STATE OF TENNESSEE
FINANCE AND ADMINISTRATION, BENEFITS ADMINISTRATION

REQUEST FOR PROPOSALS # 31786-00135 AMENDMENT # THREE FOR POPULATION HEALTH AND WELLNESS

DATE: May 26, 2017

RFP #31786-00135 IS AMENDED AS FOLLOWS:

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

EVENT	TIME (central time zone)	DATE
1. RFP Issued		April 21, 2017
2. Disability Accommodation Request Deadline	2:00 p.m.	April 26, 2017
3. Pre-response Conference	1:30 p.m.	April 28, 2017
4. Notice of Intent to Respond Deadline	2:00 p.m.	May 1, 2017
5. Written "Questions & Comments" Deadline	2:00 p.m.	May 4, 2017
6. State Response to Written "Questions & Comments"		May 26, 2017
7. Response Deadline	2:00 p.m.	June 12, 2017
8. State Completion of Technical Response Evaluations		June 27, 2017
9. State Schedules Respondent Oral Presentation		June 28, 2017
10. Respondent Oral Presentation - Primary Population Health and Wellness Programs	9 a.m. - 4:00 p.m.	July 11-12, 2017
11. State Opening & Scoring of Cost Proposals	2:00 p.m.	July 13, 2017
12. 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
13. End of Open File Period		7 CALENDAR DAYS LATER
14. State sends contract to Contractor for signature		1 BUSINESS DAY LATER

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

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

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

QUESTION / COMMENT	STATE RESPONSE
1. We appreciate the opportunity to ask clarifying questions regarding the RFP. The answers to these questions will allow us to tailor our proposal specific to your desired solution. However, receiving answers as scheduled on May 15 does not allow sufficient time to revise proposals if the answers dictate changes to our solution before having to beginning production and shipping proposals to meet the May 22 submission deadline. In order to allow proposers to fully incorporate responses to the vendor questions, we are requesting an extension until June 9.	The schedule of events has been updated to allow more time for vendor responses. Please refer to Amendment two on the CPO website.
2. We respectfully request that the State allow for a four-week extension on the response deadline to promote more competition and achieve higher value proposals to the State. Will the State extend the response deadline to 2P CT, June 19, 2017?	See response to question #1.
3. Given the innovativeness, scope, and scale of the State's vision for health promotion, we recommend that the State allow for a four-week extension on the response deadline to promote more competition and achieve higher value proposals to the State. Will the State extend the response deadline to 2P CT, June 19, 2017?	See response to question #1.
4. Given that the State's responses to vendor questions will be provided one week before proposal responses are due, and accounting for production and mailing time of hard copies, would it be possible to obtain responses to our included questions earlier than Monday, May 15th?	See response to question #1.
5. Based upon the change in the Pre-response Conference date and the mailing logistics	See response to question #1.

over the weekend with the current Monday submission date, Respondent respectfully requests the State consider extending the response deadline.	
6. Are all of the services outlined in the scope and the RFP currently provided by HealthWays? This includes Marketing/member materials, fulfillment, splash page management, Disease Management, Lifestyle Management, Wellness Portal, Claims analysis, Risk stratification, call center, incentive administration, labs and biometric testing, the organizing and planning of all logistics for labs and biometric testing, member services that handle benefits questions including making referrals, providing information, sharing data files, vendor information, TPA, EAP/BHO, and PBM inquiries? Can the state identify exactly what services are being performed by the incumbent today, what services are being outsourced (if any), and what services will be new services that have not been offered in the past?	Yes. Healthways is providing all services listed in your question either as the primary contractor or through a subcontracted third party. The biometric screenings and physician screening forms are provided through a subcontractor. The splash page is a new requirement and the weight management program is a new program and has not previously been provided by any vendor.
7. Did your current screening vendor meet all of the PGs outlined in the contract? If not, which ones were missed?	The state is unsure how to respond to this question. There were no PGs specific to the screening vendor included in the current wellness contract.
8. How many support staff members are currently dedicated to the state? What are their respective roles and job titles? Can the state provide us with an approximation of monthly hours dedicated for the account team to successfully manage the state wellness program as a whole?	Under the current contract, we have a dedicated account rep, dedicated reporting/finance representative and communications representative. Since they are employed by Healthways, we cannot confirm their job titles/roles nor can the State approximate the amount of hours. They are full time on our account.
9. How would you like us to identify any deviations to the pro forma contract provided? For areas we deliver our solution differently than outline in the contract, we'd like to call those out clearly. Should we provide any redlines within the document directly when we respond to the RFP?	Those should have been included in the RFP Questions and Comments period of the RFP. After the awarding of the contract and if in the best interest of the State, the State will consider limited and narrow in scope modifications to scope of services (contract section A). Please see RFP Section 5.3.5
10. Can you confirm the budget for the existing program and next years program so we can best recommend solutions that fit within the States financial budget for programming?	For calendar year 2016, the State Plan spent approximately $12 million for all wellness activities associated with the State and Higher Education employees and their eligible dependents. For January – March of 2017, the State Plan has spent

	approximately $1.9 million for wellness activities for this same population. The budget for calendar year 2018 has not been finalized and is dependent on several factors including the programmatic costs bid by the winning contractor, member participation rates and budgeted incentive amounts. The state does not guarantee a minimum budget amount and the contractor will only be paid for goods or services provided, as requested by the state, under the contract. All programs are subject to annual appropriations and may change. Also, given the substantive changes in the program design from the current year, the prior budget may not provide an accurate comparison
11. Is the State ok with us presenting two pricing options for call center management, one based on a dedicated team and one based on a designated team?	No. The State has modified the language regarding dedicated versus designated call center management. Call center costs should be included in the general fee listed in the cost proposal and Section C.3 of the Pro Forma Contract. See Amendment Section #3 below.
12. Is a Word version of the RFP available?	Yes. See Amendment Section #33 below.
13. What is the immediate or near term strategy with the newly selected vendor for your population health, wellness, and weight management program?	To provide a comprehensive wellness program that is evidence-based, simple to understand and interact with and provides multiple modalities so that members may choose how to interact with the program.
14. What is the long term strategy/goals with the newly selected vendor for your population health, wellness, and weight management program?	Our long term aim is to reduce the prevalence of poor lifestyle behaviors and help those who have been diagnosed with a chronic condition to properly manage their condition.
15. What have been the pain points or challenges experienced with your current vendors' support of your program?	Due to the program design it is administratively complex for our vendor to administer and for our members to understand.
16. What are your current participation (interactive engagement as defined in the current RFP) statistics for the following? a. Telephonic b. Online/Digital Coaching c. Onsite	Participation rates have been extremely high due to the benefit design which will change for 2018. a. At the end of 2016, about 41% of those members enrolled in the Partnership PPO were participating in lifestyle management coaching and 21% were enrolled in disease management. b. We do not currently offer online/digital coaching. c. We have averaged about 15 hours of onsite coaching per month.

17. Do you or will you require a minimum number of interactive sessions to qualify for the Disease Management or Health Coaching credit? Will it be less for moderate verse high risk? If so, can you please share those requirements and or initial thoughts on what you are likely seeking from the selected vendor?	Yes, the State will require a minimum number. The State has a placeholder in the incentive design to collaborate with the winning vendor on that threshold. There is an expectation that a high risk individual would need more interaction than a moderate risk.
18. On page 12, 3.2.2.2, the State requests the Cost Proposal in the form of a digital document in "XLS" format. Can the State provide the Cost Proposal included in the full RFP as a separate XLS?	Yes. See Amendment Section #33 below.
19. Per page 16 4.4.1, how do we get prior approval for a third party that we are using for a portion of these services? Is prior approval needed for a WMBE that will be part of our proposal per the terms in section B.15, page 29?	All subcontractors or third party businesses performing work on the contract should be listed in the proposal. Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.
20. On page 21, 5.2.1.5.4, does this mean the presentation will be recorded or that finalists must provide leave-behind materials of the presentation?	Respondents are able to bring leave-behind material as part of the oral presentation. We will have a recording of the presentation for procurement file purposes.
21. Who manages the "splash page" today? Does HealthWays manage the splash page and do they remotely host it as well?	Currently, we do not have a splash page for the wellness program. Members are directed to the ParTNers for Health website for more information. On this website homepage members can find links to the login for the Well-Being Assessment and Physician Screening Form (PSF). The vendor selected would create, manage and host a new splash page with links to whatever program specific information members would need to access, including other vendor partners website links.
22. Regarding the splash page on page 84 section G, are we being asked to set up a splash page and host it as well?	Yes, the vendor selected would create, manage and host a new splash page.
23. What is the expectation around transferring the splash page domain to a new vendor per section I) on page 84?	As we currently do not have a wellness program splash page for our members and do not have a site to transfer to the new vendor. Per Contract Section A.14. j, when this contract ends the contractor (new vendor) will transfer ownership of the domain name(s) templates, and content to the State upon termination without delay and at no cost to the State.
24. What is the expected turnaround time for	

Physician forms to be processed once received by the Contractor?	The State would like to see that information processed and posted on a weekly basis.
25. How many physician forms were processed in 2014, 2015, and 2016? Please list each year separately.	2014 – 89,000 2015 – 88,000 2016 – 88,000
26. How many members participated in state sponsored labs and biometric testing in 2014, 2015, and 2016? Please provide totals organized separately by year	2014 – 26,000 2015 – None. The State did not offer onsite screenings in 2015. Members required to participate in LM and DM coaching had to complete a physician screening form. 2016 – 16,000
27. Please provide historical participation with form submissions.	See response to question #25.
28. What percentage of the population participates in state sponsored labs and biometric screening events? How many members total does this equate to?	See response to question #26.
29. What percentage of the population goes elsewhere for labs and biometric testing? How many members total does this equate to?	The State is unclear what you mean by "goes elsewhere." Members have the option of going to their provider and submitting a physician screening form or attending an onsite screening.
30. How many members chose to get their screenings from their own provider and sent them in via physician form separately?	See response to question #25
31. What is your participation percentage for your partnership PPO population for labs and biometric testing? Please include the numerator and denominator used to derive this percentage. Are these tests performed and tracked annually? Can you please provide data on participation rates from 2014 – 2016?	The numerator is the number of Partnership Promise members who completed a biometric Screening. The denominator is the total number of Partnership Promise members required to complete a biometric screening. Because enrollment is not static, the State is unable to provide the exact denominator used. This information was based on year to date screening completion numbers. 2014 – 113,157 (84%) 2015 – 87,158 (73%) 2016 – 101,717 (80%) Tests were performed for all members every other year. In 2015, those required to participate in LM and DM coaching were required to complete a biometric screening.
32. How many data suppliers does the state use that the successful vendor will need to interface with? Who are these suppliers?	The vendor should be prepared to interface with the following vendors as needed; Vendor names are as of this response date and are subject to change. 2 medical vendors – BCBST, Cigna 1 BHO vendor - Optum

	1 PBM – CVS Caremark 1 decision support vendor – Truven 1 employee clinic vendor - UCHS
33. Do you want a hard-copy health assessment included in the solution? If so, how should price for it in the cost proposal?	No. The State is no longer offering paper health assessments.
34. What is the current utilization of the telephonic health assessment?	There were approximately 350 in 2015 and 2016. Telephonic assessments have not been offered in 2017 due to the EEOC regulations for spousal consent.
35. Should challenges be included in the pricing? If so, how should we price for it in the cost proposal? Please describe the types of challenges you envision (digital, on-site, etc.) and what you are doing today, including the associated volume and locations.	No. The State has modified the RFP cost proposal and Contract Section C.3 to show challenges as a separate cost item. See Amendment Section #5 and 6 below. There are no on-site challenges. All are delivered digitally. Here are the participation totals by year with four challenges per quarter: 2013 – 10, 527 (challenges were offered was part of the wellness requirements) 2014 – 5,060 2015 – 5,304 2016 – 3,569
36. Will you include a section in the cost proposal for additional services that may benefit the State's program? We have some ideas we would like to offer. If a section for additional services is not added, can we include additional lines in the pricing sheet?	No. The State will not include a section in the cost proposal for additional services. You can include additional services but they MUST be at NO ADDITIONAL COST to the State.
37. Does the State have an existing 24/7 Nurse Line vendor, or will these services be unavailable?	Yes, but we are eliminating the service effective with this new contract.
38. Will you be including a 24-hour nurse line in this procurement? If not, who will be providing this service going forward? If so, how should we price for it in the cost proposal?	See response to question #37.
39. How does the Primary Population Health and Wellness vendor interact with the Nurse Line vendor?	See response to question #37.
40. Please describe your on-site wellness programs, beyond what is being delivered at the on-site clinic, to include locations	The on-site clinic is the only place where face to face coaching is offered. The Regional Wellness

throughout the state. What services are being delivered by an on-site specialist, at how many locations, and at what frequency of interaction? What on-site wellness programs are currently being offered by Healthways versus what is provided by State employees?	Coordinators employed by the State also work with the executive branch departments to coordinate on-site activities. Healthways delivers quarterly Lunch N Learn programs at the Health Center. Our regional wellness coordinators will also assist with delivery of onsite Lunch N Learns and educational activities, as requested.
41. How many on-site staff members does the incumbent currently provide the state? What are their roles, hours, titles, job descriptions and credentials?	There are no on-site staff members beyond the coach and clinician who work ad hoc in the Health Center delivering face to face lifestyle and disease management coaching. They are employees of Healthways and meet the education criteria outlined in our current contract. We do not have details about hours, titles or job descriptions.
42. Please provide additional information on your Diabetes Prevention program including utilization statistics and results.	We piloted the DPP in 2015 with approximately 225 participants. There was strong attendance in the core classes and an average weight loss percentage around the 5% target. We are currently offering limited classes in the Health Center. We have a total of four classes that have been held in the Health Center. Two that have been completed, one that is now in the post phase and another that just started. The attendance for these classes has averaged around 98% with a 3% average weight loss.
43. Throughout the document, there are several references to a Diabetes Prevention Program. Does the State have an existing vendor for this service? If so, what is the volume of members referred to this program?	No. There is no existing vendor for the program. The DPP will be a covered service payable through the medical plan starting in 2018.
44. The State indicates there are 278,000 members, but in the grid there are 187,986 members. Could the State please explain the difference?	Dependent children account for the difference in the numbers. Children under the age of 18 are not eligible for the wellness program or any wellness incentives.
45. RFP PAGE 3 - 1.1 - The State mentions they are managing benefits for 278K members, but only gives a breakdown of the population for 188K members. Can the State clarify if the difference is driven by dependent children that would be ineligible for the program?	See response to question #44.
46. Can members in the standard and Limited PPOs commit to the Partnership Promise if they want to?	There is no partnership promise going forward. Regardless of the health plan chosen, any enrolled state employee or their spouse may participate in the wellness program. Only active state employees are

eligible for incentives. Members from Local Government, Local Education and retirees may participate in DM only and are not eligible for incentives.

47. What is the total enrollment by plan (Partnership PPO, Standard PPO, Limited PPO, etc.) for each of the populations?

May 2017	Partnership	Standard	CDHP	Limited
State Retiree	7,797	4,174	24	0
Local Ed Retiree	4,249	1,570	38	265
Local Govt Retiree	171	79	208	320
State Active	93,516	29,892	10,015	0
Local Ed Active	61,693	19,033	3,453	19,550
Local Govt Active	7,804	4,535	1,142	9,398
Total	175,230	59,283	14,880	29,533

48.

Enrollment as of December 2016			
	Total	**Heads of Contract**	**Spouse**
State Retiree	**12,193**	8,693	3,500
State Active	84,380	58,702	25,678
Local Ed Retiree	**6,287**	4,915	1,372
Local Ed Active	68,440	50,951	17,489
Local Govt Retiree	**284**	211	73
Local Govt Active	16,402	13,914	2,488
Total	**187,986**	**137,386**	**50,600**

Regarding the enrollment table above, for State and Higher Education, can you confirm that the total Heads of Contract is reflected as 96,573? Are all retirees reflected in this table pre-65?

Heads of contract for state and higher education in this table total 67,395 (8,693+58,702). When you add 29,178 state and higher education spouses (3,500+25,678), who are also eligible to participate in the wellness program, there are a total of 96,573 state plan members (HOC & spouse) eligible for the wellness program.

The vast majority of retirees are pre-65, however, there are some that may be eligible to stay on the plan even when Medicare eligible, but these are few.

49. Can the State provide the existing volume of total annual calls for each program (member services, disease management, and lifestyle management) broken out by inbound and outbound?	Here are the volume of total annual calls for member services, disease management and lifestyle management provided by Healthways. They are broken out by inbound and outbound. Member Services – 99,024 (all inbound) Disease Management – 35,276 inbound and 41,413 outbound Lifestyle Management – 112,352 inbound and 121,716 outbound
50. Does the pricing spreadsheet need to be filled out exactly as its asked on page 56? Since implementation is a one-time up-front fee and will not be included in the PEPM cost, can we add that in a simple line item? Are there other line items that we can add or do you want every service in the scope (outlined on page 67) included in the general PEPM fee?	Yes, the cost proposal is to be filled out exactly as it is listed in the RFP and in the excel document provided. No, you cannot add additional lines. Every service without its own line item should be included in the general PEPM fee. If there is an implementation fee it should be added to the PEPM.
51. Weight Management Scope pricing: • Our standard weight management pricing model is a pay-for-results pricing model that outside of an initial enrollment fee per participant charges only when someone has both attended a session and is on track for weight loss. While we can accommodate the pricing as set in the contract language, would the State be willing to consider our standard model, which would put the State ahead financially? • Our weight management program is a 52-week long program. For the pricing model that the State suggests, would 26 sessions need to be attended for the second 1/3 payment?	No. The State does not agree to make a change to the proposed pricing model. Yes. You are correct. Twenty-six sessions would need to be attended for the second 1/3 payment.
52. Would the State consider payment through claims for the Weight Management program?	Payment as a claim is something the state may consider should the vendor demonstrate they are an in-network provider with the medical carriers. However, until that occurs, we will pay for the program as described in the RFP.
53. Out of the 145,000 total members on page	

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<td>57, how many members are on the partnership PPO plan vs. the more expensive plan?</td>
<td>The state employee enrollment in each plan option is listed below. Reminder: Any enrolled active state employee, regardless of their plan option, will be eligible to participate in and receive incentives from the wellness program. Retirees will be eligible for disease management but not eligible to receive wellness incentives.
<table>
<tr><th>May 2017</th><th>Partnership</th><th>Standard</th><th>CDHP</th><th>Total</th></tr>
<tr><td>State Retiree</td><td>7,797</td><td>4,174</td><td>24</td><td>11,995</td></tr>
<tr><td>State Active</td><td>93,516</td><td>29,892</td><td>10,015</td><td>133,423</td></tr>
<tr><td>Total</td><td>101,313</td><td>34,066</td><td>10,039</td><td>145,418</td></tr>
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<td>54. On page 5 of the RFP, the state mentions that 59% of the total membership falls on the partnership PPO plan. Please confirm that this is this 59% of 145,000? Please confirm the partnership PPO eligibility.</td>
<td>The 59% partnership enrollment was calculated using the total population of 278,000. Partnership enrollment in the state plan is currently 69%. See numbers in response question #53.</td>
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<td>55. Section A – Mandatory Requirements - The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.” – Can you please explain further?</td>
<td>The technical response cannot restrict the State to any additional terms or conditions other than what is listed in the RFP and Pro Forma Contract except for modifications made through RFP amendments</td>
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<td>56. Please provide member services statistics to include overall utilization, utilization by type of service, number of appeals handled each year, call volume by month, top five caller needs, number of Health Assessments completed by phone, number of calls on a Saturday, and when Saturday services are needed most and for how long.</td>
<td>We are providing the information requested for the most recent completed program year. However, we caution proposers to remember that the plan design and program requirements are changing substantively and vendors should not assume the same level of utilization.

Utilization by type of service (2016)
LM Coaching (active participants)
January – 47,008
February – 48,793
March – 50,296
April – 53,670
May – 56,195
June – 52,279
July – 50,801
August - 51,721
September -48,997
October – 47,073
November – 41,279
December – 28,694
DM Coaching (active participant)</td>
</tr>
</table>

	January – 11,623 February – 11,747 March – 12,364 April – 12,577 May – 12,682 June – 12,591 July – 12,991 August – 13,102 September – 13,521 October – 12,639 November – 11,945 December – 11,805 • Number of appeals handled each year – see response to question #198 • Call volume by month (2016) January – 7,244 February – 11,996 March – 20,435 April – 7,457 May – 10,305 June – 10,305 July – 10,935 August – 10,221 September – 5,524 October – 5,651 November – 2,560 December – 2,410 • Top five caller needs – the State does not track this information. Generally, member needs are driven by the approaching wellness requirement deadlines. • Number of Health Assessments completed by phone –see response to question #34 • Number of calls on a Saturday – no inbound Saturday calls. • When Saturday services are needed most and for how long – currently the coaches and clinicians do outbound calls on a Saturday. There are no inbounds calls.
57. Can we use a designated member service team as long as it is staffed for proper coverage?	See response to question #11.
58. Page 5 "Local Education and Local Government Plan agencies shall have the ability to enter into a separate contract with	This requirement has been removed.

the Contractor for population health management services utilizing the payment rates outlined within this contract". • Would the State accept size limitations on the Local Education and Local Government Plan agencies that would be able to enter into a contract at the same rates? • Would the State accept a requirement that Local Education and Local Government Plan agencies must provide a minimum incentive to be able to enter into a contract at the same rates? • Would the State accept a qualification that Local Education and Local Government Plan agencies would not be eligible for the same Performance Guarantees and Liquidated Damages as under this contract?	See Amendment Section #7 and 8 below.
59. Page 5 states that the PPO Promise "is an annual commitment and generally includes completing a health questionnaire, participating in disease management coaching if identified and, if coaching, completing a biometric health screening." How does the State define "identified" for Disease Management for incentive programs? Is it identification through the vendor's stratification process, or is a member considered identified if they answer they have a condition on the health assessment?	A member is identified through the vendor's stratification process which should include medical and pharmacy claims that indicate a diagnosis of the chronic condition.
60. Section A – Mandatory Requirement A.8 May the proposer rely on a subcontractor to fulfill NCQA or similar accreditation requirements?	No. The State has updated the contract language in A.18.n. See Amendment Section #9 below.
61. Section B - Provide customer references from individuals who are not current or former State employees for projects similar to the goods or services sought under this RFP and which represent: two (2) accounts Respondent currently services that are similar in size to the State; and three (3) completed projects."	Yes, a completed project reference can be a current reference as well. Completed project would be the completion of a program or end of project deadline. It would not include completion of implementation of a program. The State is looking for client references and their thoughts on the entire project from beginning to end.

Can a completed reference also be one of the current references? What is the definition of a "completed project"? Is that a customer that has completed implementation or completed a full year in the program?	
62. On page 41, item C.10.c, iii. Member inquiry capabilities and iv. Employer inquiry capabilities, can you please clarify/provide an example of what is required?	Member inquiries would include things such as the ability to search on the wellness activities they have completed, the points/dollars they have earned to date, and options available to them to gain the full wellness incentive. Employer inquiry capabilities refer to the reporting available directly to the employer from the website. Examples include searches that report on the number of people who have completed a certain activity or the amount of rewards that will be paid to members based on completed activities.
63. Page 41, C.10.h "Provide source information for your web resources." Please define source information.	The origin of resource information.
64. C.11 How do you define Member Services for the Population Health scope of work? What types of calls do the member service staff get now?	A team to answer questions about the program, incentives, appeals, available resources and to warm transfer to coaches/clinicians.
65. Page 42 C.13 c) Does the state also require fulfillment for the marketing material by the Contractor? Who is providing marketing fulfillment services for the state today? What is the per member cost (or any other cost) associated with providing marketing fulfillment today?	Yes, as outlined in the contract on page, 82, A.13, section k, "Unless otherwise specified in this Contract, the Contractor shall be responsible for all costs related to the design, development, printing, distribution, mailing (if applicable), and revision of all Member materials that are required to be produced under the terms of this Contract. Per A.13.l, "If the State requires mailings above those identified in the contract, the State shall pay the postage, printing and production costs of such mailings pursuant to Contract Sections C.3 Either Healthways or a subcontractor provides marketing fulfillment services currently. The costs are part of our current general fee so we are unable to provide a PM cost. Proposers should estimate the costs of design, development, printing, distribution, mailing of all materials as outlined in this contract and include those costs in the General Fee.

66. Does C.12 for Population Health refer to Member Service staff or to all call centers including wellness coaches and Disease Management nurses?	It refers to member service staff. See Amendment Section #10 below.
67. C.9 How do you define Member Services for the Weight Management scope of work? Does this include the weight management coaches?	No. It refers to member services staff. Please see response to question #64.
68. RFP C.9.b. Please confirm that the 'client' is the State.	Yes, the client is the State.
69. Does C.10 for the Weight Management scope apply only to member services, or does it apply to all call centers including weight loss coaches?	C.10. applies only to member services.
70. For your current condition management programs, what and how many remote monitoring tools are being used? What chronic condition programs include management with remote monitoring tools?	We currently do not utilize any remote monitoring tools.
71. Per the outcome measures document included in the RFP, please confirm that the number of people in your population who were identified as having a risk factor associated with Asthma, CAD, CHF, COPD, and Diabetes are accurately depicted as follows: Asthma: 2014 – 5,015 2015 – 4,290 Coronary Artery Disease: 2012 – 6,354 2013 – 5,772 2014 – 5,496 2015 – 5,106 Coronary Heart Failure 2012 – 1,081 2013 – 982 2014 – 963 2015 – 959 COPD 2014 – 2,509 2015 – 2,298 Diabetes 2013 – 24,423 2014 – 25,421 2015 – 25,857	Based on the methodology used (and outlined in the contract) these numbers represented are correct as of the date the data were pulled from our DSS vendor. Note there are multiple variables to this data: • Participation in DM depends on several variables: when diagnosed, risk level, plan group, time period (program vs. calendar year, etc. • Algorithm/risk stratification used by Healthways. • Asthma DM does allow for member graduation • MPR calculation based on unique individual AND unique GPI code (COPD and Asthma)
72. Can the state please confirm the	

engagement percentages and participation numbers for those who were engaged in Disease Management programs on a monthly basis? Additionally can the state confirm the engagement percentages and participation numbers for those who were engaged in Disease Management programs on an annual basis?	We caution potential vendors to not place too much emphasis on previous engagement. Two of the health plans (Local Education & Local Government) will no longer have access to the wellness program and although the program has always been voluntary, members enrolled in the Partnership PPO did not view it as such. Also, members enrolled in the other health plans had access but most opted to not participate in DM coaching. Moving to a cash incentive, we fully anticipate engagement to drop significantly. The State has never offered a cash incentive and has no frame of reference as to how many members will take advantage of the incentives. Healthways provided the following statistics for annual program participation: 2013 – 27,699 2014 – 21,462 2015 – 17,268 2016 - 17,536 Here is the break down by month for all DM program combined for the most recent program year (2016): January – 11,623 February – 11,747 March – 12,364 April – 12,577 May – 12,682 June – 12,591 July – 12,991 August – 13,102 September – 13,251 October – 12,639 November – 11,945 December – 11,805
73. If the outcomes measurement document is accurate, of the 25,857 diabetics that were identified in 2015 what percentage or how many of them were engaged on a monthly basis? How many were engaged on an annual basis?	The data used to provide detail answers required an updated pull from our DSS. The specific answer is provided based on the updated information. This data is based on the full population, not just those required to participate in a lifestyle or disease management program. The numbers below represent a member with diabetes enrollment in any of the disease or lifestyle management programs, broken out by month and an annual aggregate total for 2015.

	2015 January - 9,193 February – 9,174 March – 9,956 April – 10,114 May – 10,629 June – 10,811 July – 10,983 August – 11,088 September – 10,920 October – 10,763 November – 9,901 December- 9,287 2015 Annual Aggregate – 13,800
74. If the outcomes measurement document is accurate, of the 959 members with Coronary Heart Failure that were identified in 2015 what percentage or how many of them were engaged on a monthly basis? How many were engaged on an annual basis?	The data used to provide detail answers required an updated pull from our DSS. The specific answer is provided based on the updated information. This data is based on the full population, not just those required to participate in a lifestyle or disease management program. The numbers below represent a member with CHF enrollment in any of the disease or lifestyle management programs, broken out by month and year for 2015. January – 285 February – 297 March – 317 April – 317 May – 334 June – 339 July – 342 August – 346 September – 336 October – 339 November – 303 December- 265 Annual Aggregate – 445
75. If the outcomes measurement document is accurate, of the 4,290 members with Asthma that were identified in 2015 what	The data used to provide detail answers required an updated pull from our DSS. The specific answer is provided based on the updated information. This data

percentage or how many of them were engaged on a monthly basis? How many were engaged on an annual basis?	is based on the full population, not just those required to participate in a lifestyle or disease management program. The numbers below represent a member with Asthma enrollment in any of the disease or lifestyle management programs, broken out by month and year for 2015. January – 944 February – 950 March – 1,058 April – 1,061 May – 1,120 June – 1,279 July – 1,350 August – 1,379 September – 1,351 October – 1,329 November – 1,225 December- 1,000 Annual Aggregate – 1,779
76. If the outcomes measurement document is accurate, of the 2,298 members with COPD that were identified in 2015 what percentage or how many of them were engaged on a monthly basis? How many were engaged on an annual basis?	The data used to provide detail answers required an updated pull from our DSS. The specific answer is provided based on the updated information. This data is based on the full population, not just those required to participate in a lifestyle or disease management program. The numbers below represent a member with COPD enrollment in any of the disease or lifestyle management programs, broken out by month and year for 2015. January – 549 February – 560 March – 585 April – 577 May – 612 June – 623 July – 628 August – 627 September – 601 October – 581 November – 550

	December- 509 Annual Aggregate – 733
77. If the outcomes measurement document is accurate, of the 5,106 members with Coronary Artery Disease that were identified in 2015 what percentage or how many of them were engaged on a monthly basis? How many were engaged on an annual basis?	The data used to provide detail answers required an updated pull from our DSS. The specific answer is provided based on the updated information. This data is based on the full population, not just those required to participate in a lifestyle or disease management program. The numbers below represent a member with CAD enrollment in any of the disease or lifestyle management programs, broken out by month and year for 2015. January – 1,922 February – 1,938 March – 2,111 April – 2,142 May – 2,248 June – 2,265 July – 2,285 August – 2,284 September – 2,256 October – 2,232 November – 2,101 December- 1,944 Annual Aggregate – 2,830
78. Can the state please confirm the engagement percentages and participation numbers for those who were engaged in Lifestyle Management programs on a monthly basis? Additionally can the state confirm the engagement percentages and participation numbers for those who were engaged in Lifestyle Management programs on an annual basis?	We caution potential vendors to not place too much emphasis on previous engagement. Two of the health plans will no longer have access to the wellness program through the health plan and although the program has always been voluntary, members enrolled in the Partnership PPO did not view it as such. Also, members enrolled in the other health plans had access but most opted to not participate in LM coaching. Moving to a cash incentive, we fully anticipate engagement to drop significantly. The State has never offered a cash incentive and has no frame of reference as to how many members will take advantage of the incentives. Healthways provided the following statistics for annual program participation:

	2013 – 33,577 2014 – 55,575 2015 – 65,205 2016 – 62,387 Here is the break down by month for all LM programs combined for the most recent program year (2016): January – 47,008 February – 48,793 March – 50,296 April – 53,670 May – 56,195 June – 52,279 July – 50,801 August – 51,721 September – 48,997 October – 47,073 November – 41,279 December – 28,694
79. Similar to the disease management metrics provided in the outcomes measurements document, can the state provide similar information about the population who leverages lifestyle management? Specifically, how many members were at risk for tobacco cessation, high cholesterol, hypertension, stress management, sleep, nutrition and exercise in 2014, 2015, and 2016? Of these members how many of them were engaged in Lifestyle counseling on a monthly and annual basis?	The State is able to provide the most recent program year (2016) broken out by each risk outlined in your question. This information was pulled from the Healthways monthly participation report and is stratified based on Healthways algorithm. These are members who presented with each unique risk. Note – the member could present with multiple risks and appear in multiple responses. The information represented below is the number of members who presented with each risk along with enrolled in an LM program in parenthesis. We are unable to crosswalk the risk with monthly engagement. Also note that the sleep program is new for the next contract and we don't have any information on that risk. January: **All Members (Enrolled Members)** Tobacco Cessation – 6,803 (2,075) High Cholesterol – 33,121 (16,184) Hypertension – 793 (369) Stress – 14,793 (5,130) Nutrition – 42,306 (18,520) Exercise – 26,633 (11,294) February:

	Tobacco Cessation – 6,041 (2,225) High Cholesterol – 30,450 (17,603) Hypertension – 1,128 (648) Stress – 14,132 (6,551) Nutrition – 38,955 (20,322) Exercise – 27,592 (14,402) March: Tobacco Cessation – 6,992 (2,804) High Cholesterol – 30,791 (18,972) Hypertension – 2,132 (1,299) Stress – 15,692 (8,222) Nutrition – 46,525 (25,709 Exercise - 32,217 (18,244) April: Tobacco Cessation – 6,835 (3,132) High Cholesterol – 30,140 (19,044) Hypertension – 2,892 (1,898) Stress – 15,306 (8,751) Nutrition – 47,973 (28,399) Exercise – 31,259 (18,855) May: Tobacco Cessation – 6,750 (3,334) High Cholesterol – 31,102 (20,095) Hypertension – 3,836 (2,677) Stress – 14,925 (9,028) Nutrition – 50,490 (31,402) Exercise – 31,518 (19,860) June Tobacco Cessation – 6,401 (3,239) High Cholesterol – 31,436 (20,432) Hypertension – 5,127 (3,682) Stress – 13,931 (8,759) Nutrition – 52,887 (33,930) Exercise – 30,996 (6,964) July Tobacco Cessation -5,613 (2,917) High Cholesterol – 32,700 (21,566) Hypertension – 7,212 (5,324) Stress – 13,019 (8,355) Nutrition – 55,906 (37,216) Exercise – 29,997 (19,640)

	August Tobacco Cessation – 4,084 (1,968) High Cholesterol – 21,403 (14,564) Hypertension – 7,318 (5,315) Stress – 15,256 (8,808) Nutrition – 50,994 (32,998) Exercise – 25,712 (15,643) September Tobacco Cessation – 4,309 (2,044) High Cholesterol – 20,991 (14,526) Hypertension – 6,499 (4,775) Stress - 15,886 (9,187) Nutrition – 48,238 (31,485) Exercise – 25,620 (15,654) October Tobacco Cessation – 4,426 (1,989) High Cholesterol – 21,524 (14,073) Hypertension – 4,955 (3,379) Stress – 15,909 (8,562) Nutrition – 42,487 (25,686) Exercise – 24,786 (14,080) November Tobacco Cessation – 4,210 (1,693) High Cholesterol – 18,678 (11,219) Hypertension – 3,751 (2,331) Stress – 15,141 (7,400) Nutrition – 36,200 (19,520) Exercise – 22,795 (11,513) December Tobacco Cessation – 4,426 (1,989) High Cholesterol – 21,254 (14,073) Hypertension – 4,955 (3,379) Stress – 15,909 (8,562) Nutrition – 42,487 (25,686) Exercise – 24,786 (14,080)
80. Does the state wish to keep the two part-time health coaches who are currently working on-site at the employee health center in Nashville? Or does the state want the new Contractor to provide new staffing? Are the health coaches under a non-compete with their current employer? What is the hourly rate for the two health	The two coaches are employed by our current vendor. The expectation is that the new vendor would provide the staffing. We cannot respond to the non-compete question or the hourly rate. As required by the current contract, all coaches/clinicians are appropriately licensed and have a degree in a related field.

coaches? What are the credentials of the two on-site health coaches?	
81. Who is the state's current weight management vendor?	The State does not currently have this program in place.
82. On the attached contract between HealthWays and the State, what is the eligibility number that was used to determine their pricing and response?	The State cannot speak to the assumptions regarding eligibility used by Healthways to determine their pricing and response. The total population numbers referenced in the 2012 RFP were 277,000. All vendors were also provided the following counts in the 2012 RFP: Currently there are 150,862 members enrolled in the Partnership PPO. 108,404 employees (head of contract – HOC) and 42,458 dependent spouses Given the planned changes in the program for 2018 vendors should carefully consider how this information is used since there is no longer a wellness requirement on the partnership plan.
83. On the original RFP from 2012, what was the membership size that the state wellness RFP was asking a Contractor to manage?	The total population in the 2012 RFP was referenced as 277,000. While all members were eligible for the wellness program only members in the partnership PPO were required to complete wellness activities. At that time there were 150,862 members enrolled in the Partnership PPO (108,404 employees (head of contract – HOC) and 42,458 dependent spouses). Given the planned changes in the program for 2018 vendors should carefully consider how this information is used since there is no longer a wellness requirement on the partnership plan.
84. Will the state accept any other form of pricing for disease management other than a monthly PEPM based on engagement?	No. The State will only accept the cost proposal structure listed in the RFP.
85. If the Contractor can still provide monthly engagement reports on DM and LM and can still honor the percent at risk for clinical outcomes, can the Contractor provide DM and LM pricing in a different format based on a PEPM number for the entire population of 145,000?	No. The State will only accept the cost proposal structure listed in the RFP.
86. How firm is the state on paying the Contractor monthly based on DM and LM engagement reports? Is there any flexibility with this model?	No. The State will only accept the cost proposal structure listed in the RFP.
87. We don't traditionally offer health counseling services to members under the	The State has removed reference to dependent children under the age of 18. Eligible dependent

age of 18. The state mentions that children can participate with a parent's consent. Can the state confirm if children are/are not a part of the program. If they are, can the state provide participation information for minors under the age of 18?	children defined as 18 to 26 may opt-in to any program. See Amendment #5 and 6 below.
88. What is the projected budget for this program?	Please refer to the answer question #10.
89. B.17 requests references from three "completed projects". May the Respondent include contracts that have been fulfilled and have been renewed?	Yes.
90. Please confirm the contract term is five years with two optional one-year renewals.	No. Both the primary population health and weight management contracts are for five years with a five-month implementation.
91. Will you provide the cost proposal in Excel format?	Yes. See Amendment Section #33 below.
92. RFP PAGE 11 - 3.1.2 - Please provide an excel version of the Cost Proposals for RFP ATTACHMENT 6.3.- Table A – Primary Population Health and Wellness Program and Table A – Weight Management Program.	See Amendment Section #33 below.
93. What outreach modality (ex. telephonic or mail) are you expecting for moderate-risk Disease Management?	Telephonic or some other modality such as text, email or video chat is acceptable if the Contractor can document that interactive contact. Mailing materials is not considered interactive and is not acceptable.
94. Who currently operates the on-site clinic? How long has that relationship been in place?	University Community Health Services, Inc. (UCHS) is the current Contractor. The contract began May 1, 2014 and will end December 31, 2018.
95. Page 12 Please clarify the number of copies and labeling required. What should be included in the "RFP #31786-00135 TECHNICAL RESPONSE ORIGINAL" versus the "RFP #31786-00135 TECHNICAL RESPONSE COPY – PRIMARY POPULATION HEATH AND WELLNESS PROGRAMS" and "RFP #31786-00135 TECHNICAL RESPONSE COPY – WEIGHT MANAGEMENT PROGRAM"? Do you want one original Technical Response of each Population Health and Weight Management scopes plus seven digital copies of each?	Yes, the State wants an original technical response for both the Primary Population Health and Wellness Program and the Weight Management Program. If bidding on both programs, you would submit one original Primary Population Health and Wellness Program technical response; seven digital Primary Population Health and Wellness Program response copies; one original Weight Management Program technical response; and seven digital Weight Management Program response copies. The State has clarified the language in the RFP. See Amendment Section #11 below.
96. B.15.b Should we list all current diversity contracts or just those within the State of Tennessee?	Only list a few contracts. They do not have to be within the State of Tennessee.
97. B.15.c Do the diversity vendors for the	No.

<table>
<tr><td>estimated participation need to be located in the State of Tennessee?</td><td></td></tr>
<tr><td>98. Please confirm that the benefit level will be included on the eligibility file.</td><td>The State is unsure what you mean by benefit level. The file will include the plan each member is enrolled in, the coverage level, and all enrolled dependents.</td></tr>
<tr><td>99. Please confirm that the 24-hour eligibility load requirement is within 24 hours of a business day not a calendar day.</td><td>Business days.</td></tr>
<tr><td>100. Are home mailings, in particular the welcome mailing, required to be sent via first class postage?</td><td>As outlined in contract section A.18.k. Unless otherwise directed by the State, the Contractor should send all correspondences first class mail (as required and/or appropriate) with no “Return Service Requested.”</td></tr>
<tr><td>101. Is the State open to modifications to the ParTNers for Health brand to enhance the communications and engagement strategy?</td><td>The ParTNers for Health brand encompasses all of our benefits products and that will not change, but we will consider tag lines and enhancements or perhaps even co-branding specific to the Population Health and Weight Management program. One recent example is Here4TN, which is the name of the Employee Assistance Program.</td></tr>
<tr><td>102. On page 56, do the numbers in the Evaluation Factor column equate to a number of members expected to be engaged in the program?</td><td>No.</td></tr>
<tr><td>103. RFP PAGE 56 - Is the evaluation factor shown in the cost proposal the expected participation the state is expecting?</td><td>No.</td></tr>
<tr><td>104. RFP PAGE 55 - Can the State send us the number of interactively, as defined in the current RFP, engaged participants (preferably by program) that they were able to achieve for the past two years?</td><td>The definition of ‘engaged participants’ in this current RFP is not the same as our current contract.

Please see response to question #56. We were able to provide by program month, those who were active participants for 2016.</td></tr>
<tr><td>105. What’s the utilization of on-site coaching and on-site Disease Management coaching? Please provide per week utilization and per month utilization. How many FTEs do you have of each? Is the State open to a full-time staff person charged at an annual rate (assuming this is a lower cost option)?</td><td>We can provide that information per month, not weekly. The utilization is presented as number of hours each month:
<table>
<tr><td>2013 LM onsite coaching hours (No DM)</td><td>2014 LM onsite coaching hours (No DM)</td></tr>
<tr><td>April – 14.5
May – 7</td><td>Jan – 6
Feb – 6</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>June – 9 July – 7.5 Aug – 7 Sept – 4 Oct – 6 Nov – 8.5 Dec - 4</td><td>March –6 Apr – 6 May – 6.5 June – 14 Jul – 11 Aug – 5.5 Sept – 8 Oct – 2 Nov – 9 Dec – 6.5</td></tr></table> <table><tr><th>2015 LM onsite coaching hours (No DM until Sept)</th><th>2016 onsite coaching hours LM and DM</th></tr><tr><td>Jan – 13.5 Feb – 6.5 Mar – 16.5 Apr – 7 May – 12.5 June – 13 Jul – 9.5 Aug – 9.5 Sept – 12.5 (DM – 2) Oct – 8 (DM – 1) Nov – 8 (DM – 1) Dec – 10.5 (DM – 1)</td><td>Jan – 10.5 (DM – 1.5) Feb – 10 (DM – 2.5) Mar – 11.75 (DM – 7) Apr – 13 (DM – 2) May – 14 (DM – 7.5) June – 9.5 (DM – 4.5) Jul – 10.5 (DM – 2) Aug – 10.5 (DM – 1) Sept – 9 (DM – 3) Oct – 9 (DM – 3) Nov – 7 (DM – 9) Dec – 9.5 (DM – 3.5)</td></tr></table> <table><tr><th>2017 onsite coaching hours LM and DM</th></tr><tr><td>Jan – 8 (DM – 4) Feb – 6.5 (DM – 1 Mar – 14.5 (DM – 5.5)</td></tr></table> There are no FTEs for either LM or DM coaching. The State would be open to a FTE provided that the individual had a full case load.
106. Page 36, C6d – What tobacco cessation program does the State have today? What's the State's prevalence of tobacco use? What quit rate has your vendor achieved?	QuitNet is our current tobacco cessation program. The aggregate prevalence is about 6% according to self-reported responses by members on the health assessment. We feel this is under-reported since the plan required participation in a tobacco cessation program if you use tobacco. We do not have quit numbers to share.

107. Page 39, C6e – What delivery methods does your current coaching vendor provide today?	Members currently have telephonic coaching for LM and DM. That is the only option other than those state employees in the downtown Nashville area have access to face to face coaching in our Health Center.
108. Page 40, C6g – What local resources does that State and/or your wellness vendor work with today that the successful vendor will need to integrate with going forward?	There are no specific local resources that are used.
109. Page 43 – Please describe your current wellness champion network structure. How many champions are currently in place? What activities are champions implementing today?	We have 27 Executive Department Wellness Councils that vary in size due to their department size. Wellness Councils serve an employee population that ranges from under 100 to over 1000. All of these champions volunteer to serve in this capacity. There are three regional wellness coordinators employed by Benefits Administration that are assigned to these wellness councils to provide guidance and resources for programming/activities in three focus areas; Physical Activity, Healthy Eating and Tobacco Cessation. Some of the activities includes: group walks, Lunch And Learns, challenges (which can include challenges with other departments in healthy eating or physical activity) , capturing success stories.
110. C14 – Please describe the current culture of health at the State.	Since the start of Working for a Healthier TN, a culture of health has emerged over time - one that supports healthy choices with that choice becoming the default. Employees are able to take Wellness Rest Breaks (with written supervisor approval) that allows for healthy activity during working hours. They also have access to more healthy vending options and almost every day there are wellness challenges (between departments or between employees), walking meetings or scheduled walks with department leadership. Department Commissioners can often be seen leading the charge.
111. C16 – What other vendors will the contractor need to integrate with for total member management?	See response to question # 32.
112. C17 – what's the current coach to member ratio? What's the current Disease Management nurse to member ratio or caseload?	As provided by Healthways, the current "Member to Coach" ratio for both DM and LM is: Disease Management --- 318:1 Lifestyle Management --- 229:1

113. Page 69, A3b – What is the incentive for biometric screening completion today? What is the anticipated incentive for biometric screening completion in 2018?	Completion of the biometric screening today is a requirement to remain in the Partnership PPO which offers lower premiums and cost sharing for members, or the Promise HealthSavings CDHP which offers HSA dollars for agreeing to wellness activities. Beginning in 2018 members will receive a cash incentive in their paycheck for completing the biometric screening. The exact amount of the incentive will be determined by the Insurance Committee at the same time that the wellness contract is awarded.
114. Page 69 – What customizations does the State request for the physician screening form? Please provide the current form. Did you customize the current form? If so, how? If not, what customizations would you make to the current form if you could?	The State would need to review the Contractor's form before requesting customizations. See Amendment Section #33 below for the current sample form. Yes, the form was customized. The State used the Contractor's standard form and it was modified by our legal counsel as well as our Privacy and Security Officer. The current form was customized in the consent section.
115. Page 136, #14 – Please describe the Biometric Exit Survey. How is it different than the client satisfaction survey and the participant satisfaction survey?	The biometric screening survey is specific to a member's experience at the onsite screening. The survey asks questions that are specific to the workplace biometric screening experience, including questions about the screening site set up and experience with the screening staff. The client satisfaction survey is specific to the interactions between the Benefits Administration team's and the Contractor's account team. The survey should solicit feedback about the overall account team on this contract as well as specific areas of the Contractor's account team like finance/reporting, marketing/communications, etc. The participant satisfaction survey is a survey about all aspects of the program/services offered by the Contractor and does include some questions about the worksite/physician screening form experience for the member. Since the participant satisfaction survey is an annual survey, the monthly biometric screening survey will provide more real time feedback to address any issues that might arise. See Appendix 7.10 for a sample of the biometric

	Screening Survey.
116. Please outline the acceptable hardships that members can cite to obtain an at-home screening kit.	The reasons that a home kit have been requested and approved have been as follows: religious reasons and needle phobia. We only have about 4-5 home kits per year.
117. For the quarterly summary report for biometrics, what are the plan types or plan codes you would like to have the data summarized by?	The State will work with the vendor during implementation to finalize the report layout. In general, we are looking to include the plan code (which health plan the member is enrolled in and the region (east, middle or west)
118. Is the State interested in a tobacco cessation program that includes nicotine replacement therapy? Does the current vendor provide nicotine replacement therapy today?	The current vendor does not provide nicotine replacement therapy. The state health plan provides free nicotine replacement therapy as part of the health benefit and expects the Contractor to provide members with information about how to access those free resources.
119. At the bidders conference, it was indicated the response should be written at a sixth-grade reading level. Would the State prefer offerors to use Flesch-Kincaid, the measurement tool indicated to be used for members?	If you are asking if the proposer's response to the RFP must be written at a sixth-grade reading level, the answer is no. There is no reading level requirement for RFP responses. However, there is a reading level requirement outlined in the contract for member materials. A. 13. s. references the Flesch-Kincaid Index since it is the most common example of reading ease metrics, however the state would consider approving other suitable and similar programs The State would have to approve any other metrics measuring program in advance.
120. Please identify who the State is using as a consultant in review/recommendations for this RFP?	The State is not using a consultant in the review/recommendations of this RFP.
121. 1.1 Statement of Procurement Purpose - Has the State included dependent children in any of its health and wellness efforts previously? What was the experience?	Dependent children between the ages of 18 and 26 could opt in, but they were never required to participate. We have no specific information on the uptake.
122. 1.1 Statement of Procurement Purpose Given that the overwhelming percentage of unhealthy lifestyles begin in childhood (obesity, caries, tobacco abuse), would the State consider optional pilot program for dependent minors?	No. Not at this time.

123. 1.1 Statement of Procurement Purpose The State indicates there are 278,000 members, but in the grid there are 187,986 members. Could the State please explain the difference?	Dependent children account for the difference in the numbers. Children under age 18 are not eligible for the wellness program. No dependent children are eligible for any wellness incentives.
124. Section 1.1 – Statement of Procurement Purpose, our understanding is that the Local Education and Local Government agencies will have access to Disease Management services only (no portal access). Please confirm identification and outreach for eligibility and enrollment in disease management is done through an ongoing claims feed and analysis by the selected vendor? Who will send the claims feed to the vendor and at what frequency? Requested Services: Given the local education and local government agencies will contract directly for portal services, does this also mean each entity wishing to contract directly will have their own eligibility file data feeds, unique rewards design, branding and wholly separate contract?	Your understanding is accurate. DM eligibility identification and outreach for enrollment will be the responsibility of the vendor utilizing claims and biometric data. All participation is voluntary. State employees are eligible for a wellness incentive for DM participation but Local Education and Local Government members are not. Claims feeds will be sent by the medical and BHO vendors on a monthly basis. The PBM will send the files on a weekly basis. This is no longer applicable as the State has removed the requirement to extend pricing to Local Education and Local Government. See Amendment Section #7 and #8 below.
125. How will the Local Education and Local Government plan agencies be made aware of the opportunity to enter into TPH services by a separate contract at the rates in the Cost Proposal?	This is no longer applicable as the State has removed the requirement. See Amendment Section #7 and #8 below.
126. Would these local entities have access to the same portal configuration as the state government employees, or would a separate configuration/branding be required?	This is no longer applicable as the State has removed the requirement to extend pricing to Local Education and Local Government. See Amendment Section #7 and #8 below.
127. Page 11, 3.1.1.2 states that text must be in 12 pt. font. Does this requirement include headings, graphics labels, footnotes, page numbers, etc.?	This requirement pertains to the 75-page written response and does not include maps, graphs, charts, communications material examples as noted and included as an appendix. The font size does not pertain to headings, graphics, labels, footnotes, or page numbers.
128. If we include an Executive Summary and	An Executive Summary is not a requirement of the

are responding to both scopes, do we need to include it twice? If it is only included once, which scope's page limit does it count against?	technical response and therefore you can add it to one, both, or none. The State does not have a preference. If the respondent wishes to include it, it does count towards the 75 page limit.
129. Regarding the 75 page limit, the pre-bid call included discussion that questions didn't count toward the total page count. Is there a recommendation for the final layout? Typically we include the question immediately followed by a response. Or was this statement referring to the scoring matrix, which would be inserted before the actual questions and responses?	The RFP lists a column for the Respondent to include a page number which is associated with the question. If the Respondent includes the Technical Response and Evaluation Guide at the beginning of the section response (Section A, B, C), it would not count towards the page limit. If the Respondent includes the question with the answer/response, there is not a way to separate it out from the page limit and therefore it would be included in the page limit.
130. Are there specific services that will be going live on 1/1/18 (p. 102-103) versus the 3/1/18 (p. 174-175) dates that were provided in the SOW/Contract?	All primary population health programs and services will go live effective 1/1/18. We are staggering the go live of the weight management program to start 3/1/18.
131. While the State provided a location list for screenings, does the State have any historic screening participation by event or location that can be provided? Or a total number of events offered?	The historic screening participation included the Local Education and Local Government plans. Since those plans will no longer have access to the onsite screenings, the location list provided in the appendices was a historic list of all state health plan sites, minus the local education and local government sites.
132. If we are proposing both programs—population health and wellness and weight management—should both original paper proposals be included in the same binder labeled: "RFP #31786-00135 TECHNICAL RESPONSE ORIGINAL" (We understand we must submit 7 separate digital copies for each program proposal, each under 75 pages, not including appendices.)	If you are bidding on both programs, please separate them out into separate binders.
Do the Evaluation Guide table of contents pages get counted toward the 75 page maximum?	See the response to question #129 above.
Can pricing for both programs be included together in the original Cost Proposal paper document and digital copy?	Separate the cost proposals into two paper documents and digital copies.
133. Will the participant need to select their incentive choice with in the portal? Per the RFP it appears the two options are cash or HSA dollars? Or is this based on the health	For 2018, we are only allowing the incentive to be included in the paycheck. In the future, we may provide those enrolled in an HSA the choice to receive

plan the participant chooses?	cash in their paycheck or funds in their HSA account. Members will not need to choose this option in the vendor portal. Instead, the vendor may need to send different incentive files depending on the member's chosen health plan.
134. With respect to your planned member incentives, can you assist with the following questions to help us better understand the program: Will the incentive be broken up in parts; say a partial payout upon completion of gateway activities, and then if high risk diabetes; they would have too interactively participate a number of sessions in order to obtain the remainder? Or will the incentive be structured where you have to complete the gateway activities, then if identified; you must be interactive per the agreed upon schedule between the state and vendor in order to obtain your full incentive. b. If that interactive , participation, agreed between the vendor and state, is only once a quarter, how will the vendor get reimbursed for the remaining two months given the vendor payment schedule indicates only monthly interactive participation payment or per participant per month pricing?	a. All members will have to complete the gateway activities first. Using the gateway results, members not identified for additional activities will earn the full incentive at that time. Those identified for additional wellness activities will then have to participate in the agreed upon number of sessions/activities to obtain the remainder of the full incentive. b. The vendor is only paid during the month in which the interactive contact occurs. In your example, the vendor would be paid once during the quarter.
135. To what extent will the State be open to recommendations on an incentive design to support your wellness goals?	After the first year, the State will be open to recommendations.
136. Can you confirm the components and design of the current incentive design in place today? Is it the same for all participants?	Completion of wellness activities is a requirement to remain in the Partnership PPO which offers lower premiums and cost sharing for members. Members in the Promise HealthSavings CDHP receive $500/$1000 HSA dollars for agreeing to wellness activities. Members in other plans (Standard, Limited, Non-Wellness CDHP) may participate in wellness activities but receive no incentive.
137. Can you provide the number of claims providers we will need to take in for DM?	Currently the State has two medical carriers, Blue Cross Blue Shield of Tennessee and Cigna, CVS

Per the TN website it appears as 5 health plans and 1 PBM. Please confirm.	Caremark as our PBM, and Optum for Behavioral Health.
138. For extracts, DM and claims purposes, who is the State DSS partner - Truven? Will the DM claims file come from DSS? Or indicators of conditions for DM outreach or will we take claims separately from each carrier?	Yes, the current DSS vendor is Truven. DM claims will come from the two medical carriers, BCBST and Cigna, CVS Caremark, and Optum.
139. Is the DSS currently providing the outcomes data on admission rates/costs and drug adherence rates (page 5-6) or is your current partner, Healthways?	No. The State's epidemiologist and Healthways each run the data and confirm agreement on the outcomes. The same process will be used to validate the outcome measures in this contract.
140. How many unique participants were in DM in 2016?	17,536
141. How many unique participants were in lifestyle coaching in 2016?	62,387
142. RFP Section D Do we need to respond to the Oral Presentation Items section? This appears to be an agenda for the Oral Presentation If yes, can you explain how you'd like us to respond?	You do not need to respond in the technical response. The State will determine the top five respondents based on technical response scoring and invite those respondents to oral presentations. The questions and information in Section D are what we are looking for during the oral presentations.
143. RFP Appendix 7.1 Will state provide office space for 3-5 health coaches that may be centered at high volume locations?	No, the State declines to make this accommodation.
144. We offer Condition Management services that address each of the conditions outlined in the RFP. It is not formal Disease Management as it does not integrate with the participants physician. Is this acceptable for the purpose of your program as most companies do not offer formal Disease Management unless outsourced to a third party.	Yes. As long as your condition management program is evidenced-based, and your program meets the requirement outlined in RFP section A.8. on page 26, the State has no issue with this approach.
145. Is it required to have a CPR certified and First Aid certified provider on site? This is not currently a designation we track on our provider team.	Yes, the requirement is to have at least one staff member trained in both CPR and First Aid at all onsite screenings.
146. Can Cholestech equipment be replaced with Cardiocheck equipment?	Yes, provided the device operates within industry accuracy standards, the state will accept either device. The reference in Contract Section A.3.e.(10) is not a requirement but rather as an example.
147. The RFP frequently acknowledges the use of multiple communication modalities (text, email, phone) to facilitate direct---	No, the State will not negotiate after awarding the contract unless it is in the best interest of the State.

to---member communications. However, the pro forma contract does not appear to include language pertaining to the use of these instruments or conditions otherwise relating to direct---to---member interactions. Will the winning bidder have the opportunity to discuss and propose additional language to the pro forma contract to ensure that the contract adequately addresses the mutual concerns of both the winning bidder and the State?	Contract section A.5.l. states "The Contractor's programs may be delivered using a variety of modalities, including options for the Contractor and Member to interact with one another: online or video chat, telephonically, text or some other method of interaction prior approved by the State and shall accommodate a participant's preferred means of communication."
148. The incentive program outlined in the RFP is very clear in its intent and specific in its execution plan. However, incentive programs will likely continue to adapt as member needs evolve and the healthcare landscape shifts. As such, would the State be willing to consider new incentive programs, methodologies, and techniques as they become available?	Yes. However, the program must fit within the existing pricing outlined in the contract.
149. Please confirm that incentivized benefit design is determined by the insurance committee and then the vendor will be expected to execute the requirements?	Confirmed.
150. If we identify through data analysis, opportunities where we can drive significant positive outcomes (i.e. ROI, risk reduction, risk mitigation) across other condition areas, will the State be willing to discuss these additional opportunities and the possibility of extending the service to those members?	The State would be willing to discuss new opportunities; however, any changes considered would require assessment about its impact on the contract.
151. Will the winning bidder have the opportunity to apply additional screening criteria for the weight management program enrollment to identify individuals who have the best likelihood of success?	Yes, the vendor may propose additional criteria, however, the State has the final decision making authority regarding eligibility.
152. Is the State willing to collaborate with the winning bidder on the design of the weight management incentives in order to ensure optimal health outcomes and mitigate the certain behavior risks (e.g., a member initiating participation solely to collect an easy reward)?	Yes, the State is willing to collaborate, however the state has final decision making authority.
153. Are the incentives for 2017 different than those from previous years as described?	No. Members in the Partnership PPO in 2017 agreed to complete wellness activities in exchange for lower

	premiums and cost sharing. Members in the Promise HealthSavings CDHP agreed to complete wellness activities in exchange for HSA dollars. Beginning in 2018 members will receive a cash incentive in their paycheck for completing wellness activities regardless of the plan option they are enrolled in. All activities will be voluntary, not required as in previous years.
154. Please further describe the "threshold payment" and how it works today.	There is no threshold payment in place today. The intent of the threshold payment is to reward the vendor for improvements in DM engagement based on predetermined targets set by the state. This clause will only take effect at the state's request.
155. RFP PAGE 67 - A.1.b – Will we need a separate contract with Local Education and Local Government Plan?	No. This contract requirement has been removed. See Amendment Section #7 and #8 below.
156. Section A.3.d. It states that we must electronically accept/upload all biometric screening data from multiple sources at no additional cost. Can you clarify what sources you are requiring and will these all be in a standard format or sent individually? We offer various remote screening options including Lab, Retail, Home Health Test Kits and Physician forms that have a cost associated with each method. We can take in a data feed in our standard format if that is the question being asked.	You are expected to upload data from three sources as identified in the pro forma contract: physician screening form, onsite screenings and home test kits. The physician screening form data will be submitted individually by the member or provider as will the home test kits. Onsite screening data will come to the Contractor via the format you have agreed upon with your screening vendor. See Amendment Section #6 below.
157. RFP PAGE 69 - A. 3 Biometric Screening - What will be the incentive amount offered to employees for completing their onsite biometric screening	Beginning in 2018 members will receive a cash incentive in their paycheck for completing the biometric screening. The exact amount of the incentive will be determined by the Insurance Committee at the same time that the wellness contract is awarded.
158. RFP PAGE 69 - A. 3 Biometric Screening - Please confirm the services that your current screening vendor includes in their "all in fee" for onsite biometrics; so all vendors are using the same criteria to create their fee proposal.	The State does not have a specific break down of what the current vendor includes in the pricing.
159. RFP PAGE 69 - A. 3 Biometric Screening - How many onsite screenings were administered to employees last year vs.	Please see the response to questions #25 and #26.

employees completing a physician form?	
160. RFP PAGE 69 - A. 3 Biometric Screening - Are screenings going to be completed every year or every other year?	The current strategy is to conduct the screening every year. The structure is always subject to change due to budget availability.
161. RFP PAGE 69 - A. 3 Biometric Screening - Confirm when screenings will begin and end; for example, screenings will begin on April 1st and end on August on 1st.	The state will work with the winning vendor on the timing of the screening events. Essentially, we want to schedule those events to assist members with completing the requirements and earning the incentive.
162. A.3.d The Contractor shall, at no additional cost to the State, electronically accept/upload all biometric screening data from multiple sources (including those listed above) into the Contractor's system and match the results to the member's health questionnaire or member record. Question: Regarding item (d) above, please confirm total number of sources from which biometric screening data will be sent electronically to [redacted]'s system.	As outlined in Section A.3., there are three different sources: workplace screenings, provider and Health Clinic which will use the vendor's physician screening form and home-kits which should be provided only under specific member hardships.
163. Page 69, A3d – What other data sources will the State expect the contractor to accept/upload for biometrics outside of the contractor's biometrics solution stated in A3b?	See response to question #162.
164. Page 69, E1 – What are the hours of the on-site biometric screenings currently? Does the State have second and third shift employees?	The screening hours are typically 7:00 a.m. to 12 or 1:00 p.m. There are second and third shift employees at some state facilities like prisons. We have not offered any screening sites to those shifts but would be open to doing so.
165. Pg 70, E6 – How are biometric screenings promoted today?	Through reminder emails and the Agency Benefit Coordinators.
166. Pg 70, E7 – How many locations out of the up to 75 have had less than 50 participants in the past?	The list provided is the current site list for 2017 and those screenings just started last month so we do not have final participation numbers. Most of the lower performing sites with less than 50 participants happen in the Local Education and Local Government sites which will not be included going forward.
167. Page 70, E7 – What percent of participants choose phone registration over online registration for on-site screenings?	The state does not have this information. Most self-register through the online portal provided by the screening vendor.

168. Biometric participant survey – Please provide the current satisfaction survey.	See Amendment Section #33 below.
169. Does the state have a preference for how the biometric screening participant satisfaction survey is administered – on-site at the time of the screening or through email as a follow-up to the screening event?	The state does not have a preference. However, we have seen a good response when the survey is provided onsite.
170. Page 75, A83 - What is the current risk stratification criterial for lifestyle counseling?	The risk stratification currently being used is proprietary to Healthways.
171. A.3.e(6) Regarding the Contractor's responsibility to organize and coordinate all planning and related logistics for the workplace screening. Does HealthWays currently provide a full time or part time employee to manage this process? Is it managed by the labs and biometrics vendor or the state?	Healthways does have an account team member who manages all aspects of the screening process. This individual is not provided by the third party vendor.
172. Contract a.3.j: "The Contractor shall suspend a participant's enrollment in the program if the participant is admitted to a custodial care facility, a psychiatric facility for a long-term stay, or to hospice care." To clarify, will the State notify the successful vendor of a participant in this situation so we can suspend their enrollment?	This contract requirement has been removed. See Amendment Section #12 below.
173. Eligibility a.4: To clarify, it appears the State would like to make those with BMI of 29.9 eligible for the program but is open to discussing the criteria/methodology prior to go-live. Is this correct?	Yes.
174. Page 72 A.4.a.(1) "Collect information on Member demographics, contact information (including preferred email address(es) and phone number(s)), lifestyle behaviors (including but not limited to tobacco use, nutrition, physical activity stress, and depression." Please clarify the purpose and intended use for collected phone numbers and other data points.	To capture the most up to date member information for outreach via phone or email by the vendor as well as to track change in lifestyle behaviors.
175. A.4.b. "The Contractor shall modify the health questionnaire in accordance with a State request for a revision or other change within thirty (30) days of said	The State might like to add a question. And we may reserve the right to remove a question that we view

request unless the issue is a legal one, in which case the health questionnaire shall be amended immediately." What are some of the reason(s) the State would be interested in changing health survey content within a 30-day timeframe?	as controversial or irrelevant. The State has modified this section to match the timeframe listed in Contract Attachment B #7. See Amendment Section #41 below.
176. A.4.b. Health Questionnaire: The Contractor shall modify the health questionnaire in accordance with a State request for a revision or other change within thirty (30) days of said request unless the issue is a legal one, in which case the health questionnaire shall be amended immediately. Q: Does the State anticipate changes to the health assessment that could impact the algorithms and scoring methodology or is this request for modification more focused on adding custom questions? We are trying to understand the full implications of "revisions or other change" given it is a universal assessment used across our entire book of business. [redacted]'s Health Assessment is NCQA certified. Modifications to the existing question set may negatively impact NCQA certification standards. If a specific need should arise, however, we are pleased to discuss the option and its impact on our Health Assessment's functionality. We are able to modify the Health Assessment; however, we want to ensure it maintains validity and meets the State's needs. Please clarify the State's definition of "modify" and/or provide examples of desired modifications.	It is unlikely the State would ask to remove a question that would impact the algorithms or methodology. The request would likely be geared toward adding a custom question or removing a question that is controversial or irrelevant. We do not have specific examples given that we have not seen your questionnaire, and the state would never jeopardize a certification. See Amendment Section #41 below.
177. A.4.b. Bluetooth scales: We can accommodate the State's request for Bluetooth scales; however, it will increase the price of our standard program. Additionally, we have been unable to find evidence that a connected scales leads to better or more accurate results. Would you be willing to entertain alternative	The State will update the cost proposal and Contract Section C.3.b. to include a Bluetooth scale and pricing without a scale, giving the State the flexibility to implement either program. The State has also updated Contract Section A.4.b. See Amendment Section #5, 13 and #14 below.

pricing for standard scales in vendor proposals or a conversation regarding a standard scale at a later date?	
178. Section A.4.e. "If available, at the member's request, the Contractor should provide telephonic assistance with completing the health questionnaire." What are the State's regulatory requirements for telephonic assistance for health questionnaires? Is IVR a preference or a requirement? How many phone or paper surveys were completed in the last year for the State? Please provide clarification on historical/anticipated volume of telephonic assistance.	IVR is not a requirement. We would like to offer telephonic assistance as an option. There were a total of 3,689 paper surveys completed in 2016. Please see state's response to question #34.
179. RFP PAGE 72 - A. 4. g. - Who is the current Decision Support System (DSS) Vendor for the State? Please review and summarize the program services. Does the State know how much the DSS vendor charges for data integration services and if so, please release or let us know where to find?	Truven Health Analytics is the current DSS vendor. Although a new contract will be awarded next year with a 1/1/2019 effective date. Note that the wellness vendor will not incur a new set-up fee should a new DSS vendor be awarded the DSS contract. The state will be responsible for the file set-up in that instance. The current contract with Truven requires a $15,000 set up fee that is to be paid by the vendor partners. The wellness vendor will be allowed three load files per month. Any additional load files will be assessed $500 per file per month paid directly to the DSS vendor and will be the responsible of the wellness vendor. The state does not anticipate more than the three file loads.
180. A.5.b: Will the State be an active participant in communicating the weight management program to its members?	The vendor will have the primary responsibility of creating material and communicating the Weight Management Program to eligible members as outlined on page 156 of the Contract in A.10 Member Communications and Materials, with the State's prior and final approval. The State has mailing addresses for all eligible employees and can directly communicate to **state** employees by email, and communicate to state and higher education agency benefits coordinators (ABCs) who are the HR contacts in the field. These ABCs have direct contact with our eligible employees and members.
181. A.5.f. At the State's request, the Contractor shall submit to the State	This information will be used in employee benefit

program descriptions for all programs. The State reserves the right to review these program descriptions and request changes. The Contractor shall notify the State, in writing, thirty (30) days prior to any significant changes to these program descriptions. The State reserves the right to review the proposed change(s) and require revisions. Question: Regarding item (f) above, please provide an example and/or intended use for the program descriptions? Is the State's desired objective that program descriptions be readable and understandable (per readability guidelines), and used in employee benefits communications?	communications, such as on our ParTNers for Health website.
182. RFP PAGE 74 - A. 5. n. - We understand the Contractor shall suspend a participant's enrollment in all programs if the participant is admitted to a custodial care facility, a psychiatric facility for a long-term stay, acute care hospital admission, or to hospice care. How is the Contractor notified of a member's admission into a facility? Will the Contractor be receiving a file from the UM vendor? If so, what is the timing of that file feed?	The state has removed this requirement. See Amendment Section #12 below.
183. On p. 74 A.5.n and on p. 150 A.3.J, "The contractor shall suspend a participant's enrollment in the program if the participant is admitted to a custodial care facility, a psychiatric facility for a long-term stay, or to hospice care." How will the contractor be notified of such events?	See response to question #182.
184. On page 75 of the RFP in section A.8. a) #3) states that The Contractor shall review with the State, prior to program go live, the criteria/methodology used to determine risk stratification for disease management and lifestyle counseling. The criteria may be adjusted at the State's request. Does this mean a discussion would take place and the criteria would be determined jointly or that the State will just dictate what the criteria is?	The state would like to review the criteria/methodology. The state will not dictate the criteria.

185. A.8.a.6: Our program is currently only available in English (content and coaches). If a member cannot participate in the program due to limited English proficiency, would our member service call center be expected to provide oral interpretation services?	Yes.
186. A.8.c and liquidated damages: Call center performance metric calculation listed on page 79, c.ii is different from the liquidated damages on page 131, #10. The calculation appears to be written differently in both. Can you confirm the calculation we should use?	The liquidated damage on page 131 is specific to A.11c.(1)i on page 79. The State has modified the language. See Amendment Section #15 below.
187. RFP PAGE 76 - A.8. c. - With respect to "robo phone tree", Respondent deploys a series of modalities: calls, letters, emails, texts, etc. over period of time; six to eight weeks, as part of our member engagement strategy. A minority, two, of those calls are automated calls. We do not blast the entire populations with constant random robo calls. Would the state be agreeable to a strategic, targeted and measured use of automated calls as a part of an overall engagement strategy describe earlier?	Yes, upon approval from the State.
188. RFP PAGE 76 - A.8. d. - Regarding making available appropriate staff to provide Lifestyle Counseling and DM services to members, either individually or in a group setting, at the State Health and Wellness Center or another site approved by the State, how often would staff be required and would it be on a continuous basis? Can you provide an estimated number of hours expected for onsite support?	The Health Center has an office that is available for face to face coaching. The Contractor could staff the office Monday – Friday but would have to alternate days for lifestyle counseling and DM services. See response to question #105 for historical hours.
189. A.8.d – Can you provide more information on the onsite coaching component. Number of hours needed? Number of coaches needed? Locations?	This is for one location in the downtown Nashville Health Center. The number of coaches would depend onif you were to offer both lifestyle and disease management coaching. There is one office so if they were there full time, they would have to alternate days. See response to question #105 for historical hours.
190. Is the vendor expected to conduct a certain number of onsite screenings per hour? (e.g., 6 screenings per hour)	The contract does not dictate how many screenings per hour.

191. Can the State provide an estimate for the number of days/hours required under the existing contract for onsite coaching?	There was no specific requirement for the number of days/hours. We wanted to provide the option for members to meet face to face with their coach in the downtown Nashville location. See response to question #105 for historical hours.
192. If 50 employees are registered for a screening event but only 30 participants attend the event, will the vendor be able to bill for the 50 expected participants? Are there other protections available?	No. The vendor will not be able to bill for projected participants. Only per individual participant. Per the pro forma contract, the state includes a minimum capacity of 50 and allows the Contractor flexibility to cancel an onsite screening if fewer than 40 members sign up. See Section A.3. e. (7).
193. Will the State of Tennessee provide a receptionist at all of the screening events? Or should the vendor include the service as a separate line item fee or bundle the cost into a single fee?	The Contractor or subcontracted screen vendor is expected to fully staff all screening events. The state will not provide any staffing. The cost should be included in the onsite screening fee.
194. A.8 and A.16.i: The Contractor shall obtain (if it does not already have) National Committee on Quality Assurance (NCQA) provisional Wellness & Health Promotion Accreditation or NCQA provisional disease management accreditation, or Utilization Review Accreditation Commission (URAC) disease management accreditation within one (1) year of the program start date or another date as approved by the State. Unless otherwise directed by the State, the Contractor shall obtain (if it does not already have) full NCQA accreditation by December 31, 2018 if URAC accreditation is not already obtained and shall retain it thereafter for the full term of this Contract. Exception: Regarding A.8 and A.16.i above – we have initiated this process for full accreditation and there is a chance this will not be in place by 12/31/18 given the length of time this usually takes.	As long as the vendor can show documentation the accreditation is in progress, this is acceptable to the state.
195. Is an IVR required for the HA back-up method or can live phone support be used as the back-up method?	Either method is acceptable.
196. On p. 72, item A.4e, Can the State provide clarification regarding the number of members requiring telephonic or IVR	See state response to question #34.

assistance to complete the HRA?	
197. A.9.b. Incentives could be in the form of cash added to the member's paycheck or funds added to the member's Health Savings Account. The total incentive amount shall be determined by the State and the value associated with each activity shall be finalized by the State, in consultation with the Contractor, during implementation and prior to program go live. The Contractor shall coordinate the collection of program data with external vendors in order to track, monitor and report Member activities online and via any other state requested methods, including activities for programs offered by the External Weight Management or Diabetes Prevention Program Contractor, as well as the State's other vendor partners, if applicable. Question: Regarding item (b) above, with how many external vendors would we be required to coordinate? Please provide number of inputs we would be tracking, monitoring, reporting.	Case management provided by two medical carriers and the BHO provider, weight management, Diabetes Prevention program provided by the YMCA. The State estimates a total of five external vendors that could report member activities for purposes of earning the incentive.
198. RFP Section A.9.d (2) "Members eligible to earn an incentive may file an appeal if they feel information is incorrect or inaccurate and therefore deemed the Member ineligible for the incentive. The Contractor shall maintain a process by which a Member may file the appeal and such appeals shall be reviewed by a committee designated by the Contractor. The Weight Management Contractor shall assist with requested information to help resolved a disputed appeal." How many appeals typically occur on an annual basis? Please clarify the volume of historical and/or anticipated appeals.	As mentioned in other areas of the questions and comments, the state does not anticipate the high volume of participation from previous years due to the change in benefit design and the move to a cash incentive. The totals below could include duplicate appeals as these are not unique counts: 2013 – 4,789 2014 – 17,794 2015 – 18,053 2016 – 14,424 2017 (Jan-March) - 700
199. RFP Section A.9.d (3) "At least one (1) month prior to the go-live date, the Contractor shall provide the State information describing in detail the Contractor's appeals process and procedures along with a sample	The primary vendor will be responsible for managing all aspects of member appeals related to incentive eligibility. The vendor will also be required to provide a final notification of the member appeal which should be in the form of a letter.

notification letter of the appeal resolution. The State reserves the right to review the appeals process and procedures and letter and require changes, where appropriate." Please provide more detail around your expectations for member communication related to appeals (e.g., mailed letters, etc.). Are alternative models for appeal negotiable?	The state is unable to answer the question about alternative appeal models without any details on what those methods are.
200. A.10.b During normal business hours, the Contractor's Member services representatives shall be dedicated to this Contract. If the Contractor receives prior, written approval from the State, then the Contractor may 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. Comment re b., above (highlighted): If vendor is confident in its ability to provide a service level without dedicated resources, would this be amenable. Can you provide call volume stats for peak and non-peak times to help us in determining the feasibility of a dedicated staff model? Exception: We cannot commit to holding a caller's place in line at this time. We are exploring this option and may be incorporated and allotted resources in our product roadmap. We would be happy to discuss further. Exception: We cannot currently commit to live-transferring calls from Member Services Tier 1 to a health coach as our clinical staffing model is developed to provide outreach, not for inbound calls. We are exploring this in our product roadmap and welcome further discussion. Exception: Turnaround time in addressing calls/inquiries within 5 days – this is highly dependent on the severity, escalation and	The State has modified Contract Section A.10.b. See Amendment Section #3 below. The current plan design and member deadlines do drive high call volume, particularly in the weeks/days leading up to a deadline. Most members wait to complete the health assessment in the week leading up to the deadlines. So as we move closer to deadline dates, call volume spikes. Here are the monthly call volume stats for 2016. In 2016, peak inbound call volume for Healthways Customer Service was primarily in the morning hours (8am-12pm CT). Followed closely by the afternoons and then evenings. **Total calls:** January – 7,244 February – 11,996 March – 20,435 (deadline for health assessment was March 15) April – 7,457 May – 10,305 June – 10,305 July – 10,935 (deadline for biometric screening was July 15) August – 10,221 September – 5,524 October – 5,651 November – 2,560 December – 2,410 We have updated the requirement in A.11.d(8)

iquiry type and we would like to discuss in greater detail.	related to holding a caller's place in line on the dial-back option. Regarding the other exceptions outlined in your question, the state will not agree to the other exceptions. See Amendment Section #4 below.
201. A.10 section d) How long is the recorded call data required to be kept?	The life of the contract and any requirement listed in contract section D.11.
202. Pg. 77-78 A.11.c(1): will you please clarify the variance between "answer times" in points (i) and (iii)? Will you please confirm whether Member Appeals would be factored into the calculation of the open call/inquiry closure rate of 90% within five (5) business days?	A.11.c.(1).i. refers to an average speed of answer of 30 seconds for **all** calls. A.11.c.(1).iii. requires that at least 80% of all calls must be answered within 20 seconds. Calls in A.11.c.(1).iii. will be included in the overall average reported in A.11.c.(1).i. Member appeals would not factor into the open call/inquiry closure rate.
203. On Page 78 A.11. 2) Does the state currently have a dedicated toll free number set up that can be directed to Contractor call center number?	Yes.
204. On Page 78 section A.11 a. (7) - Is this language requirement for specific languages or all languages?	All languages.
205. On Page 80 section A.11 d. (5) - How long is the recorded data required to be kept?	See state response to question #201.
206. RFP PAGE 80 - A.11, d.,(8) - Wait times as described in this section are not a current feature. We continually enhance our telephone technologies and this feature may be available as a future enhancement. Is this acceptable?	No.
207. A.11.d.(8) page 80 - is this a flexible requirement meaning is this a deal breaker if the technology is not presently available?	We have updated the requirement in A.11.d(8) to say the vendor may provide a dial back option that keeps the members place in the queue. The remaining requirements in this section will not be changed. See Amendment Section #4 below.
208. RFP Page 80 - A.11, d.,(9) - Respondent monitors call internally for quality purposes. We would request added clarification regarding third party remote access to listen into calls due to HIPAA concerns. We are contractually obligated to protect the privacy and security of the State's data, including member data and	Covered entities are allowed to share PHI with other covered entities for treatment, payment, and operations. The state is a covered entity bound by HIPAA Privacy and Security Rules. If the state chooses an authorized representative to monitor calls, theauthorized representative would be required to sign a business associate agreement. "Health care

providing an outside access point causes great concern as we would hold great liability according to the terms of the agreement.	operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of "health care operations" at 45 CFR 164.501.
209. A.13 b) - What is the length of information (all marketing material for first qtr, all year, etc.) that the state is requesting by the due date laid out in A.25?	Member materials shall be finalized including state review and sign-off are ready for distribution by the date specified in A. 25. Contract Section A.25 #28, #29, and #30 list deadlines for three specific communications materials – annual mailer, materials for annual enrollment and the annual communications plan. These communications material pieces via in length size and the Contractor will work in coordination with the State's communication team and program director to determine content and length.
210. RFP PAGE 83 - A. 14. Website/Mobile App - Please confirm splash page refers to the website and the app would not have a splash page as it is well accepted industry standard that apps are not customizable by client.	Confirmed.
211. RFP PAGE 84 - A.14.j – Our website will be cobranded and contains content in a similar manner and structure as all of our other client websites. Aside from the website name, please help us understand what you mean by "transfer ownership of the domain name(s), templates, and content to the State upon termination of this Contract without delay".	The splash page created is dedicated and customized for this Contract containing general program information, specific to the State plan membership, which does not require a member to login. As stated in Section A .14.g, the Contractor shall host the splash page on a non-governmental server, which shall be located within in the United States. Examples of splash pages created by current vendors can be found on our website, partnersforhealthtn.gov, and going to the "Contact Us" page. Once this contract terminates, ownership of the splash page domain name(s), templates and content is transferred to the State.
212. A.16.g – Asks about survey's for other vendors sponsored activities. Is this referring to other programs run by us or other vendors the state partners with?	A.16.g refers to other programs run by the vendor.
213. A.17.d(3) – page 87 – can you clarify what type of seminars are being referred to here? Is this to the employee population	The target audience could be Benefit Administration staff, Agency Benefit Coordinators, Insurance

on health education or to administrative staff supporting the wellness program?	Committee Members and other representatives of the State.
214. A.17.e: "The Contractor shall transmit to the State, no less frequently than monthly, a complete, electronic file that reports those members who have fulfilled the wellness requirements within that month for purposes of providing an incentive for completing said activities. The file format to include the Employee ID, Employee Name and Incentive Amount (see Appendix 7.8)." Would this member-level data need to go to the State and not your wellness vendor?	If referencing the Weight Management contract, those files are going to state payroll for the purposes of paying the cash incentive.
215. A.17.f. Can you elaborate on exactly what and how the state wants to be reported on, pertaining to section f) on page 88: f. The Contractor shall submit case management referral reports to the State (see Contract Attachment C).	If the Contractor identifies a member who would benefit from case management, then this report would reflect the number of referrals to each medical carrier and the BHO vendor.
216. Can the state provide more information on Page 88 f. The Contractor shall submit case management referral reports to the State (see Contract Attachment C). What is this specifically pertaining to?	See state response to question #215.
217. A.20.b: To clarify, could the agreed-upon mechanism for the State to access aggregate data be the dedicated client manager?	No.
218. A.20.d – it states ad hoc reporting should be available at no additional cost. We typically charge for ad hoc/custom reports based on the scope of the request. Is this acceptable? Or does the State want us to build in the cost to the overall program? Is there a specific number of ad hoc reports you'd like us to account for?	If referring to the Weight Management contract, no. The cost must be built-in as there would be no mechanism to pay for the ad-hoc reports through the contract. Over the life of the five year Healthways contract, the state requested approximately a dozen ad-hoc reports.
219. A.21: To clarify, what date would members need to be able to log in and start participating in the Weight Management program? Would that be 3/1 even though contract is effective 8/1?	Weight Management Program will go live on March 1, 2018. The reference to 9/1 is when we estimate the contract will be executed and implementation with the vendor can begin. See Amendment Section #32 below as the contract effective date has changed.
220. A.26.d states that if a Member services representative asks the caller to hold during the first sixty (60) seconds of the	For both contracts, the State is unable to provide details around how this is being handled by our

dialogue, the Contractor shall not consider the call to be "answered" for purposes of this definition until the Member services representative returns to the caller and begins an uninterrupted dialogue.) How does the current vendor manage this specific level of detail? Would setting up guidelines for the team meet this standard?	current Contractor. Setting up guidelines with member services would meet this standard.
221. RFP PAGE 135 Contract Attachment C - Time is needed to properly tabulate and verify the accuracy of the data prior to release back to the State. In most cases, reports are often delivered earlier and accessed via our online reporting tool which you are also requesting. All of our other state clients find acceptable a 30 day deliverable verses our standard 45 day at the end of the reporting period. Would it be acceptable to the State being aligned with a 30 day deliverable after the period in question ends requirement?	No, the State does not agree to this revision. The State has added language to this section of the contract that allows the state to consider alternate delivery dates should this be in the best interest of the state. See Amendment Section #28 below.
222. RFP PAGE 89 - A.18.m – This section prohibits Respondent from using information for "expanding non-State relationships or for any pecuniary gain." Please confirm data can be de-identified as to individual member and State identity and used for purposes other than the provision of services to the State, for example program and service development and improvement, quality management, data analytics, book-of-business benchmark reporting, health care studies, accreditation, etc. management and administration of Contractor.	The State agrees with the use of de-identified, aggregate data in the examples listed. A Contractor cannot use our member information to market to or about Plan members for pecuniary gain.
223. A19.d.1.i. – Page 90 – it states all DM clinicians must be appropriately licensed. In the video currently posted online about the coaching program, it shows the qualifications of the coaches being used today. Are those the level of qualifications you are looking for? Or do they have to be certified disease management clinicians?	As outlined in A.19.d.(1) i and ii, all DM clinicians shall be clinical professionals who are appropriately licensed or certified and coaches shall have, at a minimum, a degree in a related field. DM certification is an option.
224. RFP PAGE 93 - A.20.i (3) – Respondent would propose edits to include additional time to request access to information. The	No. The State does not agree to this revision. The State has modified the language to clarify situations in which the HIPAA BAA is pertinent. See

language outlined is broad and not limited to specific situations or types of information. For example, this is inconsistent with the audit/inspection sections, and the HIPAA BAA.	Amendment Section #16 below.
225. RFP PAGE 93 - A.20.j – Respondent is required use and disclose information to provide the services or perform its obligations under the contract and as otherwise permitted by the contract and BAA. Respondent must be able to disclose information to subcontractors/vendors for purposes of providing our Population Health Management program. Please confirm this is acceptable.	Yes. The State agrees with the disclosure of information to only subcontractors/vendors for the purposes of providing services per the contract.
226. A.21.f(1): Regarding the Weekly Enrollment Update language, "Weekly Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall, unless otherwise directed by the State, retrieve, via secure medium weekly enrollment files from the State, in the State's Edison 834 (see RFP # 31786–00135, Appendix 7.3 for the current file." Does the State of TN require the Vendor to "retrieve" the Enrollment file or "receive" the file?	The vendor is required to retrieve the file from the State SFTP server. See Contract Section A.21.f(1)
227. (A22): Can the Contractor report promptly (within 48 hours) to the State any unauthorized use or disclosures of PHI?	Yes. The Contractor can report unauthorized disclosures within 48 hours.
228. RFP PAGE 99 - A.22 – For additional clarity, Respondent would propose revising this section to be consistent with the HIPAA BAA in Attachment D.	The State has revised. See Amendment Section #17 below.
229. RFP PAGE 103 - A.25 – Please confirm the deliverable due date & milestone target date for Call Center Statistics and Summary is "Monthly starting January 1, 2017".	This was an error. See Amendment Section #18 below.
230. RFP PAGE 109 - A.27 – Respondent would propose revising this section as indicated below. Please confirm this edit or similar language would be acceptable? Warranty. Contractor represents and warrants	The State does not agree to this revision.

that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty general offered by Contractor, its suppliers, or manufacturers to customers of its goods or services. The goods or services provided under this Contract shall substantially conform to the terms and conditions of this Contract throughout the Warranty Period. If the goods or services provided by Contractor fail to substantially conform to the terms and conditions of this Contract and such non-conformance is solely the fault of Contractor, such non-conformance shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge. Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract. Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and with that level of reasonable care which a similarly situated provider of population health management and wellness support services would exercise under similar circumstances. If Contractor is unable or unwilling to correct a Defect, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law. Except for any warranties expressly stated	

herein, the goods and services provided hereunder are provided on an "as is" basis, and contractor makes no, and expressly disclaims any and all warranties of any kind, whether express or implied (including any implied warranties of merchantability, fitness for a particular purpose and non-infringement) to the fullest permitted by applicable law.	
231. RFP PAGE 112 - Will the State accept the following substitutions for the requested utilization and clinical outcome performance guarantees? We are asking for substitution of these performance guarantees for several reasons: (1) our clients have found the emergency department utilization to be a highly variable metric such that impact (signal) can be difficult to detect from the fluctuation in rates (noise). (2) We would like to discuss using our clinical outcomes performance guarantees which have been accepted by our client base and vetted by all the major consultants. These are evidence based measures most of which are based on HEDIS metrics.	Since the proposed outcomes were not provided, the State does not agree to this revision.
232. RFP PAGE 112 - C.3.i.(1) Utilization Rates (High Utilizers; Disease Management) - We propose to substitute our Highly Impactible Hospitalization measure for this PG. The methodology for this measure can be provided on request. It offers a reduction from historical baseline of aggregated inpatient admissions for CAD, Diabetes, Asthma, COPD, CHF and stroke.	Since the proposed outcomes were not provided, the State does not agree to this revision.
233. Page 112, Utilization Rates (High Utilizers; Disease Management) Please clarify the following: • In the "High Utilizer" definition, the ER visit requirement is ">= 3 visits in past 12 months". Admissions >=2 does not have a time parameter; please clarify if this is meant to be >=2 admissions in past 12 months. • In the Numerator definition, there is no allowance for removing scheduled admissions (example: member identified	• Yes, that is correct. • No parameters were used in this instance. As stated in Contract Section C.3.h. any inclusions, exclusions, outliers, etc. will all be mutually agreed upon between the state and the Contractor no later than Q3 of the base year (2018).

with CAD and later must have scheduled follow-up cardiac surgery). Will the State allow exclusions? Other potential exclusions that should be addressed are diagnoses unrelated to the DM Diagnosis (maternity, trauma, chemotherapy admission for Cancer, etc.) and SNF/Rehab (non-acute admissions and/or transfers).	
234. RFP PAGE 113 - C.3.i.(2)i Asthma: Contractor will improve the percent of program participants identified with asthma who are compliant with their medications. We propose to substitute two Asthma measures; one that measures compliance and a second as requested, that measures adherence. For the compliance measure we propose: Asthma: Appropriate use of controller medications (population) - This measures the percentage of patients 18-50 years old with persistent asthma who had at least one filled prescription for a controller medication during the measurement year. For the adherence measure we propose to use the 2016 HEDIS version: Medication Management for People With Asthma (greater than or equal to 75 percent). This measures the percentage of patients aged 5 to 64 years who were identified as having persistent asthma and who were appropriately prescribed and remained on asthma medication during the treatment period (defined as a PDC of 75%).	The State does not agree to this revision. We already exceed the national average and that is why we opted for a different measure.
235. Page 111, C.3.f. Does this contract term mean that if a member is working with a nurse on Diabetes Management, and that same member is working with a health coach for stress or weight management, we can only bill for the Disease Management nurse or the health coach but not for each program?	Correct. The contractor can only bill for one program.
236. RFP PAGE 113 - C.3.i.(2)ii CAD: Contractor will reduce Emergency Room (ER)	The State does not agree to this revision. Our rates

utilization rate (constrained by having CAD) of program participants. For the CAD measure we propose to substitute: CAD: Appropriate use of Statins (population) - This PG measures The percentage of patients 18 years and older with coronary artery disease who had at least 1 fill for a Statin during the measurement year.	are high in both HEDIS and medication adherence measures.
237. RFP PAGE 114 - C.3.i.(2)iii CHF: Contractor will reduce Emergency Room (ER) utilization rate (constrained by having CHF) of program participants. For the CHF measure we propose to substitute: CHF: Appropriate use of ACEi or ARB (population) - This measures the percentage of patients 18 years or older with heart failure who had a prescription filled for an Angiotensin Converting Enzyme Inhibitor(ACE-I) or Angiotensin Receptor Blocker(ARB) during the measurement year.	Same response as question #236.
238. RFP PAGE 114 - C.3.i.(2)iv COPD: Contractor will improve the percent of program participants with COPD who are compliant with their medications by 2% over the baseline in year one. For this measure we propose to substitute: COPD Bronchodilator Adherence. This measures the percentage of patients 35 years and older who have COPD and who were appropriately prescribed bronchodilator medication.	The State does not agree to this revision.
239. RFP PAGE 114 - C.3.i.(2)v Diabetes: Contractor will improve the percent of program participants who achieved management criteria as defined below within program year (PY): 1. At least 1 nephropathy screening 2. At least 1 HbA1c test 3. Two office visits for Diabetes at least 90 days apart For the diabetes measure(s) we propose to	The State does not agree to this revision.

substitute the following four measures: (1) Diabetes: Hemoglobin A1c monitoring (population) - This measures the percentage of patients 18-75 years old with diabetes mellitus who had a HbA1c performed during the measurement year. (2) Diabetes: Nephropathy screening or treatment (population) - This measures the percentage of patients 18 years or older with diabetes mellitus who either had screening for nephropathy or a filled prescription for an ACE-I or ARB during the measurement year. (3) Diabetes: Hemoglobin A1c Control less than 8% (population) - This measures the percentage of patients aged 18 to 75 years with diabetes mellitus (type 1 or type 2) who have a HbA1c result and whose most recent HbA1c value is less than 8.0%. (4) Diabetes: Appropriate use of Statins (population) - This measures the percentage of patients between 40 and 80 years old with diabetes mellitus who had a prescription for statin medication in the past 12 months.	
240. Section D Pro Forma Contract Can the State confirm that any additional modification to the contract must be bilateral and that the state may not unilaterally change the scope of work under the resulting contract?	Section D.3 of the contract provides that the contract can be modified only by a written agreement signed by all parties.
241. D.5 In the event of a termination, can the State clarify whether the final month's fees will be prorated for the amount performed, or whether the fee per member is incurred in full at the beginning or end of the particular month?	Termination for convenience requires at least 30 days notice. Termination for cause is effective immediately and the State will not pay for services not rendered. Contract sections D.5 and D.6.
242. (D6): Can the State agree to a mutual termination for cause provision?	The State does not agree.
243. RFP PAGE 117 - D.6 Termination for Cause – Respondent would propose a minor revision to this section to provide Respondent an opportunity to cure a breach condition. We would propose the following: Termination for Cause. If the Contractor fails to	The State does not agree to the proposed revision but has modified the language. See Amendment Section #39 below.

properly perform any material obligation under this Contract in a timely or proper manner, or if the Contractor violates any material terms of this Contract ("Breach Condition"),the State shall have the right to immediately terminate the Contract and withhold payments in excess of compensation for completed services or provided goods if Contractor fails to cure such Breach Condition within 30 days after receipt of notice from the State identifying the specific nature of the Breach Condition. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract."	
244. D.18 Can the State please confirm that the limitation of liability applies to all indemnification claims other than those involving infringement of third party intellectual property rights?	The Limitation of Contractors Liability Section D.18 applies to all claims other than those provided (highlighted below) in the term that reads as follows: D.18 Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims… "PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death."
245. RFP PAGE 119 - D.18 Limitation of Contractor's Liability – This section states that Contractor's liability for all claims is limited to two times the Maximum Liability. Respondent would propose editing this language with the following Limitation of Liability: Limitation of Contractor's Liability. Other than in an action between the parties for third party indemnification, in no event shall contractor be liable to the state regardless of the form or cause of action for any	The State does not agree to this revision.

indirect, special, incidental, punitive or consequential damages, including but not limited to loss of anticipated profits, business goodwill, reputation, medical malpractice, lost data, or economic loss, whether suffered directly or indirectly, even if the state has been advised of the possibility of such damages. Contractor's sole liability to the state for damages arising out of this agreement, from any cause whatsoever, and regardless of the form of action, whether in contract, tort (including negligence), strict product liability, or otherwise, shall be limited to the state's actual damages. In no event shall contractor's liability in respect of actual damages exceed an amount equal to the aggregate annual compensation paid by the state to contractor for the products and services provided hereunder during the twelve (12) months prior to the date when the cause of action arose. This limitation is cumulative, with all payments to the state by contractor for claims or costs or in connection with actions, claims, suits, and legal proceedings of any kind between the parties hereunder being aggregated to determine satisfaction of the limit. The existence of one or more claims will not enlarge this limitation on amount.	
246. RFP PAGE 119 - D.19 Hold Harmless – Respondent should propose revising this indemnification section as follows: 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 third party claims, liabilities, losses, and causes of action (collectively, "Claims") to the extent such Claims arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged solely as a result of a breach of this Contract by Contractor, its employees, or any person acting for or on its or their	The State does not agree to this revision.

behalf relating to this Contract. In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106. Notwithstanding any other provision of this Contract, no indemnification shall be available hereunder (i) for any settlement to which Contractor did not give prior, express written consent, (ii) for any Claim of which Contractor did not receive notice as provided in this Section, (iii) if the State failed to cooperate with Contractor in the defense of the Claim, (iv) for any Claim arising from or related to the acts or omissions of health care providers, (v) for any Claim caused by any act undertaken by Contractor at the direction of the State or its officers, agents or employees, or any failure, refusal or omission to act by Contractor that is directed by the State or its officers, agents or employees. In no event shall Contractor be liable for any payments for goods or services of any kind under a health benefit plan offered, issued or administered by the State."	
247. (D19): Is the State amenable to a mutual hold harmless provision?	No, the State does not agree to update this provision.
248. D.19: This Section of the Pro Forma contracts requires the subcontractor to indemnify the State for the "acts, omissions, or negligence" of the subcontractor and any person acting on behalf of the subcontractor. Due to the broad nature of this indemnification will	This section applies to the Contractor's responsibilities to indemnify the State. It does not apply to a subcontractor.

the State consider removing the language "acts" and "omissions" such that the indemnification is limited solely to negligence?	
249. RFP PAGE 120 - D.20 HIPAA Compliance – Respondent proposes replacing the HIPAA indemnification language in this section with the following standard language from the Privacy Office for consistency: A breach of the terms and conditions of the HIPAA Business Associate Agreement set forth in Attachment D shall be deemed a breach of the Contract for purposes of the indemnification provision set forth in Section D.19 above."	The State does not agree to this revision.
250. RFP PAGE 121 - D.24 Force Majeure – Respondent would propose editing the Force Majeure section to allow for more than 48 hours to assure a smooth transition with limited member impact.	The State does not agree to this revision.
251. (D25): Can the State agree to a mutual termination for convenience provision in which the parties, after the Initial Term, may provide 30 days advance written notice of termination before the termination date?	If you are referring to D.5, the State agrees to modify the language. See Amendment #40 below.
252. (D31): Is the State amenable to the following modifications? • If insurance expires during the Term, the State must receive a new COI prior to the insurance's expiration date. • At any time, the State may require the Contractor to provide a valid COI detailing coverage description; insurance company; policy number; policy effective date; policy expiration date; limits of liability; and the name and address of insured. • Also, Contractor's General Liability and Workers' Compensation shall contain an endorsement for a waiver of subrogation in favor of the State. • (Removal of the following language) Any deductible over fifty thousand dollars ($50,000) must be approved by the State.	The State does not agree to this revision.

253. D.31 Will the State consider removing the following language? The Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that the subcontractors are included under the Contractor's policy. Since our subcontractors have a limited responsibility of the overall deliverables, their coverage may not be the same. Once the State approves subcontractors, we can make the request at that time.	The State does not agree to this revision This requirement is required only at time of contract award.
254. D. 31 Will the State consider the following change? *The Contractor agrees to ~~name~~ include…..* Additional insured endorsement is provided on a blanket basis, not in an endorsement specifically naming client, but coverage is equivalent.	The State does not agree to this revision.
255. D.31 Will the State consider the following change? *b. Workers' Compensation and Employer Liability Insurance* *1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:* *i. Workers' compensation ~~in an amount not less than one million dollars ($1,000,000)~~ with statutory limits and including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.* Workers' Comp limits vary by state, and we are covered for statutory limits for each state.	The State does not agree to the proposed revision but has modified the language. See Amendment #38 below.

256. RFP PAGE 124 - E.2 Confidentiality of Records – Respondent would propose revising the second to last two sentences of this section as follows: "Confidential Information shall not be disclosed except as permitted by the Contract, including Attachment D or as required or permitted under state or federal law. Contractor shall take appropriate steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law."	The State does not agree to this revision, because Attachment D is based on HIPAA, which is a Federal law, the State will not to seek approval for the proposed change.
257. RFP PAGE 125 - E.8 Partial Takeover of Contract – Respondent would propose adjusting the partial takeover language to better define and confirm parameters allowing the State to take over portions of the contract and unilaterally. Is this acceptable?	The State does not agree to this revision.
258. RFP PAGE 125 - E.9 Personally Identifiable Information – Respondent should submit a comment stating that Respondent would propose revision of this section to be consistent with the HIPAA BAA in Attachment D. For example, the timeline for notifying the State of unpermitted disclosures of PII should be consistent with the timeline in the BAA for notification of a Breach of PHI, and requirements for the return/destruction of PII also should be consistent with the BAA.	The state does not agree to this revision. PII is not information covered by HIPAA. PHI is information protected by HIPAA. The BAA does not apply to personally identifiable information.

259. Attachment D: Is the State amenable to the following modifications? • 2.7.1 Business Associate shall provide to Covered Entity notice of an Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach. • 2.10 Business Associate shall make its internal practices, books, and records and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule. • 3.5 Business Associate shall make its internal practices, books, and records relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.	2.7.1 has been updated. See Amendment Section #19 below. 2.10 – the State does not agree to this revision. 3.5 –The State does not agree to this revision.
260. Page 132, 17: "One hundred percent (100%) of electronically transmitted enrollment updates shall be posted within one (1) business day after receipt in specified format and one hundred percent (100%) posted within four (4) business days, as required in Contract Section A.21.f." Please clarify the difference between the two separate 100% requirements noted, as both indicate 100% within two different number of days.	See Amendment Section #20 and 22 below.
261. Page 132, 18: "Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of	See Amendment Section #21 and 22 below.

the enrollment file within five (5) business days of receipt of the file from the State, as required in Contract Section A.21." Please confirm whether this requirement is only in reference to section A.21.f(6), or if it is also in reference to other requirements within section A.21.	
262. Page 133, 22: "All data required for operations other than Member eligibility data shall be loaded correctly, as required in Contract Section A.21." Please clarify the specific requirements surrounding expected turnaround time for loading non-eligibility data into the Contractor's system, as section A.21 does not state expectations for these specific types of data, only for eligibility/enrollment data.	The Contract does not provide an expected turnaround time for loading non-eligibility data since data from the State's third party vendors could impact the Contractor's ability to provide services. The expectation is that the data will be loaded timely AND correctly.
263. Can the State clarify whether the limitation on liability carve out language of "any claims covered by any specific provision in the Contract providing for liquidated damages" applies only to those claims for which the State seeks only liquidated damages? Or does it also cover those claims for which the State could seek liquidated damages but also/instead exercises its right to seek actual damages in accordance with Attachment B § 8?	Standard Term and Condition D.18: The exception applies to circumstances in which the State has actually assessed liquidated damages, and not to all possible claims for which the State has the right to assess liquidated damages.
264. Contract Attachment B: Can the State clarify whether the liquidated damages will be capped (as provided for in Attachment B) or whether there will be no limit on a contractor's liability for claims with liquidated damages?	As noted in Contract Attachment B 4. The maximum assessment in any 12 month period shall not exceed twenty percent of the annual maximum liability in the contract or the actual amount paid during the calendar year.
265. How many Wellness Champions and Wellness Committees does the State of TN have across the state? Would the wellness vendor be requested to oversee/direct this network of individuals?	Currently, we have 27 Wellness Councils representing each Executive Branch Departments (Ex; Transportation, Health, Veterans Services, etc.) These Wellness Councils vary in size due to their specific employee population size. No, the wellness vendor would not directly oversee this network of site champions. WFHT would partner with the Wellness Vendor for additional resources, lunch-n-learns, etc.
266. What digital tools/platform is used to	

share information with the current Wellness Champion Network? Is this provided by the State or the current wellness vendor?	The digital platform is http://www.tnsitechampions.com/ that is a dedicated website with tools and resources. Healthways help put together the website but the domain and the contents are now managed by Benefits Administration.
267. What is the current staffing model for on-site health promotion-- health promotion directors, regional coordinators, wellness champions? What are their roles? Are they employees of the State or Healthways? If employees of the State, how do they interact with Healthways? How do they interact with the Wellness Champions?	The Working For a Healthier Tennessee (WFHT) initiative has four FTEs state employees dedicated to the program, including a Health Promotion Manager that reports to the Population Health Director and 3 Regional Wellness Coordinators (East, West and Middle Tennessee) that report to the Health Promotion Manager. The Coordinators are assigned to 9 Executive Department's Wellness Councils providing guidance and resources for their department's programming. Healthways helps support the team by providing content that can be distributed to the councils such as materials about smoking cessation, healthy eating and exercise.
268. What does Healthways currently provide for health promotion and coordination with the wellness champions/Wellness Council?	Healthways provides Aggregate Data from their health assessment, broken out by department. And provides other educational resources when requested.
269. What are the responsibilities of the Wellness Champions?	In partnership with the State's Health Promotion Staff provide programming to their specific department's state employee population within the WFHT initiative's three focus areas; Physical Activity, Healthy Eating and Tobacco Cessation.
270. Does the State want the successful vendor to take ownership of and maintain the Wellness Council website? Or will the successful vendor supply content to State health promotion staff to maintain on the website?	No. The expectation is the successful vendor will support the health promotion staff by providing content and resources to help maintain the website.
271. How many site champion users currently	

access the wellness council website?	We do not track usage of the public website. Primarily the previously referenced 29 wellness councils utilize the website most frequently.
272. What is the State's largest need to help enable better engagement with the wellness champions?	Continue to provide relevant information, resources, tools and variety in programming.
273. Is there any expectation for the successful vendor to provide support for the Local Education and Government population's wellness champions and their access to the wellness council website as well?	We would like to continue providing them access to the tools and resources but there is not direct support of these agencies.
274. How many on-site coaches are there today, and what is their role? How are they staffed (PT, FT, Ad hoc/by the hour)? What is the current utilization/participation rate of this coaching resource?	There are two. One coach and one clinician. They are ad hoc by the hour currently. See state response to question # 105.
275. In what ways does the State of TN see the wellness vendor integrating with its current on-site clinic(s)? What levels of cross vendor integration exist now between Healthways and the on-site clinic?	The onsite clinic provides space for the coaches to meet face to face with members and also provides referrals when appropriate.
276. Does the State of TN wish to implement on-site health specialists/coaches at additional large worksite locations to perform wellness coaching, wellness advocacy, seminars, wellness activities, etc.? If so: • How many work sites would the on-site resources be staffed at? • How many employees work at each of these specified work site locations? • What are the physical addresses of the specified work sites? • What role(s) does the State of TN see these on-site resources performing? (Wellness coaching, Disease Management, Culture of Health, etc.)	No. The State is not interested in implementing onsite programs at additional locations at this time.
277. What support/backup is provided by the on-site clinic for the on-site coaching and on-site Disease Management?	Other than referrals, there is no additional support.
278. What are the hours now for on-site coaching and on-site Disease Management? Is there a commitment in terms of a base amount of hours? Is a single coach on site, or is the role staffed	There are two on-site coaches. One for LM and one for DM. They are at the clinic only when they have a scheduled appt.

with multiple people?	
279. Does Heathways have a current data sharing arrangement or referral pathway for the on-site Disease Management coaching capability?	There is no data sharing arrangement with the clinic but the clinic staff does make referrals.
280. Do the practitioners in the on-site clinic make referrals to the on-site coaching staff? Do the on-site coaches share any data on outcomes with the practitioners in the clinic? Do the in-site coaches take a predictive model work cue or is the on-site coaching program inbound only?	See state response to question #279. The coaching program is inbound only.
281. Does the clinic follow a Lifestyle medicine practice?	The Health Center does focus on the whole person with an emphasis on prevention. However, the Center does not function as a primary care office or medical home.
282. Would the State consider on-site coaching staff who also perform coaching via other modalities other than in-person (such as telephonic)?	Yes. If the vendor provides the appropriate resources for the coach to do so.
283. Please describe your current Disease Management offering in greater detail. • What is the prevalence rate by disease state? • Please provide the current ROI attained as well as a list of clinical care and utilization improvement statistics. • Please provide additional insight into what is working well and what you would like to see improved.	The current disease management program is the same as what is being proposed in this RFP. The program covers asthma, diabetes, COPD, CHF and CAD. The most recent prevalence rate based on Healthways risk stratification is as follows: Asthma – 836 medium risk and 836 high risk Diabetes – 19,614 medium risk and 518 high risk COPD – 179 medium risk and 136 high risk CAD – 5,222 medium risk and 1,645 high risk CHF – 1,138 medium risk and 742 high risk The most recent ROI report available was from 2015 and was 5:1. We do not have clinical care and utilization improvement statistics available that are specific to disease management. We have had positive results with the current program. The main issue we have is that everyone had to participate in disease management, even if well maintained. We heard some negative member feedback about that requirement and made the decision to narrow the focus of the program to include outreach to those with moderate to high risk.

284. Please describe your current wellness offering in further detail. • How many educational forums (ex. lunch and learns) do you hold each year and at how many locations? • What percent of members complete the Health Assessment each year? • Of members that complete a Health Assessment, what percent participate in lifestyle modification programs? What lifestyle modification programs are offered today? • What percent of members are outreached to by a Health Coach for telephonic counseling, and what percent perform their lifestyle modification programs on line? • What results have been achieved with current wellness programs, such as risk reduction improvement and improvements in lifestyle modifications? Please provide the actual results.	• Lunch and Learns are currently only held in the ParTNers Health and Wellness Center on a quarterly basis. • Health Assessment Completion - 2015: 92% (109,372, 2016: 93% (104,520) and 2017: 91% (106,256) • We are unable to provide the exact percentage of those who coach that complete the assessment. At a minimum Healthways provides tobacco cessation, nutrition, stress, and exercise coaching. • In previous years, of those deemed "at risk" based on Healthways risk stratification which is three or more risks were outreached to for lifestyle counseling. This is specific only to those enrolled in a Partnership Promise plan and outreached to telephonically. There are currently no online lifestyle programs. • The most recent LM ROI showed a 1:1.2 ROI
285. This Section of the Pro Forma contracts grants the State a license to use all software provided under the contract in the course of the State's business and purposes. In light of the fact that we do not feel that this is a contract for "software" per se, and the license language is written quite broadly, will the State consider limiting the scope of the license to providing its eligible population health and wellness or weight management participants with the ability to access and use the subcontractor's online portal/platform and materials during the term of the contract?	No. Participants/Plan members do not need a software license to access a website and check on their individual programs. The license granted to the State under this section gives Department of Finance and Administration, Division of Benefits Administration access to the Contractor's software platform and services.
286. On page 131 liquidated damages, Regarding the Call Center specific question #10 Average Speed of Answer – Need to maintain 30 second ASA monthly with $1000 damages owed for each month this is not attained. Will the state have their own phone line so that we can capture this for them? Would the state be providing cards to help meet this goal?	Contract section A.11.a.1. states: "The Contractor is responsible for operating a Member services call center to provide customer service to members. The Contractor shall obtain a new, or transfer from the current vendor an existing, dedicated toll-free telephone number for the Member services call center." The Contractor is expected to capture and report these statistics from this dedicated phone number.

	The State understands that the reference to 'cards' was submitted in error. Therefore, the State is not providing a response.
287. Is the state open to considering alternative Performance Guarantees in place of the one's outlined in the RFP?	No. Those alternative suggestions should have been submitted during this questions and comments period.
288. Contract Attachment C - #13 can you clarify what information you are looking for in this report? Are you asking by member what outcomes were achieved and which ones were not?	This report is specific to the outcome measures outlined in the contract in C.3.h. and i. See Amendment Section #23 below.
289. Contract Attachment D **RFP PAGE 138** - 1. Definitions - Would the State reconsider the definitions section? Our preferred approach is to remove references to non-HIPAA laws and rely on a general "compliance with applicable law" provision, if one exists in the underlying Master Services Agreement. As such, the definitions of "Information Holder" and "Personal Information" would be removed. We would propose language the following language: *Other Confidentiality Laws. The parties acknowledge that this BA Agreement is intended to supplement other federal and state laws and regulations that impose obligations to maintain the confidentiality and security of Individually identifiable personal information. To the extent not preempted by HIPAA, the parties acknowledge their obligation to comply, where applicable, with all such laws and regulations, including, without limitation, breach notification laws and laws requiring the safeguarding of such information.*	Yes. The State has updated the definitions. See Amendment Section #24 below.

290. Contract Attachment D RFP PAGES 139 and 141 - 2.4 and 3.3 - Would the State be willing to consider changing this section? Because of the variability of customer BAAs, Respondent has difficulty agreeing to apply downstream the exact provisions of any particular BAA. Respondent uses its own standard form of subcontractor BAA and finds agreeing to replicate multiple customer provisions in the standard form challenging to say the least.	Yes. The State has modified the language. See Amendment Section #25 below.
291. Contract Attachment D RFP PAGE 139 - 2.7.1- Would the State be willing to revise the deadline from "immediately" to our "10 calendar days" provision with other state clients?	The State does not agree to this revision. The State has modified the language. See Amendment Section #19 below.
292. Contract Attachment D **RFP PAGE 140** - 2.8 - Would the State consider a minor edit to this section as Respondent fulfills requests to access PHI by responding directly to the Individual, versus the covered entity.	The State will agree to this revision. See Amendment Section #25 below.
293. Contract Attachment D RFP PAGE 140 - 2.12- Similar to 2.8, would the State consider a minor edit as Respondent fulfills requests for accounting of disclosures by responding directly to the Individual.	The State does not agree to this revision.
294. Contract Attachment D RFP PAGE 140 - 2.15- Similar to above, we propose eliminating this section because Respondent fulfills requests to access PHI by responding directly to the Individual.	The State does not agree to this revision. It states that PHI will be released to individual and that BA will notify covered entity.
295. Contract Attachment D **RFP PAGE 143** - 4.8 – After section 4.8, Respondent would propose adding a new section, 4.9. Respondent needs the right to use and disclose de-identified PHI for purposes of performing Population Health Management services. We propose to add this language: *The provisions of this Agreement notwithstanding, Business Associate is permitted to de-identify PHI, provided that it does so in accordance with HIPAA*	The State agrees to a new section but has modified the language slightly. See Amendment Section #26 below.

de-identification rules. De-identified information does not constitute PHI, and may be used and disclosed by Business Associate for its own purposes, including, without limitation, for purposes of developing comparative databases, performing statistical analysis and research, and improving the quality of Business Associate's products and services.	
296. Contract Attachment D RFP PAGE 143 - 6.1 - Respondent would like to add this closing sentence for added clarity: "except that Business Associate may use PHI in its possession (i) for Business Associate's proper management and administrative services, or (ii) to provide Data Aggregation services to the Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B)."	The State does not agree to this revision. This has been documented in RFP Section 4.4
297. Contract Attachment D RFP PAGE 144 - 7.3.2 – Respondent proposes deletion of this sentence – "Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of PHI is unfeasible." Respondent proposes this change because operationally we cannot support this notice and approval requirement. Without exception, Respondent must retain PHI after termination. Respondent follows its own records retention rules so it is more efficient for the parties to stipulate to that fact in the BAA, rather than provide for an unnecessary end-of-contract process.	The State agrees with this revision. See Amendment Section #27 below.

298. Contract Attachment D RFP PAGE 145 - 8.8 – Respondent proposes editing this section to read: Governing Law. This Agreement shall be governed by and construed in accordance with the governing law provisions of the Service Contract, subject to applicable federal law. Respondent proposes this change since this is an agreement that is mandated by federal law and implements the requirements of a federal law, provisions for state law governance are somewhat irrelevant. However, to whatever small extent state law may come into play in litigation, we want the same state law as that of the services agreement to apply.	The State does not agree to this revision.
299. Contract Attachment D RFP PAGE 145 - 8.9 - After section 8.9, Respondent would propose adding a new section, 8.10 Counter Signature with the following language: This Agreement may be executed in several counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. In addition, this Agreement may contain more than one counterpart of the signature page and this Agreement may be executed by the affixing of the signatures of Business Associate and Covered Entity, or Plan Sponsor on behalf of Covered Entity, to one of such counterpart signature pages. All of those counterpart signature pages shall be read as though one, and they shall have the same force and effect as though all of the signers had signed a single signature page. Respondent proposes this language because we require countersignature language in order to make the signature process more efficient for both parties.	The State does not agree to this revision.

300. Regarding the Digital Acknowledgment of Enrollment Update language, specific to the requirements surrounding 834 file formatting, please confirm that the state is looking for a point to point transaction based file processing system with digital acknowledgements with error mitigation per transaction. Does the State of TN have any specific requirement regarding "digital acknowledgement"? Does an Email Acknowledgement to a State distribution list satisfy this requirement?	We do not require that type of response from our vendors. The only response requirements are covered in the section that addresses the weekly file statistics and error reports.
301. Regarding the requirements surrounding 834 file formatting, please confirm that the state is looking for a point to point transaction based file processing system with digital acknowledgements with error mitigation per transaction.	See response to question #300.
302. Pertaining to the following comment: The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of reports that cannot be generated using the Contractor's standard reporting package. The Contractor shall deliver such reports to the State within five (5) business days of the State's request. If requested by the State, the Contractor shall deliver up to five (5) reports annually deemed as "urgent" by the State within two business days. All ad-hoc reports shall be provided at no additional cost to the State. How often is the state requesting ad hoc reporting from the current vendor?	See response to question #218.
303. RFP PAGE 125 - At the end of the Pro Forma Contract, Respondent would propose adding the following provisions from Respondent's standard agreement to better reflect the services Respondent provides regarding our Population Health Management program: "[XX] State Acknowledgments. Notwithstanding any provision of the Contract to the contrary, the State acknowledges and agrees that: (i) in undertaking and performing the services and providing goods under the	The State does not agree to this revision.

Contract, Contractor is acting solely as an administrative services provider and does not purport to be engaged in the practice of medicine or any other professional clinical activity, and that the work product generated by such Services consists solely of information to be evaluated by medical or other health care professionals in the exercise of their independent professional judgment; (ii) in undertaking and performing the services and providing goods under the Contract, Contractor assumes no responsibility or liability for the accuracy, completeness, propriety, necessity or advisability of the medical information which is provided to Contractor, or of the medical services to which such information may relate; (iii) notwithstanding any provision of this Contract to the contrary, neither Contractor nor any Contractor employee, affiliate, subsidiary, contractor, representative or consulting physician shall have any responsibility of any kind to the State, State health benefit plan members ("Covered Persons") or any other person, firm, corporation or entity, for any of the following in connection with the services or goods provided by Contractor: (x) payment of health benefits plan benefits; or (y) diagnosis, treatment, or medical procedures or prescriptions for or with respect to any patient or other provision of direct health care services; (iv) authority for benefit determinations shall remain as set forth in the health benefits plan. The performance by Contractor of the services or provision of goods hereunder shall not give rise to any implication that Contractor is making any such determination or verification of any individual's entitlement to group medical/health plan coverage or insurance reimbursement, providing medical care, or otherwise assuming any responsibility for the scope or quality of medical care afforded to individual Covered Persons by their respective physicians or other health care providers, whether or not benefits are available for such care; (v) except as mutually agreed otherwise by the parties in writing, Contractor shall apply its	

applicable standard clinical policies and definitions (including, but not limited to, medical necessity and experimental/investigational) in the performance of the services and provision of goods; and (vi) notwithstanding any provision of this Contract to the contrary, in no event shall Contractor have any responsibility or liability to pay any covered or non-covered benefit claim of any Covered Person." [YY] Certain State Responsibilities: • PROVISION OF ELIGIBILITY AND ENROLLMENT DATA AND INFORMATION TO CONTRACTOR. The State shall provide to Contractor, or cause to be provided to Contractor, an electronic file of Covered Persons who shall receive the services or goods under a health benefits plan and this Contract, along with such information as is required to enable Contractor to verify the identity of Covered Persons (including, enrollment or Social Security number, address and phone number). The State shall, on a monthly basis, notify Contractor of any additions, changes, deletions or modifications to the list of Covered Persons on an agreed-upon schedule. Contractor shall be entitled to rely on the accuracy and completeness of the enrollment and eligibility data in providing the Services. If the State provides Contractor with information on additions, deletions or modifications to the list of Covered Persons at other times during the month, Contractor shall endeavor to implement such updated information in performing the services or providing goods as soon as is practical. Contractor shall not be responsible in any manner for any delay, error or inability of Contractor to perform the services or provide goods in accordance with this Contract that is caused by the State's failure to provide, or cause to be provided to Contractor, accurate eligibility information. • PROVISION OF OTHER DATA AND INFORMATION TO CONTRACTOR. The State shall, at no cost to Contractor, provide or arrange for Contractor to have access to all	

relevant medical records, lab and pharmacy data, claim information, eligibility, address, phone number, and other information pertaining to Covered Persons required for the performance by Contractor of its duties under this Contract, and to have all such information provided in the proper format required for the performance by Contractor of its duties under this Contract. Contractor shall be entitled to rely on the accuracy and completeness of such data in performing the services or providing goods. Contractor shall not be responsible in any manner for any delay, error or inability of Contractor to perform the services or provide goods in accordance with this Contract that is caused by the State's failure to provide, or cause to be provided to Contractor the information required by this Section. • THIRD PARTY CONSENTS AND AUTHORIZATIONS. The State shall, at no cost to Contractor, ensure that Contractor obtains from Covered Persons and any other relevant third parties, any consents, authorizations or other permissions which may be required under law or regulation or otherwise necessary or appropriate in order for Contractor to have access to the information and data referred to in this Contract and for Contractor to perform any of the services or provide the goods hereunder. Contractor shall not be responsible in any manner for the State's failure to obtain, or cause to be obtained, the consents or authorizations required by this Section. • STATE COOPERATION. The State shall cooperate fully with Contractor in implementing and fulfilling its obligations under this Contract, including but not limited to communicating with Covered Persons in order to inform such persons of Contractor's role in performing the services or providing goods hereunder and of the communications that Contractor will furnish in connection with such services. • NOTICE OF BENEFIT CHANGE. The State shall notify Contractor in writing of any proposed changes in health benefits plan documents or health benefits plan benefits that could impact the delivery of, cost to administer	

or scope of services or goods, or the number of Covered Persons who may be eligible for or seek the services or receive goods, at least thirty (60) days prior to the proposed effective date of such changes. Contractor shall have thirty (30) days following receipt of such notice to inform the State whether the changes will result in a modification of the services or goods, or an adjustment to the fees payable by the State or any other term or condition of the Contract. If the parties are unable to reach agreement on an amendment to this Contract regarding such modifications within thirty (30) days, either party shall have the right to terminate this Contract immediately upon written notice to the other party. • FIDUCIARY DUTY. It is understood and agreed that the State retains complete authority and responsibility for the health benefit plans, their operation, and the benefits provided thereunder, and that Contractor is empowered to act on behalf of the State in connection with such plans only to the extent expressly stated in this Contract or as agreed to in writing by Contractor and the State. The State has the sole and complete authority to determine eligibility of persons to participate in the health benefits plans. It is also agreed that Contractor's responsibilities under the Contract are ministerial and that has no other fiduciary responsibility under the health benefit plans."	

3. **Delete Pro Forma Contract section A.10.b (Attachment 6.6.a) and A.7.b (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

   During normal business hours, the Contractor may use a "designated" call unit (as opposed to a "dedicated" call center) provided that the unit could meet all call center standards defined in this Contract.

4. **Delete RFP section Pro Forma Contract Section A.11.d(8) (Attachment 6.6.a) and A.8.d(8) (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

   The Contractor shall inform callers of their likely wait times (based on real-time information, including call volume and Member services representative/nurse availability) as they enter the queue. The Contractor may also provide a "dial back" option that allows callers to receive a call back from the next available Member services representative without losing their place in the

queue. Note that calls receiving a call back pursuant to this provision are not counted as "abandoned."

5. **Delete RFP section Attachment 6.3 Cost Proposal Table A (Primary Population Health and Wellness and Weight Management) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

Table A – Primary Population Health and Wellness Program

Services	Fees					State Use Only		
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Sum	Evaluation Factor	Evaluation Cost (sum x factor)
General Fee[1]	$PEPM	$PEPM	$PEPM	$PEPM	$PEPM		62,000	
Disease Management (Tiered pricing based on risk level and intensity of interventions)[2]								
Chronic obstructive pulmonary disease (COPD) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		50	
Chronic obstructive pulmonary disease (COPD) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		60	
Coronary artery disease (CAD) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		150	
Coronary artery disease (CAD) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		1000	
Asthma – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		85	
Asthma – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		45	
Diabetes – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		200	

Services	Fees					State Use Only		
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Sum	Evaluation Factor	Evaluation Cost (sum x factor)
Diabetes – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		8000	
Congestive Heart Failure (CHF) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		135	
Congestive Heart Failure (CHF) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		115	
Lifestyle Counseling (to include at a minimum tobacco cessation, high cholesterol, hypertension, stress management, sleep, nutrition and exercise)	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]		4750	
Biometric Screenings								
Onsite/employment site health screenings (> 50 participants per location – all-inclusive fee)	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening		14,700	
At-home screening kits	$Per kit	$Per kit	$Per kit	$Per kit	$Per kit		20	
Provider Form	$Per returned form	$Per returned form	$Per returned form	$Per returned form	$Per returned form		27,300	
Onsite Coaching Staff for Employee Clinic								
Lifestyle Counseling	$Per hour	$Per hour	$Per hour	$Per hour	$Per hour		20	
Lifestyle Counseling	$Per day	$Per day	$Per day	$Per day	$Per day		20	
Disease Management Coaching	$Per hour	$Per hour	$Per hour	$Per hour	$Per hour		20	
Disease Management Coaching	$Per day	$Per day	$Per day	$Per day	$Per day		20	
Seasonal wellness challenges								

Services	Fees					State Use Only		
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Sum	Evaluation Factor	Evaluation Cost (sum x factor)
Fees to include program delivery and materials – i.e. pedometer for step program	$ Per participant	$ Per participant	$ Per participant	$ Per participant	$ Per participant		6,000	

[1] Only members and spouses of the state health plan will have access to these services. As of February 2017 membership in this plan is approximately 145,000 total members (68,500 unique heads of contract). The general fee is a per employee per month (PEPM) fee for all residual services and deliverables required under the terms of this Contract and which are not specifically and separately identified elsewhere in the table. Such services include, but are not limited to, the online health questionnaire, online population health and wellness programs, implementation fee website/portal, incentive tracking tool, general member services, member education and outreach, quality assurance, coordination and collaboration, administrative services, communications, reporting, and information systems.

[2] Only members and spouses shall be contacted about disease management. Dependent children between the ages of 18 and 26 may enroll at their own request.

[3] An "engaged" participant is one whom the Contractor can document a minimum of one (1) completed interactive contact with (meaning the member was responsive to the Contractor's outreach) during the month in order to be paid for that month as defined in Sections A.8.e.(1) for lifestyle counseling, and/or disease management. Engagement is not a series of outbound attempts by the Contractor, regardless of method of outreach, where there is no documented member response.

EVALUATION COST AMOUNT (sum of evaluation costs above)**:**

The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.

lowest evaluation cost amount from all proposals / **evaluation cost amount being evaluated** **x 40 (maximum section score)** **= SCORE:**

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

Table A – Weight Management Program

Services	Fees					State Use Only		
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Sum	Evaluation Factor	Evaluation Cost (sum x factor)
One time Implementation Fee*	$One time implementation fee	n/a	n/a	n/a	n/a		1,000	
Weight management program fee without Bluetooth scale**	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member		10,000	

Weight management program fee with Bluetooth scale***	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member		10,000	

*The implementation fee will be a one-time payment to be billed during the first month of the contract.

**The State will pay the Contractor 1/3 of the total fee when a member enrolls, another 1/3 when members complete at least 50% of sessions/classes, and the final 1/3 payment will be made when the Contractor demonstrates that the member achieved a total weight loss of at least 5%.

***The State will decide, based on cost, if providing a Bluetooth scale will be implemented as part of the program.

EVALUATION COST AMOUNT (sum of evaluation costs above)**:** The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.	
lowest evaluation cost amount from all proposals / **evaluation cost amount being evaluated** **x 45 (maximum section score)** **= SCORE:**	

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

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

   a. The Contractor shall be compensated based upon the following payment methodology:

Services	Fees				
	CY 2018	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**
General Fee[1]	$PEPM	$PEPM	$PEPM	$PEPM	$PEPM
Disease Management (Tiered pricing based on risk level and intensity of interventions)[2]					
Chronic obstructive pulmonary disease (COPD) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Chronic obstructive pulmonary disease (COPD) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]

Services	Fees				
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Coronary artery disease (CAD) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Coronary artery disease (CAD) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Asthma – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Asthma – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Diabetes – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Diabetes – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Congestive Heart Failure (CHF) – High Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Congestive Heart Failure (CHF) – Moderate Risk	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Lifestyle Counseling (to include at a minimum tobacco cessation, stress management, sleep nutrition and exercise)	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]	$Per engaged participant per month[3]
Onsite/employment site health screenings (> 50 participants per location – all-inclusive fee)	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening	$Per individual onsite screening
At-home screening kits	$Per kit	$Per kit	$Per kit	$Per kit	$Per kit
Provider Form	$Per returned form	$Per returned form	$Per returned form	$Per returned form	$Per returned form
Lifestyle Counseling in State Employee Clinic	$Per hour	$Per hour	$Per hour	$Per hour	$Per hour

Services	Fees				
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Lifestyle Counseling in State Employee Clinic	$Per day	$Per day	$Per day	$Per day	$Per day
Disease Management Coaching in State Employee Clinic	$Per hour	$Per hour	$Per hour	$Per hour	$Per hour
Disease Management Coaching in Employee Clinic	$Per day	$Per day	$Per day	$Per day	$Per day
Seasonal Wellness Challenges	$Per Participant	$Per Participant	$Per Participant	$Per Participant	$Per Participant

[1] Only members and spouses of the state health plan will have access to these services. As of February 2017 membership in this plan is approximately 145,000 total members (68,500 unique heads of contract). The general fee is a per employee per month (PEPM) fee for all residual services and deliverables required under the terms of this Contract and which are not specifically and separately identified elsewhere in the table. Such services include, but are not limited to, the online health questionnaire, online population health and wellness programs, implementation fee, website/portal, incentive tracking tool, general member services, member education and outreach, quality assurance, coordination and collaboration, administrative services, communications, reporting, and information systems.

[2] Only members and spouses shall be contacted about disease management. Dependent children between the ages of 18 and 26 may enroll at their own request.

[3] An "engaged" participant is one whom the Contractor can document a minimum of one (1) completed interactive contact with (meaning the member was responsive to the Contractor's outreach) during the month in order to be paid for that month as defined in Sections A.8.e.(1) for lifestyle counseling, and/or disease management. Engagement is not a series of outbound attempts by the Contractor, regardless of method of outreach, where there is no documented member response.

7. **Delete RFP section 1.1 Statement of Procurement Purpose regarding local education and local government agencies (page 5)** (any sentence or paragraph containing revised or new text is highlighted)**:**

> However, Local Education and Local Government Plan agencies shall have the ability to enter into a separate contract with the Contractor for population health management services utilizing the payment rates outlined within this contract.

8. **Delete Pro Forma Contract section A.1.b (Attachment 6.6.a and 6.6.b)in its entirety** (any sentence or paragraph containing revised or new text is highlighted)**:**

9. **Delete Pro Forma Contract section A.18.n. (Attachment 6.6.a) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

As prior approved in writing by the State (see Contract Section D.7), the Contractor may subcontract for some of the requirements of this Contract. However, the Contractor may not subcontract more than three (3) of the core functions provided by this contract. Core functions include the website, data management, health screenings, weight management (if applicable), and health questionnaire. Lifestyle counseling and DM cannot be subcontracted. If the Contractor subcontracts for any of the requirements of this Contract, the Contractor shall implement monitoring processes to ensure compliance with requirements stated herein. These monitoring processes should be provided to the State for review.

10. **Delete RFP Attachment 6.2 section C.17 – Primary Population Health and Wellness Programs and C.13 Weight Management in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

C.17.	**Staffing** Regarding staffing for your programs, please describe: a. The proposed staffing model for your programs b. Your book of business most recent annual turnover rate for clinical staff and call center staff c. The coach to member ratios you will use d. The average and maximum caseload for each disease management nurse and health coach e. The training and experience of coaches using alternative methods of interaction such as text or email f. How you monitor quality of coaching interactions with members

C.13.	**Staffing** Regarding staffing for your programs, please describe: a. The proposed staffing model for your programs. b. The qualifications, experience and expertise of the staff delivering the weight management program. c. Your most recent annual turnover rate for staff delivering the prorgram. d. The coach to member ratios you will use. e. How staff are trained to successfully engage in alternative methods of interaction such as text or email. f. How you monitor quality of coaching interactions with members

11. **Delete RFP section 3.2.2.1 in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

3.2.2.1. One (1) original Technical Response paper document labeled:

"RFP #31786-00135 TECHNICAL RESPONSE ORIGINAL - Primary Population Health and Wellness Programs

and seven (7) digital copies of the Technical Response – Primary Population Health and Wellness Programs each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard CD-R recordable disc or USB flash drive labeled:

"RFP #31786-00135 TECHNICAL RESPONSE COPY – PRIMARY POPULATION HEATH AND WELLNESS PROGRAMS"

and seven (7) digital copies of the Technical Response – Weight Management Program each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard CD-R recordable disc or USB flash drive labeled:

"RFP #31786-00135 TECHNICAL RESPONSE ORIGINAL – Weight Management Program

and seven (7) digital copies of the Technical Response – Weight Management Program each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard CD-R recordable disc or USB flash drive labeled:

"RFP #31786-00135 TECHNICAL RESPONSE COPY – WEIGHT MANAGEMENT PROGRAM"

The digital copies should not include copies of sealed customer references, however any other discrepancy between the paper Technical Response document and any digital copies may result in the State rejecting the proposal as non-responsive.

12. **Delete Pro Forma section A.5.n (Attachment 6.6.a) and A.3.j. (Attachment 6.6.b) in its entirety.**

13. **Delete Pro Forma section A.4.b. (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    The program must be a minimum of six months in length and provide, at a minimum, weekly activities and interaction between the program and the Member as well as collect the member's weight on a regular basis. At the request of the State, the member's weight must be captured via a scale with Bluetooth capability which is provided to the Member at no charge from the Contractor.

14. **Delete Pro Forma section C.3.b (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    The Contractor shall be compensated based upon the following payment methodology:

Services	**Fees**				
	CY 2018	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**
Implementation Fee*	$One time implementation fee	N/A	N/A	N/A	N/A
Weight management program fee without Bluetooth scale**	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member

Weight management program fee with Bluetooth scale***	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member	$Per enrolled member

* The Implementation fee will be a one-time payment to be billed during the first month of the contract.

**The state will pay the vendor 1/3 of the total fee when a Member enrolls, another 1/3 when Member completes at least 50% of sessions/classes, and the final 1/3 payment will be made when the Contractor demonstrates that the Member achieved a total weight loss of at least 5%.

***The State will decide, based on cost, if providing a Bluetooth scale will be implemented as part of the program.

15. **Delete Pro Form Contract Attachment B #10 (Attachment 6.6.a) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

10. **Average Speed of Answer**	
Guarantee	The Contractor's call center shall maintain a monthly average speed of answer (ASA) of thirty (30) seconds or less, as required in Contract Section A.11.c(1)i. The Contractor shall calculate the number of instances during each day during which a caller's time-to-answer exceeds this threshold (based on Contractor's internal telephone support system reports) compared to the total number of calls per day.
Liquidated Damages	One thousand dollars ($1,000) for each calendar month that the average speed of answer exceeds the threshold above.
Measurement	Measured and reported on a weekly basis by the Contractor from January 2, 2018 through July 3, 2018. Thereafter, measured and reported monthly by the Contractor. Reconciliation shall be quarterly by the State and quarterly assessment paid annually by the Contractor.

16. **Delete Pro Forma Contract section A.20.i.(3) (Attachment 6.6.a) and A.16.i.(3) (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    The Contractor shall provide within three (3) business days turnaround or better on requests for access to information. Such requests for information shall be made by the State or its authorized designee. This section does not impact the requirements and timelines regarding auditing and the HIPAA Business Associate Agreement (Contract Attachment D).

17. **Delete Pro Forma Contract section A.22 (Attachment 6.6.a) and A.18 (Attachment 6.6.b) in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    A. 22. Privacy and Confidentiality

    The following privacy and confidentiality standards apply to all forms of assistance that the Contractor provides.

    a. The Contractor shall meet all of the requirements; follow all standards; procedures; and penalties listed in the HIPAA Business Associate Agreement (Contract Attachment D), specifically Section 2 and 3: Obligations & Activities of Business Associate.

b. The Contractor shall not sell Public Sector Plan Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis.

c. The Contractor shall not use Public Sector Plan Member identified, aggregated or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

d. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with, or violation of, federal or state requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments.

e. The Contractor shall assure that all Contractor staff is trained in all HIPAA requirements, as applicable.

f. At the request of the State, the Contractor shall offer credit protection, at no cost to the State or the Member, for those times in which a Member's personal information is accidentally or inappropriately disclosed (See Section E.9).

18. Delete Pro Forma Contract section A.25 (Attachment 6.6.a) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

A. 25. Due Dates for Deliverables /Milestones

Unless otherwise specified in writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

Deliverables/Milestones		Contract Reference(s)	Deliverable Due Dates & Milestone Target Dates
Implementation			
1.	Programs, service, and information systems are fully operational	A.2.a	December 15, 2017
2.	Go-live	A.2.a.	January 1, 2018
3.	Kick-off meeting for all key Contractor staff	A.2.d	Within the first 21 days after Contract effective date
4.	Implementation plan	A.2.e	30 days after Contract start date (on or before)
5.	State readiness review	A.2.g	December 1, 2017 (on or before)
6.	Bi-weekly Status Meetings	A.2.j	Contract start date through February 15, 2018
7.	Implementation Performance Assessment	A.2.k	No later than 45 days post-implementation

	Deliverables/Milestones	Contract Reference(s)	Deliverable Due Dates & Milestone Target Dates
	Biometric Screening		
8.	Screening Protocol	A.3.a.	By go Live (January 1, 2018)
9.	Workplace Screening Schedule	A.3.e.(4)	February 1, 2018
10.	Biometric Screening One-Page Summary for Workplace Screening (final)	A.3.e. (11)	February 15, 2018
11.	Biometric Screening Completion Report	A.3.h and Attachment C	Monthly after go-live
12.	Biometric Screening Summary Report	A.3.h and Attachment C	Quarterly after go-live
	Health Questionnaires		
13.	Health Questionnaire (final)	A.4.f.	November 30, 2017
14.	Health Questionnaire Available on Member Website/portal	A.14.k.(6)	January 1, 2018
15.	Health Questionnaire Completion Report	A.4.i. and Attachment C	Monthly after go-live
16.	Health Questionnaire Summary Report	A.4.i. and Attachment C	Quarterly after go-live
	Identification, Outreach and Engagement		
17.	Review with State risk stratification/methodology for all programs	A.8.a.(3)	November 17, 2017
18.	Program Participation Report	A.8.f and Attachment C	Monthly after go-live
	Incentive Administration, Alternative Standards and Appeals		
19.	Incentive Detail and HSA Files	A.9.c, A.21.e and Attachment C	Monthly after go-live
20.	Description of Member Appeals Process and Procedures and Sample Decision Letter	A. 9.d (3)	December 1, 2017
21.	Appeals Report	A.9.d (6) and Attachment C	Monthly after go-live
	Member Services		
22.	Adherence to Customer Satisfaction Standards Report	A.10.e and Attachment C	Monthly after go-live
23.	Member Inquiries	A. 10. f. and Attachment C	Quarterly after go-live
24.	Member Services Call Center open	A.11.a. (5)	December 15, 2017
25.	Call Center Statistics and Summary Report	A.11.c.(2), Attachment B,	Monthly starting January 1, 2018

Deliverables/Milestones		Contract Reference(s)	Deliverable Due Dates & Milestone Target Dates
		and Attachment C	
	Member Complaints		
26.	Description of Member Complaints Process and Procedures and Sample Determination Letter	A.12.a (3)	December 1, 2017
27.	Quarterly Complaints Reports	A.12.a.(4) and Attachment C	Quarterly after go-live
	Member Communication/Materials		
28.	Annual Mailer (Welcome Mailer)	A.13.c.	Annually no later than the first week of January each year
29.	Materials for Annual Enrollment Period	A.13.f.	Annually three (3) months before the annual enrollment period (on or before)
30.	Annual Communication Plan	A.13.h., i.	November 1, 2017 and October 1 of each year thereafter
	Member Website/Portal		
31.	Website/Portal/Splash Page go-live	A.14.c	December 15, 2017 (on or before)
32.	State Review of Website and all Materials on Website	A.14.f	November 15, 2017 (on or before)
	Quality Assurance Program		
33.	Health Screening Exit Survey Report	A.16.g and Attachment C	Monthly after go-live and during the health screening survey periods.
34.	Program Satisfaction Survey tool and methodology	A.16.h	January 15, 2018
35.	Program Satisfaction Report	A.16.h and Attachment C	90 days after the end of the calendar year. First report due Q1 2019
36.	Accreditation Schedule (if not accredited)	A.16.i	December 1, 2017
37.	Quality Assurance Program	A.16.j	December 1, 2017
	Coordination and Collaboration		
38.	Transmission of Electronic Files to Other Vendors of Members Enrolled in LM or DM	A.17.b, A.21.d and Attachment C	Date TBD by State
39.	Monthly Operational Meetings	A.17.d.(1)	Monthly after go-live
40.	Quarterly meetings with the State	A.17.d. (2)	Quarterly after go-live
41.	Seminars	A.17.d.(3)	Date TBD by State

Deliverables/Milestones		Contract Reference(s)	Deliverable Due Dates & Milestone Target Dates
42.	State-Sponsored Vendor Summit	A.17.d.(4)	Date TBD by State
43.	Conference calls (Grand Rounds) with the medical TPAs, PBM, and EAP/BHO	A.17.d.(5)	Date TBD by State
44.	Monthly Calls with ABCs and/or Site Champions	A.17.d.(6)	Monthly after go-live
	Staffing		
45.	Account Team Satisfaction Survey	A.19.h	Annually in January beginning in 2019
46.	Account Team Satisfaction Survey Report	A.19.h and Attachment C	90 days after the end of the calendar year. First report due in Q1 of 2019.
	Information Systems		
47.	BC-DR Test Results	A.20.l.(4)	December 1, 2017
48.	Business Continuity/Disaster Recovery (BC-DR) Results Report	A. 20.l.(5) and Attachment C	December 1, 2017 and then annually beginning in 2018
49.	Duplicate set of data records	A.20.n.(8)	On or before the date of contract termination.
50.	A written copy of its most current FedRamp, ISO 27000 or SOC2 Type 2 report	A.20.n.(6)	December 1, 2017
51.	The Contractor shall also provide, at the request of the State, a FedRamp, ISO 27000 or SOC2 Type 2 report as applicable for any subcontractor.	A.20.n.(6)	December 1, 2017
	Data Integration & Technical Requirements		
52.	Completion of eligibility file testing	A.21.c	45 days prior to go live
53.	Edison System Interface/Eligibility file acceptance	A.21.c	December 1, 2017 (on or before)
54.	Weekly enrollment update	A.21.f.(1)	Weekly after December 1, 2017
55.	Weekly File Transmission Statistics Report	A.21.f.(2) and Attachment C	Within five (5) business days of receipt of the Weekly Enrollment Update
56.	State enrollment data match	A.21.f.(6)	Up to four (4) times annually, as requested by the State
57.	Completion of testing files from other vendors	A.21.d,k	December 1, 2017 (on or before)
58.	Interface with other vendors/file acceptance	A.21.d,k	December 15, 2017
59.	Data transmission to DSS vendor	A.21.l	Testing two months prior to go live and data delivery 15 days following the end of each calendar month
60.	Data transmission to third parties	A.21.d, k, p	As described in A.21., unless otherwise directed by the State

Deliverables/Milestones		Contract Reference(s)	Deliverable Due Dates & Milestone Target Dates
61.	Transmission of data and records to State	A.21.q	Within 60 days of notice of termination
	Reporting & Systems Access		
62.	Reports specified in Contract Attachment C	A.24.a and Contract Attachment C	As specified in Contract Attachment C
63.	Reporting system access	A.24.b	February 1 2018 (on or before)
64.	State staff systems training	A.24.c	January 30, 2018 (on or before)

19. Delete Pro Forma Contract section Attachment D 2.7.1 (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Business Associate shall provide to Covered Entity notice of an Actual Breach of Unsecured PHI immediately (up to 48 hours) upon becoming aware of the Breach.

20. Delete Pro Forma Contract section Contract Attachment B #17 (Attachment 6.6.a) and #11 (Attachment 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

17. **Eligibility Posting**	
Guarantee	One hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, shall be processed within four (4) business days of receipt of the weekly file, as required in Contract Section A.21.f.
Liquidated Damages	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
Measurement	Measured and reported weekly; reconciled annually by the State.

11. **Eligibility Posting**	
Guarantee	One hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, shall be processed within four (4) business days of receipt of the weekly file, as required in Contract Section A.17.f.
Liquidated Damages	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
Measurement	Measured and reported weekly; reconciled annually by the State.

21. Delete Pro Forma Contract section Contract Attachment B #18 (Attachment 6.6.a) and #12 (Attachment 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

18. **Eligibility Discrepancies**	
Guarantee	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within one (1) business days of notification by the State or identification by the Contractor, as required in Contract Section A.21.f
Liquidated Damages	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; One thousand dollars ($1,000) per business day thereafter.
Measurement	Measured and reported quarterly; reconciled annually by the State.

12. **Eligibility Discrepancies**	
Guarantee	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within one (1) business days of notification by the State or identification by the Contractor, as required in Contract Section A.17.f.
Liquidated Damages	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; One thousand dollars ($1,000) per business day thereafter.
Measurement	Measured and reported quarterly; reconciled annually by the State.

22. Delete Pro Forma Contract section A.21.f (Attachment 6.6a.) and A.17.f (Attachment 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

f. The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Public Sector Plans.

(1) Weekly Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall, unless otherwise directed by the State, retrieve, via secure medium weekly enrollment files from the State, in the State's Edison 834 (see RFP # 31786–00135, Appendix 7.3 for the current file format), which may be revised. Files will include full population records for all members and, unless otherwise approved by the State, will be in the format of ANSI ASC X12N, Benefit Enrollment and Maintenance 834 (5010), version 005010X220A1, with several fields customized by the State.

(2) The Contractor shall complete and submit to the State a Weekly File Transmission Statistics Report within five (5) business day of receipt of the Weekly Enrollment Update. The Contractor shall submit this report via email to designated State staff. (See Contract Attachment C.)

(3) The Contractor and or its sub-contractors shall electronically process one hundred percent (100%) of electronic 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.

(4) The Contractor and or its sub-contractors shall resolve all enrollment discrepancies as identified by the State or Contractor within one (1) business day of identification.

(5) 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 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 Performance Guarantees and assessments as specified in Attachment B.

(6) State Enrollment Data Match: Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its database of State members. The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.

23. Delete Pro Forma Contract section Contract Attachment C #13 (Attachment 6.6.a) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

13. **Outcome Measures Report**, submitted annually using the template prior approved in writing by the State. The report shall, at a minimum, list each outcome measure, the expected outcome, if target was met, if not, why and proposed improvement activities if the target was not met. See Contract Section C.3.h. and i.

24. Delete Pro Forma Contract section Contract Attachment D 1 (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Electronic Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 "Genetic Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 "Marketing" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.10 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.11 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.12 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.13 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.14 "Security Incident" shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

1.15 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

1.16 Other Confidentiality Laws. The parties acknowledge that this BA Agreement is intended to supplement other federal and state laws and regulations that impose obligations to maintain the confidentiality and security of Individually identifiable personal information. To the extent not preempted by HIPAA, the parties acknowledge their obligation to comply, where applicable, with all such laws and regulations, including, without limitation, breach notification laws and laws requiring the safeguarding of such information.

25. Delete Pro Forma Contract section Contract Attachment D 2.4, 2.8, and 3.3 (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.4 Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential information, to agree, by written contract with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

2.8 If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of the Individual, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 30 business days from Covered Entity notice to provide access to, or deliver such information.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, in accordance with

164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

26. Add Pro Forma Contract section Contract Attachment D 4.9 (Attachment 6.6.a and 6.6.b) (any sentence or paragraph containing revised or new text is highlighted)**:**

4.9 Business Associate is permitted to de-identify PHI, provided that it does so in accordance with HIPAA de-identification rules. De-identified information does not constitute PHI, and may be used and disclosed by Business Associate for its own administrative purposes, including, for purposes of developing comparative databases, performing statistical analysis and research, and improving the quality of Business Associate's products and services.

27. Delete Pro Forma Contract section Contract Attachment D 7.3.2 (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

7.3.2. In the event that Business Associate determines that returning or destroying the PHI is not feasible and upon mutual agreement of the Parties that return or destruction of PHI is unfeasible, Business Associate shall extend the protections of this Memorandum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

28. Delete the first paragraph of Pro Forma Contract Attachment C (Attachment 6.6.a and 6.6.b) i and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format specified by the State, and shall be of the type and at the frequency indicated below, unless otherwise approved by the State. The State reserves the right to modify reporting requirements as deemed necessary to monitor the Public Sector Plans. The State will provide the Contractor with at least ninety (90) days notice prior to implementation of a report modification.

29. Delete Pro Forma Contract section Contract Attachment C #15 (Attachment 6.6.a) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

15. **Overall Program Satisfaction Survey Report**, submitted annually using the template prior approved in writing by the State. The report shall, at a minimum, summarize the methodology and results and identify improvement activities.

30. Delete Pro Forma Contract section A.24.b. (Attachment 6.6.a) 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 provide a mutually agreed upon mechanism for the State to access aggregate data, including, for example, program and fiscal information regarding members

served, services rendered, and the ability for said personnel to develop and retrieve reports. This requirement could be met by the provision of access to a decision support system/data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees and a maximum of five (5) State employees on or before thirty (30) days prior to the go-live date. Additional or replacement users may be added at any time at the State's request.

31. Delete Pro Forma Contract section A.24.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 provide a mutually agreed upon mechanism for the State to access aggregate data, including, for example, program and fiscal information regarding members served, services rendered, and the ability for said personnel to develop and retrieve reports. This requirement could be met by the provision of access to a decision support system/data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees and a maximum of five (5) State employees no later than thirty (30) days after to the go-live date, unless otherwise directed by the State. Additional or replacement users may be added at any time at the State's request.

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

This Contract shall be effective on September 1, 2017 ("Effective Date") and extend for a period of sixty-four (64) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

33. Add the following as RFP Appendices and renumber any subsequent sections as necessary:

Population Health RFP #31786-00135 Word Format
RFP Attachment 6.2. Cost Proposal - Primary Population Health and Wellness Program Excel Format
RFP Attachment 6.2. Cost Proposal – Weight Management Excel Format
Appendix 7.10 Biometric Screening Survey
Appendix 7.11 Physician Form sample

34. Delete Pro Forma Contract section Contract Attachment C #11 (Attachment 6.6.a) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

11. **Call Center Activity Reports**, as detailed in Contract Section A.11.c, submitted weekly, then monthly.
    - Average Speed of Answer – statistics to support an average speed of answer (ASA) of thirty (30) seconds or less during each month.
    - First Call Resolution – statistics to support a monthly average rate of eighty-five (85%) for first call resolution.
    - Telephone Service Factor (TSF) - percentage of incoming telephone calls answered within 20 seconds.
    - Open call/inquiry closure rate – percentage of Member calls/inquiries resolved within five (5) business days.

35. Delete RFP Attachment 6.2 section A.9 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

A.9.	Submit a written statement indicating that the Proposer's health management and wellness services units proposed as part of this proposal meet the following minimum qualifications: (a) The Proposer is providing health management/wellness services, at the time of proposal submission, to one or more commercially insured or self- insured groups of at least thirty thousand (30,000) participating members; and (b) The above group(s) have been under contract for at least one (1) year at the time that the Proposer submits this proposal

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

The Contractor shall have a designated full-time implementation team to service this account. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of weight management services for at least one other large employer (i.e., an employer plan with at least 20,000 members). The Contractor's implementation team shall include a full-time, designated project manager ready to begin work immediately following the contract effective date until thirty (30) days after the go-live date. The team shall also include an 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 a Project Coordinator (i) to serve as backup to the Account Manager and (ii) to coordinate activities among the Contractor and the State's existing vendors and all the internal and external participating and affected entities. All implementation team members that the Contractor referenced in its proposal response to RFP #31786-00135, Attachment 6.2, Section C (Technical Proposal), item C.5.c.iv. shall be available as needed during the implementation as well as thirty (30) days after the go-live date.

37. Delete Pro Forma Contract section E.8 (Attachment 6.6.a and 6.6.b) in its entirety

E.8. Partial Takeover of Contract.

38. Delete Pro Forma Contract section D.31.b(1)i. (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

i. Workers' compensation and employer liability insurance in the amounts required by appropriate state statutes.

39. Delete Pro Forma Contract section D.6. (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

If the Contractor fails to properly perform its obligations under this Contract, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall provide written notice to Contractor specifying the Breach Condition. If within thirty (30) days of notice, the Contractor has not cured the Breach Condition, the State may terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for

damages sustained by virtue of any breach of this Contract by the Contractor and the State may seek other remedies allowed at law or in equity for breach of this Contract.

40. Delete Pro Forma Contract section D.5. (Attachment 6.6.a and 6.6.b) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Termination for Convenience. Either Party may terminate this Contract without cause for any reason. A party's exercise of its right to terminate this Contract for convenience shall not be deemed a breach of contract by either Party. The terminating Party shall give the other Party at least ninety (90) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any good or service that has not been provided, nor shall the Contractor be relieved of any liability to the State for any damages or claims arising under this Contract.

41. Delete Pro Forma Contract section A.4.b (Attachment 6.6.a) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

The Contractor shall modify the health questionnaire in accordance with a State request for a revision or other change within ninety (90) days of said request unless the issue is a legal one, in which case the health questionnaire shall be amended immediately.

42. <u>RFP Amendment Effective Date</u>. 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.