrogation policies in A.9.cc of the pro forma contract?	**A copy of the state's subrogation policy/contractor requirement is attached; please see Attachment 3 to this amendment.**
67 Is the State's intent to allow one proposer to offer multiple networks in each region, or will proposers be allowed to offer only one network in each region? For example, one of the State's current vendors offers employees the option to select either their broad network or their narrow network.	**Each proposer may offer only one network in each region, however, that same proposer may also offer the statewide network that will be available in all regions.**
68 If proposers may propose more than one network, including narrow networks, please clarify how we should complete the cost and technical responses for both of our proposed networks. For example, one of the State's current vendors offers two networks in the middle regions, including a narrow network.	**See response to question #67**
69 Understanding the importance of the Payment Reform Initiative (Section A.23, page 88), is it preferable for the Contractor to offer a smaller network with guaranteed participation in episode based payment or a broader network with intent to move those providers to the episode based payment methodology, or would the bidder be able to offer both options?	**The Contractor must offer a network that meets access requirements defined in performance guarantees #15 (statewide) and #16 (regional) and can only offer one network per region with the exception of the statewide network that will be available in all regions. Decisions on how to handle provider non-participation in payment reform will be made as the initiative progresses.**
70 Please confirm that the Payment Reform Section of the Contract (A.23, page 88) would only be applicable to the regions of Tennessee that proposers are quoting on/awarded?	**Confirmed. Contractors are only responsible for implementing the initiative with providers in their contracted region.**
71 Understanding that all in-network providers must participate in the episode based payments (A.23, page 88), what are the consequences if Contractor, after making best effort in the regions we are responding to, and are unable to solicit provider's participation? Is it the State's expectation that	**Decisions on how to handle provider non-participation in payment reform will be made as the initiative progresses.**

	QUESTION / COMMENT	STATE RESPONSE
	those providers who refuse to participate in episode based payment will become non-participating, at a future date, and members will receive an alternative level of benefit?	
72	It may be difficult if not impossible to get all providers in the network to agree to amend their contracts to include the new payment strategy for a given episode as required in Attachment 6.6 Pro Forma Contract, Section A.23. (page 88 of the RFP) If the TPA contractor provides a "best effort" to obtain network provider contract amendments, will the State accept partial implementation of this payment strategy?	**The State will not accept partial implementation; however, see response to question #71.**
73	What are the consequences to the Contractor if network access standards are no longer achieved as a result of providers refusing to participate in episode based payment (Section A.23, page 88) for the State of TN employee population? What are the consequences to the Contractor if the prescribed percentages are not achieved in the Contractor's Public Sector, fully insured and self-insured ASO members?	**Assuming the Contractor has attempted to recruit a provider and that provider is out of network solely because they do not agree to participate in payment reform (meaning they would agree to be in-network otherwise), the State will not assess the contractor liquidated damages related to missed access standards if the contractor otherwise would have met the requirement if that provider were in-network.** **If the Contractor does not achieve the prescribed percentages for the fully-insured and self-insured markets the Contractor may be subject to liquidated damages as defined in LD 36. Please refer to Amendment Sections 25 and 26 below.**
74	If we have to deviate from a requested Performance Guarantees in Contract Attachment B (page 111), will you accept an alternative guarantee?	**No, the State does not intend to negotiate Performance Guarantees once the contract has been awarded, any deviations in Guarantees should have been requested through this question and answer period for the State to review and issue a decision.**
75	Regarding the flat dollar payouts on the requested Performance Guarantees in Contract Attachment B (page 111), will you instead accept a percentage of fees at risk per performance guarantee/standard?	**No. However, Attachment B does provide Maximum Assessment and Waiver provisions.**
76	In the performance guarantee section (Attachment B, page 111), the maximum	**The Maximum Assessment provision is an annual aggregate maximum on all performance standards, guarantees, and/or provisions. The**

	QUESTION / COMMENT	STATE RESPONSE
	amount of liquidated damages payable over a 12 month period shall not exceed 20% of the annual fixed price billings. However, the contract wording also stipulates that additional liquidated damages can be assessed if a contractor fails to meet a performance guarantee where the damage isn't spelled out in the performance guarantee attachment of up to $500 per business day. Will you accept an aggregate maximum amount a contractor can be assessed for liquated damages on all performance standards, guarantees and/or provisions included in the RFP?	**$500 per business day Liquidated Damage provides the State flexibility to assess LDs for performance guarantees not otherwise specified in the table but it still falls under the Maximum Assessment provision.**
77	Regarding Performance Guarantee #33 (page 117), HEDIS Performance, can you please provide more detail as to how this would be calculated? Would the results be based on the State of TN specific results or can it be based on the carrier's book of business results?	**Please see response to question 21.**
78	Regarding section A.11 State Audits (page 70), do you have an estimate of how many claims you would be auditing and/or the number of days the State would spend on site for the auditing process?	**Most of the time a sample approach would be used, such as a stratified sample of 220 for Time to Process, instead of a full population review. Consequently, we may have to perform a full population review based on significant weaknesses discovered or as required. The number of days on site would depend on the extensiveness of the analysis required.**
79	Please confirm that the RFP is not requesting a contractor to carve out their utilization management program from their offering (Section A.4, page 60). If this is not the case, please confirm that the contractor would be given the ability to re-assess pricing, as Utilization Management is an integral part of the value we are able to include in our pricing and guarantees.	**The State is not requesting that contractor's carve out their utilization management programs.** **The contractor will not have another opportunity to re-assess pricing. The value added by these programs should be factored into the Trend Guarantee and ASO fees bid in the cost proposal.**
80	Do all the in-network hospitals contracted today with the current medical health insurance TPA carrier(s) participate in Leapfrog (Section A.5, page 71)?	**It is possible that some do not. However, it is a contract requirement that the Contractor work with the in-network hospitals to complete the Leapfrog Hospital Survey.**
81	In the contract provisions in the RFP (D.7,	**Confirmed. The state is only interested in**

	QUESTION / COMMENT	STATE RESPONSE
	page 101) you included: "Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract." Please confirm that the subcontractors you require approving would be only those that provide substantial and direct service to this contract.	**approving those subcontractors handling core services or providing direct service required in this contract. Core services include things such as implementation and account management, claims processing, provider networking, utilization management services, quality assurance, audits, fraud and abuse oversight, appeals, call center, communications, website development and maintenance, information systems, and reporting. These are the subcontractors that you should also identify in RFP Attachment 6.2 Section B.14.**
82	In the contract provisions in the RFP (D.19, page 102) you included: "Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its …" Please confirm that it is not the intention of this Hold Harmless provision to transfer to Contractor liability for network providers, and to not transfer malpractice responsibility from network providers to the Contractor.	**This is not our intention; however this language would apply if the State of Tennessee was named as a party to a malpractice suit relating to the contract. As a practical matter, the State is not often included in malpractice suits since it can only be sued in the Claims Commission, where attorney fees and punitive damages are not recoverable. Tennessee Code Annotated Section 9-8-307.**
83	Please provide additional description and clarification of the "all payer claims database" referenced in provision #A.9.l (page 66). Specifically, what type, format and frequency of claims data is required? What is the function of the all payer claims database?	**File Type: Medical Claims, RX Claims, Member, Provider** **File Format: Fixed Length** **Frequency: No less than quarterly** **Per TN Code Annotated § 56-2-125 the purpose of the all payer claims database is to enable the commissioner of finance and administration to carry out the following duties:** **(A) Improving the accessibility, adequacy, and**

	QUESTION / COMMENT	STATE RESPONSE
		affordability of patient health care and health care coverage; **(B) Identifying health and health care needs and informing health and health care policy;** **(C) Determining the capacity and distribution of existing health care resources;** **(D) Evaluating the effectiveness of intervention programs on improving patient outcomes;** **(E) Reviewing costs among various treatment settings, providers, and approaches; and** **(F) Providing publicly available information on health care providers' quality of care.**
84	For contract provision #A.9.ff (page 68), please describe the type of claims/data requests the State anticipates requesting.	**These types of requests are frequently regarding member issues around payment/denials of services, Legislative requests to determine fiscal impact of bills, and Agency deductible or OOP information for transferring of benefits.**
85	Please provide further clarification and description of the type and level of access you are requesting to the Contractor's internal client reporting system in contract provision #A.9.gg.4 (page 68). Would access to our utilization reporting system meet this requirement?	**The contractor shall provide access to the reporting systems that allow for detailed reconciliation of individual claim amounts to the amount drafted. In addition, the contractor must provide top level static reports to provide a summary result of claims paid. Currently, vendors provide access to the reporting cubes that report much of the same information in a detailed manner, on a monthly or weekly basis. One such static report provided by a current vendor has payments broken down by enrollment, grand division, division, plan type, plan, and net payment.**
86	Please confirm that a designated member services staffing model is acceptable to the State. In this model, a designated team of customer service representatives would be assigned to the State of TN, but may support additional customer accounts as needed.	**Please refer to contract section A.12.b. indicating this is acceptable to the State assuming that the unit could meet all call center standards defined in this Contract. This will require approval by the state following submission of such documentation.**
87	In connection with Contract provision A.10d (page 69), we would appreciate more clarification on what is considered to be a "transaction", and how you define an "unusual transaction."	**Transactions are in the normal course of business or otherwise appear to be routine because of their timing, size, or nature. Unusual Transactions are transactions outside the normal course of business or that otherwise appear to be unusual because of their timing, size, or nature.**
88	There is a recurring statement in many of the sections of the Pro Forma Contract that specifies that the State can unilaterally require the Contractor to alter or modify their	**The State's intent is to work with the contractor to ensure that the programs are running efficiently and providing the best service to the State and its members.**

	QUESTION / COMMENT	STATE RESPONSE
	existing programs, such as A10e (page 69), Fraud program. Is it the State's intention to compel the Contractor to materially alter a Contractor's processes, systems and internal programs or rather, is it the State's wish to work with the contractor to ensure that the programs are running efficiently and providing the best service to the State and its members? What types of changes has the State typically requested of Contractors historically?	**While no examples of such past requests are available, it is feasible that the state could request changes to reporting or frequency of reports in order to better understand impact on our member population specifically as opposed to including our membership/results in with the Contractor's entire book of business.**
89	In connection with Contract provision A20b (page 84), could the State please provide clarification on the intent of this provision regarding enrollment data?	**The State determines eligibility. The Contractor shall load the eligibility file as provided and confirm any errors or questions identified during the load with the State prior to correction.**
90	In connection with Pro Forma Contract provision A20n (page 86), could you please provide estimated number and/or frequency of accumulator data feeds that are completed today by your current medical carrier?	**Accumulator Data feeds are shared between the PBM and EAP/BHO vendors and the TPAs on a daily basis. Additionally approximately 200 Grand Division/Benefit Option changes are made per year.**
91	In connection with Pro Forma Contract provision A.7b4 (page 64), could you please provide estimated number and/or frequency of claim and accumulator data feeds that imported and exported today by your current medical carrier?	**Accumulator Data feeds are shared between the PBM and EAP/BHO vendors and the TPAs on a daily basis. Claims Data is shared with the HSA vendor on a daily basis. Claims Data is shared with the DSS vendor on a monthly basis. The Contractor shall have the ability to receive Claims data from the Health Center Vendor as directed. Admissions/discharge data will be shared with the HM/W vendor daily. Other data sharing as specified in the contract.**
92	Can you please provide a copy of the "Authorization Agreement for Automatic Deposit Form" discussed in Contract Section C.9 (page 100)?	**Yes, please see Attachment 4 to this Amendment.**
93	**Logistical Questions** Can you confirm we can provide separate PDF documents for the technical response (rather than one combined document) for the CD-ROM requested in Section 3.2.2.1 (page 12)?	**Yes, you may provide separate PDF documents for the digital technical response copies as long as they fit on 1 CD-ROM or USB flash drive, which is also acceptable.**
94	Can you provide us with the requested	**Respondents should be aware that all**

	QUESTION / COMMENT	STATE RESPONSE
	method to mark documents which should not be released through an Open Records requests propriety and confidential, and, as discussed in Section 4.8 (page 16)?	**documentation submitted to the State through this RFP process is subject to public review through the State's Open Records Provision as indicated in RFP section 4.8.** **Respondents may mark documents as proprietary and confidential, however; if the State determines that the documents submitted do not fall under any exception to the Open Records Law, they will still be subject to release.**
95	Can you confirm we could put larges samples and files (such as the disruption and full Geo Access results) only on CD-ROM?	**No, this is not confirmed – these documents should also be part of the Original Technical response in hard copy.** **Also, you can provide copies of your proposal on USB flash drives instead of CD-ROMs.**
96	For Samples we need to print, where in the binder would you like us to put them? For example, should they be put it directly after the question that asks for them, or could we put it in a separate section at the end of our proposal, and refer the reader to that section? (For example for C10 and C11 on page 35 both ask us to provide a variety of samples and screen shots)	**The State does not have a preference – this is at the Respondent's discretion – they should be properly labeled wherever they are located.**
97	Can you confirm that if we quote on multiple Regions, we could put our entire responses in the same proposal binder, as long as we have each region in a separate section?	**This is confirmed, the State doesn't expect different proposals for each region; however, if the Respondent needs to provide different information for separate regions, this approach is fine.**
98	In Section 3.2.2.2 (page 12), you ask us to provide out Cost Proposal response (6.3) in excel (xls) format. However, this section converts as a Word Document with tables. Can you confirm that the Word version would be acceptable? If not, can you provide us what you would like filled out in excel?	**Providing the cost proposal response as a .pdf document is acceptable, please see Amendment Section 3 below.**
99	Can you confirm we can restart the page numbering in the RFP by section (for example. 6.1 would be page "1", then numbering would start again at "1" for 6.2 Section A, then again at "1" for 6.2 Section	**The State does not have a preference in how the Respondent numbers it's response to the State.**

	QUESTION / COMMENT	STATE RESPONSE
	B", etc.)?	
100	e. Pursuant to Section D.16., the Contractor and the State will jointly work to interpret and implement the requirements of the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148 as amended by Public Law 111-152. To the extent that any foregoing requirements of this contract conflict with PPACA then the Contractor shall immediately consult with the State and adjust its process in order to comply with the federal law. Does the State agree that as the plan sponsor of a self-funded benefit plan, it is financially responsible for state or federal surcharges, assessments, or similar taxes or fees imposed by governmental entities or agencies on the its self-funded employee benefit plan, including but not limited to those imposed pursuant to the Patient Protection and Affordable Care Act of 2010 (PPACA)? This includes responsibility for determining the amount due, funding, and remitting the PPACA Transitional Reinsurance fee and the PCORI fee which are remitted to the government (federal and/or state). Contractor's administrative fees will not include assuming the State's financial liabilities under PPACA.	**The state agrees that it is financially responsible for the PPACA Transitional Reinsurance fee and the PCORI fee. However, the state cannot agree to the broad statement that we are responsible for "state or federal surcharges, assessments, or similar taxes or fees imposed by governmental entities or agencies on the its self-funded employee benefit plan, including but not limited to those imposed pursuant to the Patient Protection and Affordable Care Act of 2010 (PPACA)".**
101	c. The Contractor shall have a dedicated full-time implementation manager who is responsible for leading and coordinating all contract implementation activities as well as a designated implementation team. Unless otherwise directed by the State, the implementation manager should be dedicated full-time to this implementation project through sixty (60) days after the go-live date. All other implementation team members that the Contractor referenced in its proposal to the State and reflected in Attachment F, shall be available as needed during the implementation but should be dedicated to this project at least two (2) months prior to the go-live date specified in Contract Section A.24. and thirty (30) days after the go-live date. The Contractor's implementation team shall include a full-time Account Manager	**A designated implementation manager is acceptable assuming they are readily accessible, capable of delivering on the state's requirements and capable of meeting all State deadlines.** **Contract section A.2.c. has been updated to reflect this, please see Amendment Section 12.**

	QUESTION / COMMENT	STATE RESPONSE
	designated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of this Contract. Also, the Contractor shall assign an Information Systems Project Coordinator to coordinate information technology activities among the Contractor and the State's existing vendors and all internal and external participating and affected entities. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of claims administration services for at least one other large employer (i.e., employer with medical plans covering at least 30,000 lives). Would the State require a dedicated full time implementation manager if a vendor is chosen for one region (versus all 3)?	
102	f. The Contractor may develop a high performance or tiered network of providers and/or facilities without State direction. Before implementing a high performance or tiered network, the Contractor shall submit its plan for developing and implementing such a network to the State, and the plan shall be approved in writing by the State. The Contractor's plan shall include the information specified by the State, including at a minimum the (1) quality and cost efficiency measures that the Contractor will use to determine whether a provider or facility satisfies the criteria to participate in the network; and (2) proposed member cost-sharing incentives (e.g., lower rates of co-insurance, copayment in lieu of co-insurance, waiver of or provision of lower deductible amounts) or other incentives for members who receive covered benefits from high performance providers or facilities. The State may approve the Contractor's use of such member incentives regardless of whether other third party administrators for medical services have implemented such member incentives. "*Name Redacted*" has a high performance network in place in Tennessee. Does the State require any information on this from us at this time?	**While it is not required at this time, including information about/describing your high performance network would be a valuable addition to your response to C.2.in RFP Attachment 6.2 Section C.** **Note that the state defines the benefit plan and any member cost sharing incentives associated with such a network must be approved by the state prior to implementation and cannot be guaranteed or a requirement of network participation.**

QUESTION / COMMENT	STATE RESPONSE
103 bb. The Contractor shall notify the State in writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Does the State have a specific provider group size in mind at which they are alerted of payment change?	**In line with the notification requirements in A.3.q. the State requests that the Contractor notify the State of any such changes impacting hospitals or physician groups of twenty (20) or more. Section A.3.bb. has been updated to reflect this requirement, please see Amendment Section 13.**
104 ee. The Contractor shall have available for implementation at the State's request a Telemedicine/TeleHealth benefit option that meets or exceeds T.C.A. and State of Tennessee Medical Board requirements and regulations. We will work with the State to offer a telemedicine benefit that meets the State's yet to be determined legislative requirements.	**The State sees this as a comment, and does not issue a response.**
105 (3) Inclusion of pharmacy benefits information in the Contractor's annual enrollment materials for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other vendors (as directed by the State), and other updates and/or changes that may be helpful to the State's members. At the state's request and direction, the Contractor shall also include in its annual Welcome Packet to plan members, at the conclusion of the state's open enrollment period, any letter or other pharmacy benefits related materials. Is the goal to have information from all vendors in one welcome packet or is the request to consolidate information from all vendors onto one document included in the welcome packet?	**No, we don't want one universal welcome packet nor do we want to dictate how a vendor designs handbooks. We do however want to have included appropriate information about our benefits. And from time to time, when we believe new benefits or changes call for communicating in multiple ways, we will ask our vendors to include individual fliers or letters with information the vendors are distributing.**

QUESTION / COMMENT	STATE RESPONSE
106 (4) Accepting and maintaining prescription drug data from the PBM in a manner and format and at a frequency specified by the State. Is the prescription drug data from the PBM designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	**At the current time, the Partnership and Standard PPOs have separate pharmacy and medical out-of-pocket maximums which, when combined, are less than the amounts allowed under PPACA. The Limited PPO (available only to Local Education and Local Government groups and not to state or higher education employees in the State Plan) does have an integrated medical and pharmacy out-of-pocket maximum. Those amounts for 2015 are $6,600 for employee only coverage and $13,200 for all other coverage tiers.** **The state most likely will want the TPAs selected under this RFP to receive prescription drug file from the state's PBM on either a bi-monthly or monthly basis (as is currently happening). This file would only be for all of the group insurance program members who are enrolled in that particular TPA's plans with the state (e.g. Partnership PPO, Standard PPO, Limited PPO, and CDHP).** **This claims data is also intended for your case managers to use for case management in order to have a "total picture" of a member's medical and Rx claims data.**
107 e. The state seeks to move as much specialty drug dispensing as possible to our carved-out pharmacy benefits manager (PBM) or for those specialty medications that are physician administered, to a physician's office. The state recognizes that some dispensing of specialty drugs will continue through the medical benefit, but seeks to reimburse providers for the provision of specialty drugs via our third party administrators of these contracts on an Average Sales Price plus (ASP+) model, refer to Contract Section C.3.f. Is it the State's intent to carve specialty medications out of the physician outpatient setting and have them handled directly by the PBM?	**No, that is not the State's full intent and we could never move 100% in that direction. However, the state does desire to move as much utilization of specialty medications away from the outpatient hospital setting as possible and into either an outpatient physician's office or clinic or to the state's PBM. In general, the State's desire is to have our TPAs be cognizant of the State's spend on specialty medications in the outpatient hospital setting (as we are self-insured), and have your case managers, clinicians, and provider representatives stress this need to your network facilities and providers. We want to move the needle and have more of these expensive medications transitioned away from the outpatient hospital setting and either to a physician's office, where it would be paid under the medical benefit OR have your case managers, clinicians, and physicians work with the state's PBM to transition plan members to having specialty medications filled through a pharmacy in our PBM's specialty pharmacy network or to the actual PBM's specialty pharmacy itself.**

QUESTION / COMMENT	STATE RESPONSE
108 b. The Contractor is responsible for working directly with the State's "carve-out" Employee Assistance Program (EAP)/Behavioral Health Organization (BHO) vendor. Coordination by the Contractor shall include the following: (1) Inclusion of behavioral health benefit information in its member handbook (see Contract Section A.15.f.), including the toll-free telephone number to contact the EAP/BHO vendor. (2) Inclusion of the EAP/BHO vendor's telephone number on the back of the member identification card (see Contract Section A.15.e.). (3) Inclusion of behavioral health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members. (4) Accepting and maintaining data from the EAP/BHO in a manner and format and at a frequency specified by the State. The Contractor shall also share medical claims data claims amounts with the BHO for the purpose of allowing the TPA Contractor and the BHO to routinely track member out of pocket maximums. (5) Assistance in the co-management of medical/psychiatric disorders to include consultations when necessary between medical staff. (6) Clinical education of network providers regarding screening and management of depression and anxiety in the primary care setting, including depression and anxiety as a secondary diagnosis. (7) Providing individualized and face-to-face (when requested by the State) clinical education to network providers identified by the EAP/BHO vendor, the PBM, the HM/W vendor, the H&W Center vendor, the State, or any other State contracted vendor as needing additional education regarding prescribing patterns and clinical interventions/treatment for behavioral health conditions. (8) Participating, as applicable, in the EAP/BHO vendor's discharge activities for individual members with both medical and behavioral health needs. (9) Other activities necessary for the appropriate coordination of benefits and claims payment of medical and behavioral health benefits.	**Is the data from the EAP/BHO vendor designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs?** **Yes, the medical TPAs are currently required to receive and integrate behavioral health and EAP claims data. The medical TPAs use this information to track a member's deductible and out-of-pocket expenses, coordinate care and subrogate behavioral health claims.** **Behavioral health data is shared in order to appropriately manage patients with co-occurring behavioral health and medical conditions, including co-management to include consultations when necessary between the clinical staff of the EAP/BHO vendor and the medical TPAs.**

	QUESTION / COMMENT	STATE RESPONSE
	Is the data from the EAP/BHO vendor designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	**On a daily basis, or as otherwise requested by the State, using the agreed upon format and methodology.**
109	a. The State contracts with a vendor to provide certain health management services, including wellness and disease management. The Contractor is not responsible for the provision of these health management services. However, the Contractor is responsible for coordinating with the Health Management and Wellness (HM/W) vendor as necessary to ensure that members receive appropriate health management services. Coordination by the Contractor shall include the following: (1) Inclusion of health management information in its member handbook (see Contract Section A.15.f.), including the toll-free telephone number to contact the HM/W vendor and the Nurse Advice Line and how to access decision aids. (2) Inclusion of the HM/W vendor's telephone number on the back of the member identification card (see Contract Section A.15.e.). (3) Inclusion of health management benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members. Such materials shall include website information, toll-free member service number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members. (4) Accepting and maintaining data from the HM/W vendor in a manner and format and at a frequency specified by the State. Is the data from the HM/W vendor designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	**Data from the wellness vendor could result in, for example, waivers or lowering of cost-sharing for members who complete wellness activities. Currently, the state is not implementing such a program but it is possible in the next 2-3 years.** **As for frequency, the wellness vendor will send a file to the Contractor each month detailing coaching participation to coordinate care and avoid duplication.**

QUESTION / COMMENT	STATE RESPONSE
110 b. The Contractor shall provide to the HM/W vendor either a daily discharge file or a daily admissions file in a manner and format approved by the State. Admissions files shall include the number of days authorized for inpatient hospitals, rehabilitative facilities, or skilled nursing facilities and any authorizations for home health services. Please provide a sample of the current report associated with this request.	**Currently there is no standard report layout. The wellness vendor will work with the Contractor to determine what should be included.** **Note – if an admission file is provided by the Contractor, a discharge date should be included on the file.**
111 c. As directed by the State, the Contractor shall implement cost-sharing incentives (e.g., lower rates of co-insurance, provision of co-payments in lieu of co-insurance, waiver of or provision of lower deductible amounts) for members engaged in disease management and other programs as reported to the Contractor by the State or the HM/W vendor. Does the State have benefit cost sharing incentives in place today? Can you please provide a summary of these benefits? Can you list the disease states that have the current improved cost sharing incentives?	**This is not a benefit that is currently in place.**
112 d. As directed by the State, the Contractor shall report to the HM/W vendor and/or the State those members who fail to complete state specified wellness requirements delivered by the Contractor such as, but not limited to, case management. Can the State specify the requirements that are currently in place and being reported on as well as provide a sample report and the frequency?	**The Contractor will meet with the wellness vendor during implementation to establish the criteria. Currently the Contractors report to the wellness vendor, at least monthly, those plan members who decline enrollment or do not actively engage in case management. There is no standard report established. At a minimum, there are certain key fields that should be included on the report (member ID, closure description, patient relation and diagnosis).**
113 l. At the State's request, the Contractor shall load Public Sector Plan claims data into an all payer claims database. Can the State provide information on the file layout that are currently in place for meeting this requirement as well as the database this information is to be sent to?	**Truven is the State's current DSS Vendor; for the file layout, please refer to Appendix 7.11 which was previously provided with the RFP.** **The Database used by the State is implemented by Truven Health Analytics.**

QUESTION / COMMENT	STATE RESPONSE
114 p. Explanation of Benefits (EOB) (1) The Contractor shall generate and mail an explanation of benefits (EOB) to the member each time the Contractor processes a claim from a provider. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include, but not be limited to, the date the Contractor received the claim, the date the Contractor adjudicated the claim, the claim number, identification number of the head-of-contract, the patient name, the date of service, type of service furnished, the provider name, the Contractor's contact information, submitted charges, total amount paid by the plan, the amount paid by another insurance carrier, total amount owed by the member by cost-sharing category (deductible, co-payment, co-insurance, etc.), any non-covered amount, the out-of-pocket amounts paid for the year, how to file an appeal, adjustments or corrections that affect a member's out-of-pocket costs, and any other information legally required. The Contractor may substitute an electronic EOB if requested by the member. (2) The Contractor shall also generate and mail an EOB to the member each time the Contractor processes a claim submitted by the member. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include information similar to the EOB for provider-submitted claims but tailored to member-submitted claims. The Contractor may substitute an electronic EOB if requested by the member. Please provide a sample of the current EOB associated with this request.	**A sample copy of EOB's from both Cigna and BCBST of Tennessee are attached. Please see Attachment 5 to this amendment.**
115 v. The Contractor shall pass directly to the State the payment terms that the Contractor has negotiated with providers. The Contractor shall not receive any differential between the provider contract rate and the payment funded by the State; the Contractor shall ensure that the State and the member receives the full benefit of any provider payment terms, including, but not limited to,	**The current RFP is not structured to evaluate such a program. However, after award of the contracts the State would be open to evaluating whether such a program would be in the State's best interest, please see Amendment Sections 22 and 23.**

	QUESTION / COMMENT	STATE RESPONSE
	provider fee schedules, contract rates, other payment arrangements, discounts, rebates, refunds, or credits negotiated by the Contractor. All special pricing considerations and financial incentives shall accrue to the State and plan members. The majority of our clients access our secondary network program (Network Savings Program) to obtain network savings on providers outside "*Name Redacted*"s directly contracted network. The access fee for these secondary networks is a percent of savings. Would the State want to participate in this type of program? And if so, would the shared savings reimbursement arrangement be acceptable only for those claims?	
116	cc. The Contractor shall implement a process to carry out subrogation recoveries and report subrogation activities to the State in compliance with the State's subrogation policies, which shall be provided to the Contractor prior to the benefits go-live date. Can the State provide a copy of the subrogation policy that the Contractor is being requested to administer as well as a sample copy of the current reporting?	**A copy of the state's subrogation policy/contractor requirement is attached along with the required Performance Tracking reports. (See Attachments 3 and 4 to this amendment.) These reports include an example of the Monthly YTD summary of Subrogation Recoveries, Monthly Summary of Subrogation Recovery Efforts detailing the claims review of opened, pending and closed cases, Non-Response Reports, Quarterly Report of cases closed, and the Quarterly "Made Whole" report.**
117	gg. Reconciliation (1) The Contractor shall submit claims reports to the State in sufficient detail for the State to record and reconcile claims. The format of the claims reports shall be prior approved by the State and the frequency shall match the frequency of the Contractor's bank drafts. (2) The Contractor shall submit to the State a monthly recoveries report in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements). (3) The Contractor shall reconcile, within ten (10) business days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State. (4) The Contractor shall provide authorized State	**The current contract requirements vary from this requirement. However, information on current reporting is described below.** **We receive a weekly spreadsheet from one vendor with the claims to be drafted for each of the plans. Sample attached.** **We receive daily emails from the bank on behalf of the other vendor. There is one email each day for each bank account to be drafted.** **Additional detailed account information is also available to state staff through the vendor reporting cubes.** **Please see the excel spreadsheet labeled "117-Weekly Invoice Sample-1".**

	QUESTION / COMMENT	STATE RESPONSE
	users with access to its internal client reporting system for use in the State's reconciliation process. Please provide a copy of the current report your Contractors are providing for this requirement.	
118	b. During normal business hours, the Contractor's member services representatives shall be dedicated to the Public Sector Plans. A Contractor may be allowed through written approval by the State to use a "designated" call unit (as opposed to a "dedicated" call center) provided that the unit could meet all other call center standards defined in this Contract. Is the State willing to accept a designated call unit based on the membership threshold enrolled by the vendor? (ex. Dedicated based on higher enrolled membership and designated based on lower enrolled membership.)	**The state will not make this decision based strictly on enrollment. Assuming that the Contractor can sufficiently confirm/document that the unit can meet all call center standards defined in this Contract then the state is willing to accept a designated call unit.**
119	v. The Contractor shall use the Edison employee identification number as the primary unique identifier for members and shall include this number on the member's identification card. Can the State's employee ID number be formatted to a 9-digit numeric number?	**The State is ok with allowing a 9-digit ID as long as the pharmacy contract will always require our 8 digit ID to be printed on the cards. We need to have at least one card for all employees that we can direct them to in order to find their ID.**
120	(8) As directed by the State, the Contractor shall re-issue identification cards to reflect approved plan design changes, including but not limited to changes in cost-sharing, within the timeframe specified by the State. – Please confirm what the required timeframe is for reissued ID cards.	**Given that annual enrollment typically occurs in October, annual plan design changes are known months before the beginning of the new plan year (January). When there are plan changes for the upcoming plan year the contractor must mail new cards no later than 21 days prior to the new year during the first year of the contract and thereafter no later than fourteen (14) days prior to the start of each benefit year as required in contract section A.15.e.5.** **Mid-year design changes are very rare but if they were to occur the state would provide the Contractor at least a 30 day window to reissue cards.**

QUESTION / COMMENT	STATE RESPONSE
121 f. Member Handbook (1) The Contractor, following review and approval by the State, shall annually, prior to the new benefit year, update member handbooks and shall maintain on its website an up-to-date version of the member handbook that incorporates changes made between annual printings. (2) The member handbook shall be specific to each of the three Public Sector Plans and shall detail benefits and excluded services and procedures; detail cost sharing requirements and out-of-pocket maximums for each benefit option; describe additional features specific to any of the benefit options; describe procedures for accessing services, including use of network and out-of-network providers and utilization management; describe appeal procedures; include information specified by the State regarding pharmacy benefits, behavioral health benefits, and health management/wellness benefits; and provide other information helpful to members. (3) Upon the State's request, the Contractor shall provide member handbooks to Agency Benefits Coordinators within fifteen (15) days of the State's request to provide copies. (4) The Contractor shall mail a member handbook no later than ten (10) days from receipt of a member's request for a copy. Does the State have a desired format for the member handbook that each vendor uses to input their information or does the State use the vendors member handbook as the format? Can you provide a copy of the current member handbook as a sample for us to reference?	**No, the State does not have a desired format for the member handbook that each vendor uses to input their information.** **Yes, the State uses the vendors' member handbooks as the format and we do have input on content.** • 2015 BlueCross Partnership PPO http://www.state.tn.us/finance/ins/pdf/blue_partnership_2015.pdf • 2015 BlueCross Standard PPO http://www.state.tn.us/finance/ins/pdf/blue_standard_2015.pdf • 2015 BlueCross Limited PPO http://www.state.tn.us/finance/ins/pdf/blue_limited_2015.pdf • 2015 Cigna Partnership PPO http://www.state.tn.us/finance/ins/pdf/cigna_partners_2015.pdf • 2015 Cigna Standard PPO http://www.state.tn.us/finance/ins/pdf/cigna_standard_2015.pdf • 2015 Cigna Limited PPO http://www.state.tn.us/finance/ins/pdf/cigna_limited_2015.pdf
122 h. Unless otherwise directed by the State, the Contractor shall mail an annual welcome packet to all enrolled members no later than twenty-one (21) days prior to the go-live date and, thereafter, fourteen (14) days prior to the start of each benefit year. During the benefit year the Contractor shall mail a welcome packet within ten (10) days from receipt of new enrollment or change in enrollment. The welcome packet shall include, at a minimum,	**It would be acceptable to the State to allow members to call customer service and request a copy of the provider directory only if information about how and when to do that is clearly explained in all member materials.**

	QUESTION / COMMENT	STATE RESPONSE
	a welcome letter, a member handbook, an I.D. card, a provider directory order form, the Contractor's website address, website logon information, and a confidentiality statement. – provider directory form? – RELATED PG/LIQUIDATED DAMAGE 9. Initial Welcome Packet Distribution Ninety-seven percent (97%) of welcome packets, containing ID cards and member handbooks, shall be produced and mailed no later than twenty-one (21) days prior to the go-live date. Assessment: Ten thousand dollars ($10,000) if the guarantee is not met. Measurement: Measured, reported, reconciled and paid no later than three months after the go-live date. 10. Distribution of Ongoing Welcome Packet Ninety-seven percent (97%) of new member welcome packets shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information Assessment: Five thousand dollars ($5,000) per year in which the guarantee is not met. Measurement: Measured, reported, reconciled and paid annually. Would it be acceptable to the State to allow members to call customer service and request a copy of the provider directory rather than providing a paper order form?	
123	A16. a,b,c,d: ". In addition to the Contractor's own website where plan and member specific information shall be incorporated, the Contractor shall maintain a "splash" page dedicated to and customized for this Contract containing general plan information that does not require a member to login. . . . etc.: So that we may fully understand the parameters of this requirement and meet the expectations of the State, please provide a copy of the current custom website provided by your current Contractors.	**Below are the links to the websites of our current contractors.** www.bcbst.com/members/tn_state www.cigna.com/stateoftn www.assurantemployeebenefits.com/stoftn www.deltadentaltn.com/statetn www.lifebenefits.com/stateoftn www.info.caremark.com/stateoftn www.here4tn.com/
124	i. Decision Support System (1) The Contractor shall transmit medical claims data to the State's current health care decision support system (DSS) vendor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 31786-00125 Appendix 7.11 "DSS	**Truven is the State's current DSS Vendor; for the file layout, please refer to Appendix 7.11 which was previously provided with the RFP.**

	QUESTION / COMMENT	STATE RESPONSE
	Vendor File format" or in a mutually agreed upon format. The data feed(s) shall be provided at no additional charge to the State. The Contractor shall transmit the claims data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State, until all claims incurred during the term of this Contract have been paid Please confirm who the State's DSS vendor is. Please also provide a copy of the current/requested file layout.	
125	In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract. Please confirm whether the State intended the Maximum Liability amount to be specific to administrative services fees, exclusive of claims dollars.	**The maximum liability is currently specific to administrative service fees and does not include claim dollars.**
126	Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address: Sylvia Chunn, Procurement & Contracting Manager Tennessee Department of Finance & Administration Benefits Administration Division William R. Snodgrass Tennessee Tower 312 Rosa L. Parks Avenue, 19th Floor Nashville, Tennessee 37243	**Currently, the State self-bills based on a snapshot of enrollment as of the first day of the month. In this case, the State generates the invoice. Upon agreement of the State and Contractor, this option will be available.** **The Division of Accounts would require:** • **Vendor's remittance address;** • **Invoice number and date;** • **the payment terms (due upon receipt, net 30, net 45, etc.); and** • **Enrollment counts by fund (state retiree, state active, local education retiree, local education active, local government retiree, and local government active) and by plan (Partnership, Standard, CDHP, Limited)**

	QUESTION / COMMENT	STATE RESPONSE
	Please provide a copy of your current invoice so that we may more fully understand the requirements and expectations of this request.	
127	D.20. HIPAA and HITECH Compliance. Given that the State's plan is self-funded, would the State consider adding ", except in the case of payments that exceed the amount payable under the Plan for which a standard of gross negligence shall prevail" as a clarifier to the first sentence?	**The State declines to add this language.**
128	Cost Proposal / C - Network / page 47 of 127 Related to table C - Network in the Cost Proposal, on page 47 of 127, the file feed *"Name Redacted"* submits to Aon Hewitt from Actuarial is for the *"Name Redacted" "ZZZ"* network. Will it be permissible to submit adjustment factors to the *"ZZZ"* network files as we have done in the past for other *"Name Redacted"* networks, such as *"XXX"* or *"YYY"* PPO if more up to date information is available on the network being quoted?	**The RFP process does not allow for the submittal of adjustment factors. You may submit a written explanation of the impact of these new contracts to the State of Tennessee.**
129	Would you be able to provide me the RFP in Word (Non-PDF format)?	**Yes, the Word version of the RFP will be posted to the Procurement Website, located at:** **http://tn.gov/generalserv/cpo/sourcing_sub/rfp.shtml**
130	May we request these RFP files in Excel versions or will they be distributed later? • Appendix 7.2- Zip codes • Appendix 7.3 – PCP disruption	**These documents have already been provided in Excel format on the Procurement website, they can be found at:** **http://tn.gov/generalserv/cpo/sourcing_sub/rfp.shtml**
131	Based on the pre-bidders conference yesterday and the conversations around the data needed by AON Hewitt for the financial analysis we wanted to confirm AON Hewitt did have our most current data or if we needed to provide anything further for this component. Do you have a contact we need to work with to confirm?	**There is an Aon contact available to send data to, however if you need to ask a general question regarding data already submitted, please submit your question through the State, which has been added to the RFP, please see Amendment Section 4.**

QUESTION / COMMENT	STATE RESPONSE
132 *"Name Redacted"* has provided the MY14 UDS discount data with projections that presents a more updated view of our network contracts compared to the FY13 UDS discount data. In addition, there would be additional contract adjustments that would need to be incorporated above and beyond the MY14 projections. Can we provide a list of discount adjustments by zip3 that should be added to either the FY13 or MY14 discount submission results for the *"Name Redacted"* discount analysis for State of Tennessee? Please let us know if adjustments should be from the FY13 or MY14 data.	**Aon will be using the Mid-Year 2014 Discount Database for the discount analysis. Please provide the adjustment factors for that time period along with a comprehensive description of the adjustment factors, why they are necessary, and why they have not been included in the data submitted to Aon. The State of Tennessee will carefully consider this information.**

3. Add the following as RFP Section 3.2.2.2. and renumber any subsequent sections as necessary:

3.2.2.2. One (1) original Cost Proposal paper document for each region the Respondent is proposing to offer services in labeled:

"RFP # 31786-00125 COST PROPOSAL ORIGINAL - (APPLICABLE REGION, I.E. EAST, WEST, MIDDLE, STATEWIDE)"

and one (1) copy in the form of a digital document in "PDF" format properly recorded on separate, blank, standard CD-R recordable disc or USB flash drive labeled:

"RFP # 31786-00125 COST PROPOSAL COPY – (APPLICABLE REGION, I.E. EAST, WEST, MIDDLE, STATEWIDE)"

In the event of a discrepancy between the original Cost Proposal document and the digital copy, the original, signed document will take precedence.

4. Add the following as RFP Section 3.2.5 and renumber any subsequent sections as necessary:

3.2.5. A Respondent must ensure that the Aon receives all network and claims information no later than the Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

William Lin
400 Atrium Drive, 5th Floor South
Somerset, NJ 08873

5. Delete RFP Attachment 6.2 Section C in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

	C.12.	**Staffing** a) Identify the designated account management team you propose to work on this account. Provide an organization chart, including names and titles, of

		management and key personnel that will be responsible for account management. Indicate whether the person who will fill each position is already employed by your firm or whether he/she will be recruited upon Contract award. If the person(s) are already employed, provide resumes and length of time with your firm. At a minimum, the positions below should include: i. Account Director – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and overseeing contractual services. ii. Account Manager – Responsible for providing daily operational support as well as strategic planning and analysis. iii. Operations Manager – Responsible for all claims operations and reporting. iv. Clinical Program Director/Clinical Program Manager – Responsible for all UM, Case Management, and other clinical support. v. Member Services Manager – Responsible for all customer service functions, call center and reporting. b) Describe how the implementation team will be phased out and replaced by the ongoing Account Team with minimal disruption to the State and members. c) Detail the level of decision making authority available to the Account Team to resolve issues of importance to the State. d) Define how the Account Team will be responsive, creative, and innovative in developing solutions and recommendations to reduce healthcare cost, improve quality of healthcare and access, and increase Member satisfaction.

6. Delete RFP Attachment 6.3 Cost Proposal Table A in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

TABLE A - Administrative Services Only (ASO) Fees

Provide Administrative Services Only (ASO) fees for active employees and eligible retirees. This 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.

Use the stated enrollment for your enrollment assumptions. **When bidding on multiple regions, bidders are required to submit administrative fee bids that are uniform across all regions.**

*"Total enrollment levels" reflects all members (i.e., employees, retirees and dependents) covered in all regions by the Contractor.

January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The Contractor's total payment will be the product of the PEPM multiplied by the number of employees (or heads of contract), not total enrollment levels. For reference, the current number of employees (heads of contract) as well and the total number of members are available in Appendices 7.4, 7.5 and 7.6.

TOTAL ENROLLMENT* LEVELS (all members, not only employees)	TOTAL FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD					State Use Only
	1/1/2016 – 12/31/2016	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	Evaluation Cost
Below 10,000						

10,000 – 29,999						
30,000 – 49,999						
50,000 – 74,999						
75,000 – 99,999						
100,000 and above						

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.

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 <u>all</u> proposals **evaluation cost amount being evaluated**	**x 6 (maximum section score)**	**= SCORE:**	

State Use – Solicitation Coordinator Signature, Printed Name & Date:

7. Delete RFP Attachment 6.3 Cost Proposal Table C in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

TABLE C - Network	
Provide the name of the proposed network for each region in which the Proposer intends to deliver services. The State's Actuarial Contractor, Aon Hewitt, will supply the State with a ranking for each Respondent to this RFP based on the Respondent's proposed network claims information already on file with Aon Hewitt and Aon Hewitt's analysis and evaluation of the information. Refer to Appendix 7.1. The Respondent with the most favorable claims cost ranking will be ranked a one (1), with each other Respondent falling in line thereafter based on claims cost favorability to the State. (i.e. 2nd best will be ranked a 2, 3rd best a 3, etc.). This calculation will be performed separately for each region proposed.	
	Proposed Network(s)
Identify the **STATEWIDE** network being proposed – leave blank if not proposing a statewide network	
Identify the network being proposed for the **EAST REGION** – leave blank if not proposing this region	
Identify the network being proposed for the **MIDDLE REGION** – leave blank if not proposing this region	
Identify the network being proposed for the **WEST REGION** – leave blank if not proposing this region	

	State Use Only **Total Claims Cost Ranking** (ranking to be provided by the State's actuarial Contractor, Aon Hewitt)
STATEWIDE Network Rank	
EAST Region Network Rank	
MIDDLE Region Network Rank	
WEST Region Network Rank	

CLAIMS COST RANK (as shown above)**:**

The Solicitation Coordinator will use the number shown above and the formula below to calculate the Cost Proposal Score for Claims Cost separately for each network proposed. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.

Highest ranked claims cost **Claims cost rank amount being evaluated**	**x 25 (maximum section score)**	**= Table C SCORE:**	

8. Delete RFP Attachment 6.3 Cost Proposal Score Grid in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

State Use Only **Cost Proposal Total Score**		
Table A Score		
Table B Score		
Table C Score		
Table D Score		
TOTAL SCORE: The Solicitation Coordinator will add the scores from Table A, Table B, Table C, and Table D to determine the total Cost Proposal Score for the specific region. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.	**= SCORE:**	

9. Add the following to RFP Attachment 6.3 Cost Proposal:

TABLE A - Administrative Services Only (ASO) Fees - Statewide

Provide Administrative Services Only (ASO) fees for active employees and eligible retirees. This 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.

Use the stated enrollment for your enrollment assumptions. **When bidding on multiple regions, bidders are required to submit administrative fee bids that are uniform across all regions.**

*"Total enrollment levels" reflects all members (i.e., employees, retirees and dependents) covered in all regions by the Contractor.

January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The Contractor's total payment will be the product of the PEPM multiplied by the number of employees (or heads of contract), not total enrollment levels. For reference, the current number of employees (heads of contract) as well and the total number of members are available in Appendices 7.4, 7.5 and 7.6.

TOTAL ENROLLMENT* LEVELS (all members, not only employees)	TOTAL FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD					State Use Only
	1/1/2016 – 12/31/2016	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	Evaluation Cost
Below 10,000						
10,000 – 29,999						
30,000 – 49,999						
50,000 – 74,999						
75,000 – 99,999						
100,000 and above						

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.

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.

$$\frac{\text{lowest evaluation cost amount from all proposals}}{\text{evaluation cost amount being evaluated}} \times 8 \text{ (maximum section score)} = \text{SCORE:}$$

State Use – Solicitation Coordinator Signature, Printed Name & Date:

10. Add the following to RFP Attachment 6.3 Cost Proposal:

TABLE C – Network - Statewide	
Provide the name of the proposed network for each region in which the Proposer intends to deliver services. The State's Actuarial Contractor, Aon Hewitt, will supply the State with a ranking for each Respondent to this RFP based on the Respondent's proposed network claims information already on file with Aon Hewitt and Aon Hewitt's analysis and evaluation of the information. Refer to Appendix 7.1. The Respondent with the most favorable claims cost ranking will be ranked a one (1), with each other Respondent falling in line thereafter based on claims cost favorability to the State. (i.e. 2nd best will be ranked a 2, 3rd best a 3, etc.). This calculation will be performed separately for each region proposed.	
	Proposed Network(s)
Identify the **STATEWIDE** network being proposed – leave blank if not proposing a statewide network	
Identify the network being proposed for the **EAST REGION** – leave blank if not proposing this region	
Identify the network being proposed for the **MIDDLE REGION** – leave blank if not proposing this region	
Identify the network being proposed for the **WEST REGION** – leave blank if not proposing this region	
	State Use Only **Total Claims Cost Ranking** (ranking to be provided by the State's actuarial Contractor, Aon Hewitt)
STATEWIDE Network Rank	
EAST Region Network Rank	
MIDDLE Region Network Rank	
WEST Region Network Rank	
CLAIMS COST RANK (as shown above)**:** The Solicitation Coordinator will use the number shown above and the formula below to calculate the Cost Proposal Score for Claims Cost separately for each network proposed. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.	

Highest ranked claims cost **Claims cost rank amount being evaluated**	**x 31** **(maximum section score)**	**= Table B SCORE:**	

11. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.1.b. in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    b. The Contractor is serving Grand Division Service Area East/West/Middle/Statewide (refer to Contract Section A.25), and providing the State Network Name for the Region Name region.

12. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.2.c in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    c. The Contractor shall have a designated full-time implementation manager who is responsible for leading and coordinating all contract implementation activities as well as a designated implementation team. Unless otherwise directed by the State, the implementation manager should be designated full-time to this implementation project through sixty (60) days after the go-live date. All other implementation team members that the Contractor referenced in its proposal to the State and reflected in Attachment F, shall be available as needed during the implementation and at least thirty (30) days after the go-live date. The Contractor's implementation team shall include a full-time Account Manager designated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of this Contract. Also, the Contractor shall assign an Information Systems Project Coordinator to coordinate information technology activities among the Contractor and the State's existing vendors and all internal and external participating and affected entities. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of claims administration services for at least one other large employer (*i.e.*, employer with medical plans covering at least 30,000 lives).

13. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.3.bb. in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    bb. The Contractor shall notify the State in writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Such notification shall be made for all hospitals or physician groups of twenty (20) or more.

14. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.9.b in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    b. The Contractor shall operate a claims management system that tracks accumulations toward deductibles and out-of-pocket maximums, tracks co-payments and co-insurance amounts and appropriately links claim history, enrollment information, member services, provider network, and utilization management information. This shall include the daily electronic exchange of all claims data to the HSA vendor as well as member-level deductible and maximum out-of-pocket accumulator data with the Pharmacy vendor, EAP/BHO vendor, Health Savings Account (HSA) fiduciary, and any other State contracted vendor as needed.

15. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.9.w in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    w. The Contractor shall remit to the State no less frequently than quarterly, a check for 100% of all rebates accrued during the claim period ending a maximum six (6) months prior to the rebate payment date which were obtained on behalf of the State due to the use of medical services, devices and pharmaceuticals by members of the Public Sector Plans. A report shall accompany each check containing a breakout by group fund (i.e. State Actives, State Retirees, etc.) and

further broken down by service or product name and the appropriate codes to identify the service or product (e.g. NDC, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). Contractor shall include for each breakout the total amount invoiced to the manufacturer, the total amount collected on behalf of the state, and the amount being paid to the state.

16. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.16.n.(3) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    (3) Present price information based on how a current claim would process, not historical claims data. Transparency tools should be updated at least quarterly to ensure most accurate pricing is presented;

17. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.16.n.(8) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    (8) Include up-to-date information on a member's HSA and FSA balance (if applicable);

18. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.20.f in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    f. CMS Data Match: The Contractor shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) providing for a data match, no less frequent than monthly, of Contractor's full file of members against CMS Medicare files for purpose of determining the primary payer. Furthermore, the data match shall generate a report of all Medicare enrollees identified, if they have both parts A and B and the effective dates, which shall be shared with the State. The Contractor shall also provide a monthly report of all Local Government retirees who will become eligible for Medicare in the subsequent month (refer also to Contract Attachment C, Reporting Requirements).

19. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.20.h in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    h. The Contractor shall provide transmittal of claims data via secure medium at a frequency determined by the State to any additional third parties including the State's HM/W vendor, EAP/BHO vendor, PBM vendor, HSA Vendor or others as identified by the State.

20. **Delete RFP Attachment 6.6 Pro Forma Contract Section A.23.a.(9) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    (9) For each episode chosen by BA, the Contractor shall require participation in episode based payments for all in-network providers who are expected to have at least 40 of these episodes of care across all of their commercial members in the upcoming performance period. The Contractor shall apply the episode model to any episode experienced by:

        i. Public Sector Plan members by January 1, 2017;

        ii. At least fifty percent (50%) of the Contractor's fully insured members, and at least ten percent (10%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2017; and

        iii. At least sixty percent (60%) of the Contractor's fully insured members, and at least fifteen percent (15%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2019.

The Contractor shall provide a report after each of the above performance dates documenting achievement of the fully insured and self-insured ASO percentages.

21. Add the following as RFP Attachment 6.6 Pro Forma Contract Section C.3.c and renumber any subsequent sections as necessary:

FOR REGIONAL CONTRACTS ONLY

The Contractor shall maintain an annual medical trend rate at or below six percent (6%). During any plan year, if the trend rises above six percent (6%) as calculated using allowed amounts for in-network claims incurred, the Contractor guarantees to reimburse the State or have withheld the percentage of administrative fees detailed in the table below.

	PERCENTAGE OF ADMINISTRATIVE FEES AT RISK			
	1/1/17 – 12/31/17	**1/1/18 – 12/31/18**	**1/1/19 – 12/31/19**	**1/1/2020 – 12/31/2020**
REGIONAL NETWORK TREND GUARANTEE				

22. Delete RFP Attachment 6.6 Pro Forma Contract Section C.3.e.(1) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

e. The State shall reimburse the Contractor for the actual cost of the following in the performance of this Contract, provided that the Contractor provides documentation of actual costs incurred as required by the State.

(1) TEXT DELETED

23. Add the following as RFP Attachment 6.6 Pro Forma Contract Section C.3.h. and renumber any subsequent sections as necessary:

h. Value Oriented Payments. The State shall reimburse the Contractor the costs resulting from any State approved value oriented initiatives.

24. Delete RFP Attachment 6.6 Pro Forma Contract Attachment B.15 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

15. **Statewide Provider/Facility Network Accessibility** – Applies only if awarded the Statewide contract		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's statewide provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan members shall have the Access Standard indicated.	
Definition	**Provider Group – Urban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 10 miles
	Obstetricians/Gynecologists	1 physician within 10 miles
	Pediatricians	1 physician within 10 miles
	Cardiologists	1 physician within 15 miles
	Endocrinologists	1 physician within 15 miles
	Acute Care Hospitals	1 facility within 20 miles
	Provider Group – Suburban	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 15 miles
	Obstetricians/Gynecologists	1 physician within 15 miles
	Pediatricians	1 physician within 15 miles
	Cardiologists	2 physicians within 20 miles
	Endocrinologists	2 physicians within 20 miles
	Acute Care Hospitals	1 facility within 25 miles
	Provider Group – Rural	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 25 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Cardiologists	1 physician within 25 miles
	Acute Care Hospitals	1 facility within 30 miles
Assessment	Seventy-Five thousand dollars ($75,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a GeoNetworks report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use GeoNetworks' default definitions for urban, suburban, and rural areas. At the Contractor's request, the State may also approve other methodologies.	
Measurement	Compliance report is the semi-annual GeoNetworks Analysis submitted by the Contractor. Measured, reported reconciled and paid semi-annually.	

25. Add the following as RFP Attachment 6.6 Pro Forma Contract Attachment B.36 and renumber any subsequent sections as necessary:

36. **Payment Reform – Regional Contracts Only**	
Guarantee	Contractor shall apply the episode model to i. at least fifty percent (50%) of the Contractor's fully insured members, and at least ten percent (10%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2017; and ii. At least sixty percent (60%) of the Contractor's fully insured members, and at least fifteen percent (15%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2019.
Assessment	Ten Thousand dollars ($10,000) for each percentage measure; fully insured and self-insured, per awarded regional Contract.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after each deadline.

26. Add the following as RFP Attachment 6.6 Pro Forma Contract Attachment C.29 and renumber any subsequent sections as necessary:

29. **Payment Reform Performance Reports**, in compliance with contract sections A.23.a (7,9) c, and d.

27. Delete RFP 31786-00125 Appendix 7.8 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Optum™GeoAccess® GeoNetworks®
Provider & Facility Network Accessibility Analysis
RFP # 31786-00125
Data Requirements & File Layouts

The State would like to know the potential of your organization's provider network to service the accessibility needs of its members who choose to enroll in the Public Sector's Health Plan. To measure that potential, this RFP requires each Proposer to submit a GeoNetworks® Provider Network Accessibility Analysis. Each network's relative potential will be measured by 1) the number of providers in the network and practicing; and 2) the average distance to providers for all Public Sector plan members within the pool of possible enrollees.

Data Items

To analyze the accessibility of Proposers' provider network for the State's population, the GeoNetworks® program requires both an employee data file and a provider data file. Tennessee employee data, listed with tallies by zip code are included in a file accompanying the RFP. The file is in Microsoft Excel format, and has also been provided to GeoAccess. Your provider files must contain the following:

- Provider Name (Last Name, First Name)
- Street Address – NOTE: For Network Providers who have more than one office location, the file should contain a distinct record for each office address.

- City
- State
- Five digit Zip Code
- Specialty Code – please include the coding scheme used
- Accepting/Not Accepting Patients Practice Indicator (A=Accepting, N=Not Accepting)

Data Format
If you intend to have GeoAccess conduct this analysis, you must submit your data to GeoAccess in one of the following formats: dBase, Access, Text (Fixed Width or Delimited) or Excel, on 3 ½ inch diskettes, or sent electronically.

Regardless of your preferred format, you may refer analysis-specific questions to Shawn Kearl at Optum™GeoAccess®GeoNetworks®. He can be reached at 801-982-4593; his email address is Shawn.Kearl@Optum.com. For technical support on how to utilize the software the software team can be contacted at support@ingenix.com.

Standards and Specifications

The standards and specifications listed are to be followed by all proposers. This will enable the State to compare, on a consistent basis, the accessibility of each Proposer's provider network. It is critical that each analysis meet the following data standards and report specifications.

A. Analysis Requirements

1. Use the GeoNetworks managed care accessibility analysis system, version 8.5 or greater with system data 9.4 installed. If you do not have the GeoNetworks system, call Shawn Kearl at Optum, to receive a quote for them to perform the analyses for you.
2. Use the most current system data – released four times per year.

B. Data Standards

1. Use all employee zip codes data contained in **APPENDIX 7.3 - TN Zip Code Counts**, to analyze your network relative to the State of Tennessee member population.
2. Your Network Provider addresses should be geocoded at the address level. For any Network Provider's address that cannot be exactly geocoded, the address should be geocoded using a technique which takes into account population density, such as the Representative GeoCoding used by GeoAccess. Placing providers at zip code centroids or randomly within zip codes is **not permissible**. Distance is to be calculated based on Estimated Driving Distance, not on an "as-the-crow-flies" distance.
3. If more than one provider is located at the same address, all providers at that address should have the same geographic coordinates.
4. Providers should be classified based on their primary specialty.
5. Analyses should include all providers in your network which are delivering services **within the Proposed specific service area only.** Include only providers currently accepting new patients.
6. Providers who are currently contracted, but will not be on January 1, 2016, shall not be included in your analysis.

C. Report Specifications

1. Prepare a network accessibility analysis for the entire State. The report should closely resemble the Sample Analysis contained in **APPENDIX 7.9 - Sample GeoAccess®GeoNetworks® Analysis Report** and should include:
   - a title page;
   - a table of contents,
   - a complete set of reports for EACH provider type in each location category listed below (#2), and as described in the table at the bottom of this page; and
   - a "GeoAccess®GeoNetworks® Report" which details the specifications utilized to conduct the analysis (Note: this report is not included in the Sample, but is a standard product of the analysis).

2. Conduct a separate independent analysis for urban, suburban, and rural employee access to providers, with an access standard as shown in the boxes below.

STATEWIDE NETWORK ACCESS STANDARDS

Provider Group - Urban	Required Access Standard
Primary Care Physicians	**2 physicians within 10 miles**
Obstetricians/Gynecologists	**1 physician within 10 miles**
Pediatricians	**1 physician within 10 miles**
Cardiologists	**1 physician within 15 miles**
Endocrinologists	**1 physician within 15 miles**
Acute Care Hospitals	**1 facility within 20 miles**

Provider Group - Suburban	Required Access Standard
Primary Care Physicians	**2 physicians within 15 miles**
Obstetricians/Gynecologists	**1 physician within 15 miles**
Pediatricians	**1 physician within 15 miles**
Cardiologists	**2 physicians within 20 miles**
Endocrinologists	**2 physicians within 20 miles**
Acute Care Hospitals	**1 facility within 25 miles**

Provider Group - Rural	Required Access Standard
Primary Care Physicians	**2 physicians within 25 miles**
Pediatricians	**1 physician within 20 miles**
Endocrinologists	**1 physician within 20 miles**
Obstetricians/Gynecologists	**1 physician within 25 miles**
Acute Care Hospitals	**1 facility within 30 miles**

REGIONAL NETWORK ACCESS STANDARDS

Provider Group – Urban & Suburban	Required Access Standard
Primary Care Physicians	**2 physicians within 20 miles**
Obstetricians/Gynecologists	**1 physician within 20 miles**
Pediatricians	**1 physician within 20 miles**
Cardiologists	**1 physician within 30 miles**
Endocrinologists	**1 physician within 30 miles**
Acute Care Hospitals	**1 facility within 30 miles**

Provider Group - Rural	Required Access Standard
Primary Care Physicians	**2 physicians within 20 miles**
Obstetricians/Gynecologists	**1 physician within 30 miles**
Pediatricians	**1 physician within 30 miles**
Acute Care Hospitals	**1 facility within 30 miles**

3. Analyses are to be conducted on provider groups and facilities **within the proposed specific service area only.**

4. Mileage should be calculated on an estimated driving distance basis.

5. Analyses (one each for: PCPs, Obstetricians/gynecologists, Pediatricians, Cardiologists, and Hospitals) must include the following pages (see Appendix 7.9, GeoNetworks®GeoAccess® Sample Report):

Page	Content/Display
Cover	Report title, Proposing organization's name, Date
1	**Accessibility Summary** (for employees **with desired access**): Detail the required *Accessibility analysis specifications*, *Average Distance to a Choice of Providers for Employees with Desired A*ccess, and *Key Geographic Areas*.
2	**Accessibility Summary** (for employees **without desired access**): Detail the required *Accessibility analysis specifications*, *Average Distance to a Choice of Providers for Employees without Desired A*ccess, and *Key Geographic Areas*.
3	**Access Standard Comparison** – include the following: • indicate by graph the percentage of ALL employees having access to one, two, three, four, and five providers for distances up to 40 miles, at intervals of five miles. • indicate by table the average distance to a choice of one, two, three, four, and five providers, for ALL employees.
4	**Zip codes not meeting the access standard:** Report the accessibility detail of all employees **without desired access** at the zip code level. Sort by city and zip code, and use the columns and sub-columns as shown on the Sample page. **Note:** This report is not included with the Sample Analysis, but is a standard listing resulting from the analysis.
5	**GeoAccess®GeoNetworks® Report:** This is a summary page detailing, among other things, the report creation date, the software version, analysis inputs, and calculation method.

***NOTE: The sample report included in the RFP, and referenced above includes just one set of pages – for PCPs only. Your report analysis will include a minimum of five pages for EACH provider type in each location category: PCP, Obstetricians/Gynecologists, Pediatricians, Cardiologists, Endocrinologists, and Acute Care Hospitals.**

6. **Checks for accuracy:** Proposers are responsible for ensuring their GeoNetworks®GeoAccess® Analyses are accurate. The following items should be reviewed for accuracy:
    a. Title Page:
        - Company name should appear on the GeoAccess® Analysis title page.
        - The date of the report should appear on the GeoAccess® Analysis title page.
    b. Accessibility Summary – Accessibility analysis specifications:
        - Provider Groups –
            1. Total for PCPs shall include only Doctors of Internal Medicine, General Practitioners, and Family Practitioners. Pediatricians SHOULD NOT be included in this group.
            2. Total for Pediatricians shall NOT include Pediatric specialists.
            3. Total for Cardiologists shall NOT include Pediatric Cardiologists.
            4. Total for Endocrinologists shall NOT include Pediatric Endocrinologists.
            5. Hospitals shall include only licensed free-standing, full service Acute Care Hospitals.
        - Employee Group – The total number of State employees MUST MATCH EXACTLY the number contained in **Appendix 7.3 – Zip Code Counts**
        - Access Standard – The GeoNetworks Analysis report MUST MATCH EXACTLY standard required by the State (see page 2 of these instructions)

28. **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.