STATE OF TENNESSEE
FINANCE & ADMINISTRATION, BENEFITS ADMINISTRATION

REQUEST FOR PROPOSALS # 31786-00148 AMENDMENT # ONE FOR MEDICAL THIRD PARTY ADMINISTRATIVE SERVICES

DATE: January 8, 2021

RFP # 31786-00148 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		November 25, 2020
2. Disability Accommodation Request Deadline	2:00 p.m.	December 2, 2020
3. Pre-response Conference	2:30 p.m.	December 4, 2020
4. Notice of Intent to Respond Deadline	2:00 p.m.	December 7, 2020
5. Written "Questions & Comments" Deadline	2:00 p.m.	December 11, 2020
6. State Response to Written "Questions & Comments"		January 8, 2021
7. 2nd Round Written "Questions & Comments" ***NOTE: Vendors may submit no more than 5 questions to the State in the 2nd round of Written Questions and Comments.**	2:00 p.m.	January 15, 2021
8. State Response to 2nd Round Written "Questions & Comments"		January 28, 2021
9. Deadline to Submit Network and Claims Information to Aon		January 28, 2021
10. Response Deadline	2:00 p.m.	February 10, 2021
11. State Opening of Cost Proposals	2:00 p.m.	February 10, 2021
12. State Completion of Technical Response Evaluations		March 5, 2021
13. Scoring of Cost Proposals	2:00 p.m.	March 5, 2021
14. State Notice of Intent to Award Released AND RFP Files Opened for Public Inspection	3:00 p.m.	April 22, 2021
15. End of Open File Period		April 29, 2021

16. State sends contract to Contractor for signature		May 3, 2021
17. Contractor Signature Deadline	2:00 p.m.	May 7, 2021

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.

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		1.	Can you provide the process proposers should follow if we need to ask clarifying questions about the responses to these bidder questions?	If there are any additional questions or clarifications, potential respondents are able to email the State up to five additional questions/concerns/comments by the RFP Schedule of Events deadline for Round 2 Q&A. The State recommends providing the question/comment/reference to the RFP item or pro forma contract section, any industry standards, justification for the change, and any redline edits.
		2.	"Can you please expand on the Scope of Service for this RFP specifically the Statewide TN (95) County vendor solution to include current efficient and broad vendor networks proposals? Part 2: Will the State accept, evaluate and award vendor proposals based on a Grand Division basis, i.e. 1 or 2 of three TN divisions or will Statewide proposals only be considered?"	The State is seeking to evaluate and award only 2 statewide contracts that will serve all enrolled members. Both statewide contracts shall include an efficient network and a broad network that can be offered to enrolled members at the State's discretion. The State will not be accepting, evaluating, or awarding contracts on a Grand Division basis as we have in the past. Only Statewide proposals will be considered.
		3.	Please provide an electronic census that includes date of birth, gender, enrollment tier, plan elected, carrier elected, network elected, and class (active, retiree, COBRA)	Please see Appendix 7.18.
		4.	Please provide the current number of employees and total members enrolled with BCBS as well as the total current number of employees and members enrolled with CIGNA.	Please see Appendix 7.18

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		5.	Please provide the current number of employees and total members enrolled in the broad network.	Please see Appendix 7.18
		6.	Please Provide the most current month subscriber count and member count per plan, per carrier.	Please see Appendix 7.18
		7.	Please provide additional description and requirement regarding the onsite clinic (vendor, services rendered, is there a requirement for integration of claims (ded/oop maximum accumulation) H&W Center: ParTNers Health & Wellness Center (i.e. onsite employee clinic).	The current process is an optional data feed file to each TPA of claims for employees enrolled in said TPA network on a monthly basis. Also, the ParTNers Health & Wellness Center is an in-network provider and claims are submitted to the TPA for services rendered to CDHP enrolled employees. Those claims are adjudicated and paid in the same way as any other in-network provider. There are no current plans for accumulator integration.
		8.	Please define any programs/fees that are not included in current administrative fee. For instance (fraud, waste, and abuse and hospital bill audits, etc)?	Expert medical opinion services are the only programs/fees not included in the administrative fee. All other services listed in the pro forma contract are inclusive of the administrative fee.
		9.	In the Pro-Forma Section j: Please provide a copy of the Implementation Performance Survey assessment – Or if this is not available is the intent for this survey to be developed on a mutually agreeable basis at a later date?	Please see Appendix 7.20.
		10.	Please provide the number of dependent eligibility verifications per carrier annually per carrier.	The State handles all dependent eligibility verification with the exception of verifying disability status for dependents to continue coverage after age 26, of which we had 31 new verifications in 2020.
		11.	For the claim cost analysis that will be conducted by Aon, our current broad network data is in the UDS database that Aon uses but not our current efficient network data. In the past when this situation has occurred, we have provided Aon actuarial certified adjustment factors at their requested level of detail so that the broad network data housed in UDS can be adjusted to reflect the appropriate claim cost level for the efficient network. Would this be acceptable to the State? Is there a contact at Aon that we can	The State relies on Aon to measure the proposed efficient networks. For submission of the efficient network data, you may contact Bob Tate at Aon: bob.tate1@aon.com or +1-404-260-6378

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			work with on the submission of the efficient network data?	
		12.	Please provide the SPD for each Medical Plan.	Please see links below: State Plan – 2020 State Plan – 2021 Local Education – 2020 Local Education – 2021 Local Government – 2020 Local Government – 2021
		13.	Does the State have benefit differentials in place for members who pursue a course of treatment with certain providers? Please describe these arrangements, the scope of services, and the provider types. For example, transplant, spine and joint, etc.	The State has a few benefit differentials in place. Bariatric surgery is only covered if performed at a COE. Transplants are covered at 100% (CDHP after deductible) if performed at a COE. In-network Physical, Occupational and Speech Therapies have coinsurance with no deductible (except CDHP). Cardiac Rehab has no deductible or coinsurance for in-network, outpatient services. CDHP no coinsurance after deductible. One carrier currently has a surgery program for certain orthopedic bundles (joint and spine). Surgery is covered at 100% (CDHP after deductible) for members who enroll in the program and use a program provider. Both Carriers offer online DPP programs and members have no cost share for the program.
		14.	In regards to the benefit Home Health Care - Part-time, intermittent home nursing care limited to 125 visits per plan year. Home health aide care limited to 30 visits per plan year. Would the state accept the following suggestion. Replacing the limitation combining part-time intermittent home nursing care and home health aide care with a combined	The State does not agree. The current benefit cannot be changed without approval of the Insurance Committees.

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			visit limit per year or per lifetime. Each visit should equal four hours of care.	
		15.	In regards to the benefit Children's Glasses - covered at 30% member coinsurance for network services and 50% member coinsurance for non-network services. Would the state consider covering vision eyewear on a separate vision plan.	The quoted percentages are only correct for the Limited PPO and is only applicable for the first contact lenses or glasses purchased after cataract surgery. Otherwise, there is no eyeglass benefit under the medical plan. The State offers a separate vision plan.
		16.	In regards to the benefit Non-network primary care visit covered with $55 copay per visit. Non-network specialist visit covered at $80 copay per visit. Would the state be agreeable to removing the PCP and specialist copay for non-network providers.	The State does not agree. The current benefit cannot be changed without approval of the Insurance Committees.
Appendix 7.1 Discount Data Specifications		17.	We believe AON may already have the requested data. Can you or AON confirm for which carriers AON already houses the requested information?	The State relies on Aon to measure the proposed efficient networks. For submission of the efficient network data, you may contact Bob Tate at Aon: bob.tate1@aon.com or +1-404-260-6378
Appendix 7.4		18.	How do you determine the number of providers included in the Network Analysis reports are accurate?	The State reviews responses for reasonableness but is unable to verify every response for 100% accuracy. Therefore, the State is reliant upon RFP Attachment 6.1, which respondents are required to sign, specifically item 6 which states “To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.” The State will hold the awarded Contractor accountable for their RFP responses per RFP sections 3.3.5 and 4.10.
			How do you verify provider data accuracy and Network Access methodology has been followed?	The State reviews responses for reasonableness but is unable to verify every response for 100% accuracy. If a respondent is suspected to provide inaccurate data in their response, they will be asked clarifying questions. Evaluators will be notified of the issue and any clarifications and will be advised to score accordingly. The State will hold

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				the awarded Contractor accountable for their RFP responses per RFP sections 3.3.5 and 4.10.
			What is the source and methodology used to determine the provider counts outlined in Appendix 7.4?	Appendix 7.4 has been updated and is based upon the incumbent contractors' network analysis reports.
			Regarding Appendix 7.4, Network C it is noted there are 181/161 Acute Care hospitals noted however that exceeds the number of Acute Care Hospitals open within the state of Tennessee. Can you provide additional information on this discrepancy?	Noted discrepancies are due to factors such as provider contracts, multiple billing addresses, and contractor systems. As such, Appendix 7.4 has been updated based upon NPI counts only.
			Can you provide a list of the 181 Acute Care Hospitals included in the current Broad Network C?	The current network acute care hospitals are listed in the provider directory: Cigna. Appendix 7.4 has been updated based upon NPI counts only.
			Regarding the current Broad network C, these counts seem excessive based on the available practices within the state. Can further detail be provided including a supporting document that outlines all 11,670? Is there a methodology the State can use to compare provider networks on an "apples-to-apples" basis based on these outliers?	The current network providers are listed in the provider directory: Cigna. The State has updated Appendix 7.4 to utilize NPI counts only in order to preserve the closest "apples-to-apples" comparison.
			According to the Tennessee Hospital Association (THA website) at: https://tha.com/hospitals/directory/ There are far less than 181 General Acute Care Hospitals in the state of Tennessee. Others listed are Psychiatric Hospitals and Rehab facilities, etc. Should those be counted for all carriers under the "Acute Care Hospitals" network analysis reports?	Only Acute Care Hospitals should be counted. Appendix 7.4 has been updated.
Appendix 7.8		19.	• Please define the specific service and paid dates used in this table for each year.	The data in the table is for incurred service dates from January – December within the

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				noted year with the exception of 2020 which is January – June.
			• Please provide this appendix on a per carrier basis.	The data is intended to provide a snapshot of the entire plan experience, not by carrier, since the benefits are the same across all carriers/networks.
			• Per the Cost Proposal 6.3 there are specific parameters listed in reconciliation of the trend guarantee. Are these the only caveats allowed or is the carrier allowed to propose additional caveats/reconciliation considerations?	For the Cost Proposal 6.3, Aon will handle the trend guarantee consistently across all contracted parties. Any additional caveats or reconciliation considerations can be submitted for review at the time of reconciliation but may be rejected. Requested parameter changes should not be included in the cost proposal or RFP response.
		20.	Please provide the following additional claims information. • Paid Medical claims by month by carrier (Jan 2018 thru current), including amounts over $100,000 • Employee/member counts by month by carrier (Jan 2018 thru current) • Large Loss Reports by carrier for claims on a calendar year basis for claims over $100,000 since this is the threshold used in the trend guarantee calculation	Please see Appendix 7.19.
		21.	Can the state provide the specific % or dollars of spend in the out of network category paid at the in network benefit level and out of network paid at the out of network benefit level by carrier?	The State will not be providing additional information to the Respondents regarding this information. This information is for State and Evaluator use only.

State and Evaluator Use Only

(Provider data excluding Ancillary and Facilities)

Incumbent A Information (Evaluator Reference Only)

Network Status	Total Providers	% of Providers	% of Claimants	% of Claims
In-network (Y)	36,069	90.90%	98.11%	98.16%
Out-of-network (N)	3,610	9.10%	1.89%	1.84%

Incumbent B Information (Evaluator Reference Only)

Network Status	Total Providers	% of Providers	% of Claimants	% of Claims
In-network (Y)	14,554	84.94%	96.46%	96.59%
Out-of-network (N)	2,580	15.06%	3.54%	3.41%

Incumbent Combined Information (Evaluator Reference Only)

Network Status	Total Providers	% of Providers	% of Claimants	% of Claims
In-network (Y)	50,623	89.10%	97.66%	97.73%
Out-of-network (N)	6,190	10.90%	2.34%	2.27%

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File Integration and Feeds		22.	Can you describe the level of integration between the current vendors and your onsite clinic? Is clinical data transferred and/or are any claims from the onsite clinic filed against the medical benefit plan?	The current process is an optional data feed file to each TPA of claims for employees enrolled in said TPA network on a monthly basis. The ParTNers Health & Wellness Center is an in-network provider and claims are submitted to the TPA for services rendered to CDHP enrolled employees. Those claims are adjudicated and paid in the same way as any other in-network provider.
File Integration and Feeds		23.	Please provide details on the feeds required between the medical vendor and the other external vendors. What level of data is transferred to each vendor (rx, mental health, etc)?	Accumulator data is shared between the TPA and PBM as well as TPA and BHO. Limited medical claims data is to be shared with PBM and BHO. Full medical claims data is to be shared with the DSS.
		24.	Please describe your current Case Management offering in greater detail. a. What is your Case Management reach/engagement rate? b. Please provide engagement statistics by modality (i.e. telephonically, digitally, virtually). c. Please provide additional insight into what is working well and what you would like to see improved.	Our case management rate in 2019 was 52% and in 2020 was 48%. Over 95% of case management was delivered telephonically. The State thinks that more individuals could benefit from case management compared to the individuals currently being identified. If only certain conditions or high cost claims are used for identification, gaps may occur. The State has identified individuals with complex conditions that are being treated by separate specialists that when viewed as a single condition would not qualify for case management. However, when looking at the whole picture, the individual is in desperate need of case management and has benefited once identified. The State is seeking broader and more customized identification of individuals who may benefit from case management.

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		25.	Are the current vendors today delivering Bariatric service and Orthopedic services. If, so what is the level of utilization.	Our plan covers medically necessary bariatric services/surgeries and orthopedic services/surgeries. Please see Appendix 7.13 for some musculoskeletal and bariatric services utilization information. If you would like utilization regarding specific services or surgical procedures, please clarify.
		26.	Please provide information on you high cost claimants.	Please refer to Appendix 7.19.
		27.	In regards to the Proforma Section Provider Network: f. The Contractor shall ensure that no specific payment be made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. To ensure the scope of this requirement and better understanding, can the State of TN please provide examples of the type of payments which they are concerned?	The State is concerned with programs (e.g. bonus, rewards, payments, etc.) paid to a physician or physician group that incentivizes the limitation of services without regard to the medical necessity of the service to the individual.
MWBE		28.	Please provide the diversity percentage being met by the current vendors.	The State has an average goal of 10% in any combination of minority, women, service-disabled veterans, persons with disabilities or small businesses. To be valid, they must be certified in the Governor's Office of Diversity Business Enterprise. Businesses certified with other entities or states can be certified in Tennessee as a Reciprocal certification.
MWBE		29.	Please clarify if there is a participation goal for doing business with minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises? If so, please confirm the targeted percentage amount.	There is no specific participation goal. The diversity section is included in an over-all point evaluation in the "B" section – General Qualifications and Experience.
MWBE		30.	Are respondents able to obtain bonus point for doing business with minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises, in support of this	There are no specific bonus points. The diversity section is included in an over-all point evaluation in the "B" section –

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			RFP? If so, please clarify how this question will be evaluated?	General Qualifications and Experience.
		31.	In the Section 4 GENERAL CONTRACTING INFORMATION & REQUIREMENTS Please confirm that the subcontractors you require approving would be only those that provide substantial and direct service to this contract. 4.4.1. The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment. 4.4.3. 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. 4.4.4. After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval. 4.5. Right to Refuse Personnel or Subcontractors The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.	The State is only concerned with subcontractors that will work on items pertaining to this contract. The State requirement of prior approval of subcontractors only applies to this contract.
RFP B.12		32.	In RFP Attachment 6.2 B.12 - Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each	The State cannot agree with this request.

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			subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP. While we will provide a representative list of subcontractors and attest that such subcontractors agree to all our policies, would the State be willing to eliminate the contact information of subcontractors as this level of detail is not normally provided to the client.	
RFP C.51		33.	Provide your 2019 appeal processing outcomes for your fully insured book of business As more applicable to the components being offered as part of this RFP, is it permissible to provide State-specific data, if available instead of fully-insured data since that is more in line with the offerings included in this proposal? Additionally, we do have some concerns with the 100% expectation on expedited cases. The volume of these cases are very low and missing just one case drops the overall turnaround time significantly. Will the State consider revision of this requirement due to the low volume?	The State agrees. See Amendment item #3 below. Our appeals standards are not negotiable.
RFP C.54		34.	What are your goals for targeting members via social media?	Partners for Health utilizes Facebook, Twitter, YouTube and Instagram (to some extent) to reach our members/ABCs with general health, behavioral health, enrollment and other messaging. We have an internal social media manager who creates, manages and utilizes content created by our contracted vendors. The social media audience is small compared to the overall number of HOCs, so our goal is to not only reach members with effective content but to continue to grow our reach/engagement. Per the contract, the vendor would assist with social media content and messaging but is also asked to describe your

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				strategy around social media and other technologies to communicate health benefits to members.
RFP Section D		35.	Provider Network Access Analysis. For the currently established proposed Efficient network to be used for this contract, coordinate with Quest and submit your Network Access Analysis Report for your participating Acute Care Hospitals, Primary Care Physicians, Pediatricians, Obstetricians/Gynecologists, Cardiologists and Endocrinologists IN TENNESSEE ONLY, as required in Appendix 7.2, as illustrated in Appendix 7.4. and using the State's total Tennessee participant population data provided in Appendix 7.5, TN ZIP Code Counts. Since there are zip codes in Appendix 7.5 that are likely bordering contiguous counties to TN, and there may be providers closer to a member's home in a bordering county, is it permissible to use contracted providers in contiguous counties in order to perform the requested Network Analysis?	The State does not agree to include bordering contiguous counties for the RFP Section D submission.
		36.	Can you please confirm if the network information being provided in Section D Part 2 and Section D Part 3 will count as the documentation that our network is adequate in all 95 counties? If this is not sufficient, please let us know what documentation the State has in mind.	The State confirms.
		37.	Regarding the following statement in the Proforma …As directed by the State, the Contractor shall implement cost-sharing incentives (e.g., lower rates of Coinsurance, provision of Copayments in lieu of Coinsurance, waiver of or provision of lower Deductible amounts) for Members engaged in disease management and other programs as reported to the Contractor by the State or the PH/W contractor. Does the State have benefit cost sharing incentives in place today? Can you please provide a summary of these benefits? Can you list the disease states that have the current improved cost sharing incentives?	The State currently has a flat incentive structure for members engaging in disease management and other programs. See the benefits administration website under "Wellness" for more information about the State's population health program and benefits. Yes. 2021 incentive table. Should some or all of the incentives change to a cost-sharing structure, more information will be provided to all relevant Contractors at that time.

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A.1.Claims Processing, Payment and Reconciliation		38.	The Contractor shall process all claims for covered benefits provided to Members in strict accordance with the Plan Documents, applicable Contractor medical coverage policies and procedures, in compliance with all applicable state and federal laws, rules and regulations and the terms of this contract including, but not limited to, timely filing. The Contractor shall not modify the Plans' covered benefits or apply their standard book of business changes to benefits set up, procedures, or claims processing guidelines during the term of this Contract without the prior notification to and approval In Writing from the State. The Contractor shall retain records of all State approvals for benefit set up that do not align with the Contractor's standard book of business. The Contractor may be assessed liquidated damages as set forth in Attachment B, Liquidated Damages for any claims that are not processed according to State approved covered benefits. Given that the State's plan is self-funded, would the State consider adding ", except in the case of payments that exceed the amount payable under the Plan for which a standard of gross negligence shall prevail" as a clarifier to the first sentence?	No, the State will not add the requested language.
		39.	Regarding the following statement: The Contractor shall submit claims and bank draft reports to the State in sufficient detail for the State to record and reconcile claims. The format of the claims reports shall include at a minimum: each bank draft amount; date of bank draft; number, date range, and amount of associated claims adjudicated per draft; account number; fund code; any non-claim based payments which shall be separate and identified; etc. The report format shall be prior approved by the State and the frequency of report delivery shall match the frequency of the Contractor's bank drafts (refer also to Contract Attachment C, Reporting Requirements). Please provide a copy of the current report your Contractors are providing for this requirement.	Current reports are not relevant to this RFP and contract. The State has provided a template for what we expect to be provided under this contract. Please see the template in Appendix 7.12.
A.2.a.		40.	Would the State consider a designated Account Executive if the contractor submitted a request to the State in	The State is not willing to consider a designated Account Executive due to historical

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			writing, provided that all standards defined in the Contract could be met?	experience with both dedicated and designated Account Executives. The State has modified the definition of Dedicated. Please see Amendment item #6 below.
A.2.a		41.	Regarding the following statement in Proforma A.2.a. Account Executive: Dedicated full-time employee of the Contractor who has primary oversight and management of the Contract and all services, deliverables, and requirements within. We would request to work with the State on mutually agreeing to have a designated employee vs a dedicated employee based on our plan enrollment numbers.	Please see the State's response to question #40.
A.2.b.		42.	Account Manager: Dedicated full-time employee of the Contractor who supports the Contract primarily handling member services and issues including claims, benefits, and provider concerns. We would request to work with the State on mutually agreeing to have a designated employee vs a dedicated employee based on our plan enrollment numbers.	The State is not willing to consider a designated Account Manager due to historical experience with both dedicated and designated Account Managers, regardless of plan enrollment. The State has modified the definition of Dedicated. Please see Amendment item #6 below.
A.2.mmm		43.	Would the State allow us to use our rebate definition below to replace the Proforma language in section mmm. Our Definition: Any discount, [manufacturer administration fees,] price concession or other remuneration [REDACTED] receives Any discount, [manufacturer administration fees,] price concession or other remuneration [REDACTED] receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a prescription drug under the Plan's pharmacy benefit or the medical benefit during the Term. Rebate does not include any discount, price concession [manufacturer administration fees] or other direct or indirect remuneration [REDACTED] receives from a drug manufacturer for direct purchase of a prescription drug.	The State does not agree.
A.2.mmm *(Should be*		44.	Would the State allow us to use our specialty drug definition below replace the Proforma language in section mmm.	The State does not agree.

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A.2.rrr.)			Our Definition: A medication can be defined as specialty if it meets both of the following: Medication has at least three of the following characteristics: ● Biotechnology products. ● FDA-designated orphan drugs or ultra-orphan drugs. ● Any formulation of drug that is high cost as defined by one of the following: ● Ingredient cost (IC) less than $670 per month for either a medical or prescription claim based on normal dosing. ● Estimated IC less than $670 (for purposes of this policy this will be defined by calculating the IC using an average wholesale price minus 17 percent) per month for either a medical or prescription claim based on FDA approved recommended dosing ● Requires special storage control and/or other specific shipping and handling requirements. ● Infusion or healthcare administered injectable professionally administered by a healthcare professional or in a healthcare setting. ● Therapy requires management and/or care coordination by a healthcare provider specializing in treating the member's condition. ● Requires focused, in-depth member education and/or adherence monitoring and/or side effect management and/or injection preparation/administration education. The medication may have REMS programs requiring this level of clinical oversight beyond the standard REMS program medication guide requirements. ● Managed as part of an existing specialty therapeutic program. Medication does not meet any of the following characteristics: ● Requires nuclear pharmacy sourcing. ● Preventative immunizations (for example, influenza, DTP). ● Administration is only in the inpatient setting.	
A.4.b. and A.4.c.		45.	The Contractor shall provide advice and assistance with questions regarding effective dates, benefits, cost-sharing and cessation of coverage as requested by the State, Members, and providers.	The State agrees to modify the language. Please see Amendment item #7 and 8 below.

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			The Contractor shall keep the State apprised (through such methods as policy briefs, white papers, client communications, etc.) of any new or recently discovered federal or state laws, rules or policies that may impact the Plans. The Contractor shall advise the State on any recommended actions in order to comply with such laws, rules or policies. Please confirm this is acceptable: We are happy to review and comment on plan provisions and applicable laws, but cannot provide legal advice to the State, that the State ultimately will need to consult with its own legal counsel.	
A.4.l.		46.	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to Member information, utilization, and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain. Please Confirm: Is it acceptable if the Contractor is required to disclose certain information for accreditation purposes? Also please confirm that we can use the State's information in a manner consistent with law and for internal knowledge, understanding, experience and analytics, but not disclosing the State's information to any third party for any reason.	Yes, this prohibition does not include accreditation purposes. The State confirms and reiterates the following prohibited uses "in marketing or expanding non-State business relationships or for any pecuniary gain".
A.4.n.		47.	Please confirm: Should this reference Contract Attachment D, Service Level Agreement Scorecard, rather than Contract Attachment B, Liquidated Damages?	Yes, the State has modified the language. Please see Amendment item #9 below.
A.5.g		48.	The Contractor shall Dedicate a full time Account Executive and Account Manager as members of the account team. The Account Executive shall have the responsibility and authority to manage the entire range of services specified in this Contract and shall respond promptly to changes or inquiries in benefit plan design, changes or inquiries in claims processing procedures, or general administrative issues identified by the State. The	Please see the State's response to question #40.

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			Account Manager shall have the responsibility and authority to respond promptly to Member, claims, and provider issues or inquiries as identified by the State. At a minimum, the Account Executive shall meet in person with the State semi-annually and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference. The Account Executive shall also be available via cell phone and email after hours, including weekends. We would request to work with the State on mutually agreeing to have a designated employee vs a dedicated employee based on our plan enrollment numbers.	
A.5.i.		49.	The Contractor agrees that the State may approve or disapprove the staff assigned to this Contract prior to the proposed assignment including approving the implementation and account teams. The State may also direct the Contractor to replace staff members providing core services as it deems necessary and appropriate. The decision of the State on these matters shall not be subject to appeal. We would request that the decision to replace account management team members be made mutually.	The State does not agree.
A.5.u.		50.	The Contractor shall notify the State In Writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Such notification shall be made for all hospitals, physician groups of twenty (20) or more, or broad classification of providers. We would request that this clause is deleted as contractual provisions are considered proprietary.	The State does not agree. The State is not requesting copies of the confidential contracts. However, if a payment methodology is enacted that impacts large provider groups or classifications it may have a legislative impact and as such, we require notice to prepare ourselves, members, and legislative body of any potential concerns. Also, as a self-funded plan we must be made aware of any provisions that could have a significant impact on claims costs and as such, premiums or member cost share.
A.6.k.		51.	The Contractor shall maintain a current record of network physicians not accepting Members as new patients and	A passive approach is not acceptable to the State although

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			shall provide a report upon request by the State. Is this acceptable: We will only be able to provide notice of providers we know are not accepting new patients, and providers (although required to provide notice) don't necessarily do so…would the State clarify that this current record of such providers is based on what we have knowledge of?	it is understood that a record may have a period of inaccuracy prior to an update. The State expects that the TPA will take a proactive approach in confirming new patient acceptance status of in-network providers.
A.6.m		52.	The Contractor shall maintain NCQA's Credentials Verification Organization certification during the term of this contract and submit a copy of the certification annually. If the Contractor is not certified as of Go-Live, they must obtain the certification no later than December 31, 2022, or at a later date if approved by the State. Refer also to Attachment B, Liquidated Damages and Attachment C, Reporting Requirements. If the health plan has NCQA Health Plan accreditation and our credentialing process is consistent with NCQA, Tennessee Department of Commerce and Insurance (TDCI) and the Bureau of TennCare and we perform credentialing in-house, is this acceptable to the State? NCQA Health Plan accreditation includes Credentialing, UM and many more programs. As part of NCQA Health Plan accreditation carriers are also audited on Quality, Network Management, Population Health Management, and Member Experience. NCQA Health Plan accreditation includes all of the Credentialing standards and more.	Please see Amendment item #10 below.
A.6.t.		53.	The Contractor shall identify and sanction Network Providers who fail to meet pre-determined, minimum standards relating to referrals to Out-Of-Network Providers and shall provide a report to the State upon request In Writing. We propose amending this language to reflect that we can provide reporting that identifies in network providers who are referring to out of network providers but we would not disclose sanction actions taken.	The State does not agree to amend this language, as State audit and legislative inquiries may require additional level of detail to be responsive.

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A.6.u.		54.	The Contractor shall notify the State In Writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Such notification shall be made for all hospitals, physician groups of twenty (20) or more, or broad classification of providers. Would the State consider limiting this provision to that which are not routine/are off-cycle from the general contract negotiations with a provider, and so long as we are permitted to make the disclosure consistent with applicable law and contractual obligations?	The State does not agree to limit this language. Even annual/routine negotiations may include a payment methodology that impacts large provider groups or classifications it may have a legislative impact and as such, we require notice to prepare ourselves, members, and legislative body of any potential concerns. Also, as a self-funded plan we must be made aware of any provisions that could have a significant impact on claims costs and as such, premiums or member cost share.
A.7.k.		55.	The Contractor shall provide a personalized response, In Writing, to ninety-five percent (95%) of written (mail or email) inquiries from Members concerning requested information, including the status of claims submitted and covered benefits, within five (5) Business Days and ninety-nine (99%) within ten (10) Business Days. The Contractor shall acknowledge receipt of email inquiries from Members or the State within one (1) Business Day. We would request that the first sentence be changed to “The Contractor shall provide a personalized response, In Writing, of written (mail or email) inquiries from Members concerning requested information, including the status of claims submitted and covered benefits, standardly within 10 business days.”	The State does not agree to this revision.
A.7.l.		56.	The Contractor’s Dedicated Account Manager shall respond to Member-related issues identified by the State. For matters designated as urgent by the State, the Contractor shall contact the Member and resolve the issue and then notify the State of the resolution. We would request to work with the State on mutually agreeing to have a designated employee vs a dedicated employee based on our plan enrollment	Please see the State’s response to question #40.

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			numbers.	
A.7.m.		57.	The Contractor shall maintain a procedure for resolving complaints informally by phone, including reconsiderations and initiating peer to peer reviews. Where a complaint cannot be resolved to the Member's satisfaction, the Contractor shall advise the Member of his/her right to file an appeal and shall provide instructions and assistance as needed by the Member for doing so. Please confirm: is the State meaning member complaints about a claim being subject to appeal if not resolved by telephone?	The State confirms.
A.7.n.		58.	Please confirm: Should this reference Contract Attachment D, Service Level Agreement Scorecard, rather than Contract Attachment B, Liquidated Damages?	The State agrees. See Amendment item #11 below.
A.8.a.		59.	The Contractor shall maintain an appeals process in compliance with Section 2719 of PPACA (42 U.S.C. 300gg-19), 45 CFR 147.136, and the Plan Document, including all minimum consumer protection standards, by which Members may appeal adverse benefit determination decisions including, but not limited to, determinations based on: medical necessity; appropriateness; health care setting; level of care; medical effectiveness; determinations that treatments are experimental or investigational; whether treatments are "emergency care" or "urgent care"; coverage of items or services based on medical conditions; frequency, method, treatment, or setting of recommended preventive services to the extent not specific in HHS's published lists of recommended preventive services; whether the plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act; if applicable, whether participants or beneficiaries are entitled to a reasonable alternative standard for a reward under a wellness program; and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). If any part of section A.8. conflicts with the federal review and appeal	The State agrees.

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			requirements of Section 2719 of PPACA (42 U.S.C. 300gg-19) or 45 CFR 147.136, the Contractor shall follow the federal requirements. Will the State agree with cooperation with the State in its performance of MHPAEA testing and implementing necessary steps for appeals decisions? Carriers do not perform Mental Health Parity testing for Plans and Plans are responsible for ensuring their Plans are complaint, so we can't confirm that the State's plan's non-quantitative treatment limitations. We can, though, cooperate with the State in its performance of MHPAEA testing and implementing necessary steps for carrier to decide appeals.	
A.9.		60.	b. The Contractor's utilization management program for this Contract shall be fully accredited by URAC. If the Contractor meets this requirement as of Go-Live, the Contractor shall maintain such accreditation throughout the period of this Contract. If the Contractor does not currently meet this requirement, the Contractor shall obtain such accreditation by December 31, 2022 (or a later date as specified by the State) and shall maintain it thereafter throughout the period of this Contract. See also Contract Attachment B, Liquidated Damages and Contract Attachment C, Reporting Requirements. Will NCQA accreditation/certification suffice in lieu of URAC and are there fees at risk?	The State is removing contract section A.9.b, contract Attachment B #16 and the URAC Utilization Management Accreditation Certification from contract Attachment C.
A.9.		61.	i. Unless otherwise directed by the State, the Contractor shall complete ninety-seven percent (97%) of all PAs within the following standards for timeliness of PA and UM decision making. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard: Can you please provide clarification of these TAT's. We start the clock on TATs when we receive all the necessary clinical information to make a determination. We do not count from first submission and the days waiting while we have asked for additional clinical	The TAT starts at the time of receipt of necessary information associated with the request. Please also refer to contract section A.9.k. Please see Amendment item #36 below.

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			information to be provided—will you agree to this? Are there Fees at risk with this PG?	
A.9.		62.	p. The Contractor shall provide a written report to the State as requested regarding the demonstrated effectiveness of its UM program. Please clarify the ask here; data results? white paper? What is this to consist of?	Historically, the State has asked for total claims/program savings and any related details as to how those savings were achieved. This type of information has been requested during legislative session as part of the fiscal analysis process of bills seeing to end or limit PA and UM.
A.9.		63.	a. The Contractor shall identify, no less than every six (6) months, Members using emergency department services inappropriately or excessively. The Contractor shall outreach to those Members for the purpose of educating the Member on appropriate emergency department use, enrolling the Member in case management, if appropriate, or referring the Member to other State contractors for assistance (PH/W contractor or BHO/EAP contractor). In order the comply with the requirements of this section, will the State's wellness vendor send reports to the contractor identifying the circumstances of why the Contractor should reach out to the member? How will the Contractor be notified from the wellness vendor that the member is not actively engaged in health coaching.	The Contractor is to monitor excessive ED use and reach out to all identified members to engage in education on proper site of care. During that outreach the Contractor shall determine if case management or other programs offered by the state such as health coaching might be helpful for the member to better manage their health. The wellness vendor will not be providing the Contractor with health coaching engagement reports.
A.9.b		64.	A.9.b The Contractor's utilization management program for this Contract shall be fully accredited by URAC. If the Contractor meets this requirement as of Go-Live, the Contractor shall maintain such accreditation throughout the period of this Contract. If the Contractor does not currently meet this requirement, the Contractor shall obtain such accreditation by December 31, 2022 (or a later date as specified by the State) and shall maintain it thereafter throughout the period of this Contract.	Please see the State's response to question #60.

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			See also Contract Attachment B, Liquidated Damages and Contract Attachment C, Reporting Requirements. The biggest difference between NCQA and URAC is that NCQA is more outcomes focused and URAC is more process oriented. The RFP appears to be asking for a UM URAC accreditation, and a Credentialing NCQA accreditation. NCQA Health Plan includes both UM, Credentialing and so much more. As part of NCQA Health Plan accreditation carriers are also audited on Quality, Network Management, Population Health Management, and Member Experience. Therefore NCQA Health Plan accreditation is more comprehensive.	
		65.	In regards to the Proforma Section Value Based Initiatives b. If Contractor developed episodes or bundles are not available or approved, the Contractor shall implement the following current episodes of care as selected by BA, from the Tennessee Health Care Innovation Initiative (THCII) designed episode list. Please confirm, the RFP requirements is implement the episode/bundles as outlined in (b) as a minimum, and if implemented meets the requirement of (a) and the Contractor will still need to provide annual reports to the BA consistent with the last sentence in (a)?	The State confirms that implementation of contract section A.10.b replaces implementation of contract section A.10.a. Reporting for A.10.b is noted in A.10.b.(9).
		66.	In regards to the Proforma Section Value Based Initiatives i.Perinatal ii. Total Joint Replacement (Hip and Knee) iii. Percutaneous Coronary Intervention iv. Cholecystectomy v. Colonoscopy vi. Esophagogastroduodenoscopy vii. Bariatric viii. Coronary Artery Bypass Graft ix. Valve Replacement x. Hysterectomy xi. Knee Arthroscopy Does Cigna or Blue Cross TN have a BA approved episode/bundle value based reimbursement strategy ? If so, for what episode/bundles, and which have	Yes. All 11 of the listed Episodes are currently implemented with providers by both Contracted TPAs. All of those episodes are upside gain share only with no additional risk to the providers who participate. Perinatal, TJR, PCI, Cholecystectomy, Colonoscopy were all fully implemented in 2017. CABG, Valve, Bariatric, and EGD were added in 2019. Hysterectomy and Knee Arthroscopy were added in 2020.

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			financial risk to the principal accountable provider? If Cigna or Blue Cross TN don't have a BA approved episode/bundle value based reimbursement strategy, then: (1) have they implemented the THCII episodes/bundles outlined in (b), (2) which episodes/bundles have been implemented, (3) how many years have each episode/bundle been effective, (4) how many providers, or entities, are contracted/under each episode/bundle that meet or exceed the 40 requirement outlined below in b(6), and (5) how many providers or entities that are contracted/under episode/bundle have received a contractual reward (aka, shared savings or upside) payment since the effective date of the episode/bundle and if so, how much?	See Appendix E for Episodes of Care Experience from 2017-2019.
		67.	(1) Implement key THCII episode design choices as directed by BA, including: i. Defining a principal accountable provider (PAP) to receive preview and performance reports and be eligible for rewards; ii. Adopting the definition of quality measures and their acceptable thresholds; iii. Including care from multiple providers in the episode; iv. Utilizing risk adjustment to reduce the impact of difference between patient age, morbidity, and other patient factors on the outcomes of the provider; and v. Implementing a financial model that includes contractual rewards to providers based on the cost and quality of the THCII episodes. The Contractor may set cost thresholds at their discretion. At the State's direction the financial model may include risk share payments by the principal accountable provider based upon cost thresholds set by the Contractor. Please confirm the minimum financial model requirement under (a) or (b), depending on which is implemented, is a contractual reward to the provider (aka shared savings or upside) without any financial risk, or downside risk, to the provider?	There is no minimum financial model requirement. The financial model is mutually agreed upon by the Contractor and the State. At this time the implemented episodes program is upside gain share only.
		68.	In regards to the Proforma Section Value Based Initiatives	For all implemented episodes, Cigna has implemented Prometheus based episode

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			(2) The Contractor may customize THCII episode definitions as needed, In Writing, and approved by BA. Does Cigna or Blue Cross TN have any BA approved episode/bundle definitions that are different from the THCII definition, if so please provide definition differences and applicable episodes/bundles?	definitions, available on Change Healthcare website, with some customization to match the THCII definitions including but not limited to quality metrics. The BCBST episodes fully align with the THCII definitions.
		69.	In regards to the Proforma Section Value Based Initiatives (6) For each THCII episode chosen by BA, the Contractor shall strongly encourage participation in episode based payments for all Network Providers who are expected to have at least 40 of these episodes of care across all of their commercial members in the upcoming performance period. Does Cigna or Blue Cross TN have any providers unwilling to participate in episode/bundle value based reimbursement, and if so, what providers and what episodes/bundles? How has the BA worked with Cigna and Blue Cross of TN to encourage provider participation in episodes/bundles value based reimbursement?	Yes. Participation varies by TPA and by provider group. Specific provider participation is confidential. Letters and direct conversations with provider groups, TMA, and THA has occurred to promote participation in the episodes program.
		70.	In regards to the Proforma Section Value Based Initiatives (8) d. The Contractor shall receive prior approval In Writing from the State for any Member attribution and associated program payments in a PCMH, Accountable Care Organization, or any other similar model. Does Cigna or Blue Cross TN have any providers approved by BA and member attribution associated with PCMH or ACO value based arrangements? If so, (1) how many members, (2) what provider entity (clinical integrated network name or legal entity), (3) effective date, and (4) how many physicians/practitioners?	Yes, BA has approved arrangements with both Contracted TPAs. Cigna has implemented their CAC program and BCBST has implemented their PCMH program. Specific details regarding those programs, provider participation, and attribution is proprietary to the TPA and confidential. The State has approximately 30,000 members attributed to a Cigna CAC. The State has approximately 42,000 members attributed to a BCBST PCMH.
		71.	In regards to the Proforma Section Value Based Initiatives a. As directed by the State, the Contractor shall develop and/or implement a high performance or tiered network of providers and/or facilities as measured by their adherence to a	BA has not directed the current contracted TPAs to develop high performance or tiered networks.

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			standard set of evidence-based clinical protocols, cost efficiency (e.g., cost per episode) and quality measures. The Contractor shall collaborate with and assist the State and its other contracted partners in the development of such standard protocols and measures, shall process claims, and implement any associated Member cost-sharing benefits or incentives (e.g., lower rates of Coinsurance, Copayment in lieu of Coinsurance, waiver of or provision of lower Deductible amounts). This network may be geographically located in limited areas of the State and may be managed by another State contracted partner. Has the BA directed Cigna or Blue Cross of TN in past 3 years to develop a high performance or tiered network? If so, what are the results of their development efforts?	
A.10.a.1.		72.	The Contractor's developed episodes or bundles shall include quality measures, include care from multiple providers, and utilize risk adjustment models as needed. The Contractor shall engage in provider education and reporting as applicable to the approved strategy. The Contractor shall provide annual reports summarizing the outcomes, savings, financial details for any provider rewards or risk payments for each approved and implemented Contractor developed episode or bundle reimbursement strategy. Is it acceptable to provide these reports for State's membership only.	This is acceptable to the State.
A.10.b		73.	A.10.b – there are two ProForma Contract items, both labeled as A.10.b. Should the numbering be revised?	Yes. A.10 numbering has been revised. Please see Amendment item #12 below.
A.10.d.		74.	The Contractor shall receive prior approval In Writing from the State for any Member attribution and associated program payments in a PCMH, Accountable Care Organization, or any other similar model. What is intended by prior written approval? Confirm this would be at a program level vs. member level.	Prior written approval of a member attribution model and associated program payments at the program level. The State has modified language in A.10.e. Please see Amendment item #13 below.
A.10.h.		75.	The Contractor shall maintain a network of Centers of Excellence for treatment or surgical interventions including but not	The State does not agree to this revision.

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			limited to: bariatric surgery (COE use required), orthopedic surgery, oncology/cancer surgery, cardiology/cardiac surgery, gene therapy, and maternity. The criteria for Centers of Excellence shall be developed by the Contractor and limited to facilities that adhere to the highest standards of patient safety and quality care. As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence and/or shall provide incentives to Members to use Centers of Excellence for the specified services (including but not limited to lower Member cost sharing for procedures performed at such facilities). Additionally, the Contractor shall provide health navigators to direct Members to these facilities when medically appropriate. We request that gene therapy and maternity are removed from the Centers of Excellence list.	Please see Amendment #14 below as the State has made a correction to the language.
A.10.m		76.	Section A, Value Based Initiatives, Question A.10.m The Contractor shall offer to Members at least one web based diabetes prevention program option based upon the Center for Disease Control's Diabetes Prevention Program including, but not limited to, Member and provider outreach and education. The Contractor shall be able to vary provider program payments based on Member participation and outcomes and must be billed as a provider claim. The Contractor shall submit a quarterly Diabetes Prevention Program outcomes report that includes the cumulative enrollees, enrollees by program stage, total weight loss, average weight loss by program stage, enrollees by weight loss range (below 0%, 0-3%, 3.01-5%, 5.01-7%, 7.01-10% and 10.01%+) and starting BMI (<25,25-29.30-34. 35-39 an 40+) (refer also to Contract Attachment C, Reporting Requirements). Question: Is it acceptable for this to be billed on a monthly basis, based on member activity rather than as a provider claim.	This is acceptable to the State accepts. The claims can be processed on a monthly basis. However, the only items that can be invoiced directly to the State are listed in Contract Section C.3. as administrative fees and expert medical opinion fees. Please see Amendment item #16 below.

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A.11.i First Call Resolution		77.	First Call Resolution of 85% as measured by one or more of the following methods: a Member post-call phone or web survey; an end of call script where the member service representative asks if the Member's issue has been resolved; a voice menu allowing the Member to indicate if this is the first call they've made to resolve their inquiry or problem; or another method prior approved by the state. Please confirm methods used for resolution of FCR. Is the following acceptable? First Call Resolution of 85% as measured by one or more of the following methods: • A member post-call phone or web survey; • An end of call script where the customer service representative asks if the member's issue has been resolved; • A voice menu allowing the member to indicate if this is the first call they've made to resolve their inquiry or problem; or • Another method prior approved by the state.	The State does not see any difference in the wording provided, just a formatting change. The State does not agree to change the formatting but confirms the methods in the contract match the bulleted methods listed in the question.
A.12.m and A.12.n		78.	The Contractor shall use a clinical edit software program that automatically evaluates all claims for medical bills involving the use of current ICD and CPT/HCPCS codes. Clinical claim review software shall be updated no less than once every year, and all changes and new codes shall be incorporated by the Contractor within thirty (30) days of the change becoming effective. The Contractor's claims management system shall automatically price network claims using current Network Provider rate information. The claims management system shall store Network Provider information to determine provider status and reimbursement for claims from Network Providers. The Contractor shall provide a copy of their standards for updating Network Provider rate information in their claims management system at least 30 days prior to Go-Live. Network Provider rate information shall be updated in the claims management system according	

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			to the Contractor's documented standards. Please confirm: Does this refer to timely update of information specific to the provider and their demographics, contract changes, etc., OR does it refer to the timely update of codes and rate information based on industry standard or third-party updates? Can you please provide additional information on what specifically is needed to support this requirement prior to Go-Live?	The State confirms that A.12.n refers to timely update of information specific to the provider and their demographics, contract changes, etc., and A.12.m refers to the timely update of codes and rate information based on industry standard or third-party updates. The Contractor shall provide their documented process for updating their claims processing system with updated provider contract rate and payment information.
A.12.p.		79.	Explanation of Benefits (EOB) The Contractor shall generate and mail an EOB to the Member each time the Contractor processes a claim from a provider where the Deductible, Copayment, Coinsurance, etc. is greater than zero, unless specifically requested by a Member. The Contractor shall mail the EOB within five (5) Business Days of processing the claim. The EOB format and text shall be prior approved In Writing by the State and shall include, but not be limited to, the date the Contractor received the claim, the date the Contractor adjudicated the claim, the claim number, identification number of the head-of-contract, the patient name, the date of service, type of service furnished, the provider name, the Contractor's contact information, submitted charges, total amount paid by the plan, the amount paid by another insurance carrier, total amount owed by the Member by cost-sharing category (Deductible, Copayment, Coinsurance, etc.), any non-covered amount, the out-of-pocket amounts paid for the year, how to file an appeal, adjustments or corrections that affect a Member's out-of-pocket costs, and any other information legally required. The Contractor may substitute electronic EOB statements if requested by the Member. Please provide a sample of the current EOB associated with this request.	EOB examples are located here: BCBST (pg. 12) Cigna

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A.16.d		80.	(3) Inclusion of pharmacy benefits information in the Contractor's annual enrollment materials for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other vendors (as directed by the State), and other updates and/or changes that may be helpful to the State's members. At the state's request and direction, the Contractor shall also include in its annual Welcome Packet to plan members, at the conclusion of the state's open enrollment period, any letter or other pharmacy benefits related materials. Is the goal to have information from all vendors in one welcome packet or is the request to consolidate information from all vendors onto one document included in the welcome packet?	Typically, each contractor will send members annual enrollment information and welcome packets related to their program and members will receive multiple mailings. We do require inclusion of other contractor information on the TPA splash page, member handbook, and ID card. If, however, the State wanted to consolidate materials the State would communicate with all health benefits contractors to ensure clear direction of what materials to include and which contractor will be responsible for mailing.
A.12.k.		81.	If a Member receives a covered benefit from a Network Provider, the Network Provider's contract rate shall be used to determine the Member's Deductible (if applicable) and any Copayment or Coinsurance amount and the Member shall not be responsible for payment in excess of that amount. In addition, if a Member receives a medical service from a Network Provider but the claim for the service is denied as ineligible for payment (e.g., the service exceeded the applicable service limitation, was not medically necessary, was experimental or investigational, or the service was subject to PA and was not approved by the Contractor) the Member shall not be responsible for payment to the provider unless the Network Provider can provide a copy of an advance beneficiary notice (waiver) for the specific services rendered and the date of service, signed by the Member prior to the service by the Member prior to the service being rendered. We would request to delete the second sentence. If this is not acceptable to the State, please describe how this provision is currently enacted and enforced.	The State does not agree with this revision. It is the State's understanding with providers and TPAs that this type of language is standard in provider contracts. Failure to obtain a prior authorization is always the in-network provider's responsibility and a member shall not be balance billed. With regard to medically necessary services, we have had instances of Members being balance billed by a Network Provider for services that were denied as not medically necessary, experimental, investigational, or unproven because the Provider had a member sign an ABN. When we inquired about these situations, we were informed that this is an acceptable practice. Including this language in our contract and our member handbooks allows us to be clear regarding the scenarios in which a Member could be balance billed by a Network Provider. If a Network Provider balance bills a Member and an ABN regarding medical necessity, experimental,

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				investigational, or unproven was not signed, the expectation is that the Contractor will perform provider outreach for potentially violating their Network Provider agreement and ensure the Network Provider ceases billing the member for said services.
A.12.t.		82.	The Contractor shall not pay for preventable events and conditions, e.g., hospital- acquired conditions and preventable surgical errors that are identified as non-payable by Medicare. In addition, as directed by the State, the Contractor shall not pay for other preventable events and conditions that are identified as non-payable by other federal or state payers. At the State's request, the Contractor shall provide a report of these Denied Claims and the avoided charges to the State. Would the State add clarification that carrier will not "knowingly" make payment on such claims?	The State agrees to this revision. Please see Amendment #16 below.
A.12.v.		83.	Regarding the following statement in the Proforma A.12v: The Contractor shall pass directly to the State the payment terms that the Contractor has negotiated with providers. The Contractor shall not receive any differential between the provider contract rate and the payment funded by the State; the Contractor shall ensure that the State and the Member receives the full benefit of any provider payment terms, including, but not limited to, provider fee schedules, contract rates, other payment arrangements, discounts, rebates, refunds, or credits negotiated by the Contractor. All special pricing considerations and financial incentives shall accrue to the State and Plan Members. The majority of our clients access our secondary network program (Network Savings Program) to obtain network savings on providers outside [REDACTED]'s directly contracted network. The access fee for these secondary networks is a percent of savings. Would the State want to participate in this type of program? And if so, would the shared savings reimbursement arrangement be acceptable only for those claims?	The State does not agree to participate in this type of program.

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A.12.w.		84.	The Contractor shall remit to the State no less frequently than quarterly a check for 100% of all rebates accrued which were obtained on behalf of the State, by the Contractor (including rebate aggregators or any similar contracted entities), due to the use of medical services, devices, and pharmaceuticals (including Specialty Drugs) by Members of the Plans. A report shall accompany each check containing a breakout by Plan Group fund (i.e. State Actives, State Retirees, etc.) and further broken down by service or product name and the appropriate codes to identify the service or product (e.g. NDC, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). Refer also to Contract Attachment C, Reporting Requirements. Contractor shall include for each breakout the total amount invoiced to the manufacturer, the total amount collected on behalf of the state, and the amount being paid to the state, as well as the calendar quarter to which the various Rebate amounts are attributable. The Contractor shall not enter into any agreement with a pharmaceutical manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from pharmaceutical manufacturers as being considered Rebates. The State reserves the right to audit the rebate payments in accordance with A.24.a to ensure 100% of all rebates accrued were paid to the State correctly. Would the State consider caveating the last sentence “except as otherwise provided in the Agreement”?	The State does not agree to this revision
A.12.cc.		85.	Regarding the following statement A12cc: The Contractor shall implement a process to carry out recoveries, including but not limited to subrogation, and report recovery activities to the State. The Contractor shall submit to the State a monthly recoveries report of all recoveries including but not limited to subrogation in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements). Can the State provide a copy of the subrogation policy that the Contractor is being requested to administer as well as a sample copy of the current reporting?	Please see Appendices 7.14 and 7.15.

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A.12.dd		86.	The Contractor shall determine whether eligible expenses are medically necessary. Would the State clarify its meaning – we are concerned the statement is somewhat circular, in that an expense that is not medically necessary is by its very nature not eligible?	Eligible means that the expense is covered based upon State defined benefits and plan documents. Medical necessity is determined based upon the TPA medical policies.
A.12.jj.		87.	The State will only pay for approved and correctly Paid Claims, not for rejected, reversed, duplicate claims, claims processed but not paid, or claims paid in error. Would the State clarify that they are referring to claims paid DUE TO ERROR BY THE CONTRACTOR (i.e., we shouldn't be responsible for mistakes by the provider)	The Contractor is responsible for claims paid in error due to Contractor error and to reimburse the state and/or members for errors made by providers as noted in Section A.12.kk.
A.12.kk		88.	The Contractor shall reimburse the State for one hundred percent (100%) of claims paid in error. If the Contractor is unable to withhold the amount from the provider's next payment then the Contractor shall reimburse the State within thirty (30) days of identification of the overpayment, or within a time frame agreed to by the State. We request that this clause be deleted.	The State does not agree to this revision
A.12.mm		89.	The State shall conduct a monthly review of Pended Claims. The Contractor shall provide a current list of Pended Claims every month including the current status of prior and newly Pended Claims and the top reasons claims are pended (refer also to Contract Attachment C, Reporting Requirements). We request that this clause be deleted.	The State does not agree to this revision
A.12.oo		90.	The Contractor shall issue all related U.S. Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing the Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting. Can the state elaborate on the type of reporting it is asking for in this section.	The State requires the Contractor to report and submit directly to the IRS the appropriate forms as required to report payments made by the Contractor to individuals or corporate entities. The State will not assume IRS reporting for payments made by the Contractor, even if payments are made on behalf of the State. For more information on Form 1099 reporting requirements, please visit the following website:

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				https://www.irs.gov/instructions/i1099msc
A.13.c.		91.	Please confirm: Should this reference Contract Attachment D, Service Level Agreement Scorecard, rather than Contract Attachment B, Liquidated Damages?	Confirmed. Please see Amendment item #18 below.
A.13.c.		92.	The Contractor shall, in consultation with the State, develop and disseminate Member information and communication materials. All materials must have approval In Writing by the State prior to distribution (refer also to Attachment B, Liquidated Damages). Contractor shall ensure that all Member materials and other communications meet any state or federal regulatory compliance (e.g., Civil Rights Compliance), if applicable. The Contractor shall develop all materials in conformance with the style, formatting and other related standards developed by the State and its marketing staff. Please confirm the State's responsibility for accurate plan benefit information?	The State confirms the State's responsibility to provide plan benefit information to the Contractor.
A.13.h.		93.	Contractor shall comply with the Federal Register Nondiscrimination in Health Programs and Activities (81 FR 31375, 45 CFR 92). Would the State add the qualifier "as applicable" so that we are not being asked to comply with provisions of Section 1557 that do not apply to us?	The State does not agree to this revision
A.13.i.		94.	Please confirm: Should this reference Contract Attachment D, Service Level Agreement Scorecard, rather than Contract Attachment B, Liquidated Damages?	Confirmed. Please see Amendment item #19 below.
A.13.i.		95.	The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials (refer also to Attachment B, Liquidated Damages). The State has and retains the ability to edit and customize all communication pieces distributed by the Contractor, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters or correspondence. The	The State does not agree to this revision

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			Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements. We request that the following sentence is added: "Those communications that may not be readily available may be approved after dissemination."	
A.13.o.		96.	At any time and at the State's request, the Contractor shall notify Members, In Writing, of any benefit, Plan or program changes no less than thirty (30) Business Days prior to the implementation of the change. Is the State ok revising statement regarding receipt of proper notice?	The State agrees to revise the language. Please see Amendment item #20 below.
Communications		97.	Does the State have a desired format for the member handbook that each vendor uses to input their information or does the State use the vendors member handbook as the format? Please provide a copy of the current member handbook for each of the current vendors.	The State requests that the Contractor follow a similar format and layout as our current member handbooks. The language is written by the State and the Contractor may include additional customized language and graphics. 2021 member handbooks are posted on the Partners for Health website under publications. BCBST Cigna
Communications		98.	Please provide a link to the custom splash page for each of the current vendors.	BCBST Cigna
Communications		99.	Please provide copies of the materials included in the current custom welcome kit, including the welcome letter, and postcard.	Please see Appendix 7.22.
Communications		100.	How many printed member handbooks are mailed each year?	In 2020, 8,587 member handbooks were mailed to members or ABCs upon request.
Communications		101.	How many printed copies of the provider directory are mailed each year?	In 2020, 11,328 provider directories were mailed to members or ABCs upon request.
Communications		102.	Please provide a copy of the current custom ID card.	Copies of ID cards are included in the 2021 member handbooks are posted on the Partners for

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				Health website under publications. BCBST Cigna
		103.	ID cards shall contain a unique Member number for each Member, which shall be the employee's unique Edison ID, the full eight (8) digit number (with leading zeroes), provided on the monthly enrollment file. Such identifier shall NOT be the Member's federal Social Security Number. Contractor may add additional identifiers if prior approved by the State In Writing. Can the State's employee ID number be formatted to a 9-digit numeric number?	The State has approved the addition of leading zeros and/or leading characters in the past.
		104.	As directed by the State, the Contractor shall re-issue ID cards to reflect approved Plan design changes, included but not limited to, changes in cost sharing, within the timeframe specified by the State. Please confirm what the required timeframe is for reissued ID cards.	The State does not anticipate benefit changes that would require a reissue to occur mid-year. However, the State would anticipate at least 30 days' notice to load benefit changes and make additional updates to materials including but not limited to updating ID Cards. The reissue would then be expected within 45 days of the notification. This is just an estimated example.
A.15.d.		105.	The Splash Page shall have the capability to host streamed content (both audio and video) from other contractors including video/multimedia tools as determined by the State if useful and applicable to Members. Is it acceptable to link to benefit admin websites and other State contractor's websites instead of host?	At minimum, Splash page shall have the capability to host a link or directly link to audio or video, or other multimedia tools directly from other contractors or sources. Acceptable links would have to directly go to content and not generally to BA's, the vendor's or other contractor websites.
A.15.g.(6)		106.	"Allow for a Member shared savings payment, as directed by the State" – Please provide additional clarification on the expectation and requirement. Is this related to State legislation?	Yes, this is related to current TN legislation and any decisions similar to said legislation that the State may decide to implement.
A.15.q.		107.	The Contractor may include a mobile application for use by Members with prior approval In Writing by the State. The Contractor must agree to and adhere to all security measures as it relates to Member data. The Contractor must provide a one hundred percent (100%) secure web-based application that requires only a web-browser and an Internet connection.	The State agrees to this revision. See Amendment #38 below.

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			100% protection is an impossibility for anyone. Will State consider revision?	
A.15.s.		108.	The Contractor agrees that the State shall have the authority to request revisions to the Contractor's online Terms and Conditions or Online Service Agreement at any time and that the State shall be provided with a copy of any Terms and Conditions that a Member must consent to in order to be provided with online account access. If the Contractor revises the online Terms and Conditions or Online Service Agreement, the Contractor agrees to provide the State with a copy of the proposed changes at least sixty (60) Business Days prior to the new effective date, and will allow the State to make revisions. Will the State consider revision of this provision: The Contractor agrees that the State shall have the authority to request revisions to the Contractor's online Terms and Conditions or Online Service Agreement at any time, related to the State's member-facing content?	The State does not agree to this revision.
A.16.d(4)		109.	Accepting and maintaining prescription drug claims and accumulator data from the PBM in a manner, format, and frequency specified by the State. The Contractor shall also share medical claims data and total claim amounts with the PBM for the purpose of allowing the TPA Contractor and the PBM to routinely track Member out of pocket maximums. Is the prescription drug data from the PBM designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	The PBM and TPAs exchange accumulator data daily. The PBM shares limited pharmacy data with the TPAs on a monthly basis including but not limited to GPI, drug names, and day supply. At this time TPAs do not share medical data with the PBM but the State reserves the right to request data sharing if necessary, for clinical programs or other member benefits.
A.17.b.		110.	The Contractor is responsible for working directly with the State's EAP/ BHO contractor. Coordination by the Contractor shall include the following: Inclusion of behavioral health benefit information in its Member handbook (see Contract Section A.14.c.), including the toll-free telephone number to contact the EAP/BHO contractor. Inclusion of the EAP/BHO contractor's telephone number on the back of the	The BHO contractor and TPAs exchange daily accumulator data. The BHO contractor shares limited claims data with the TPAs on a monthly basis. At this time, TPAs do not share medical data with the BHO contractor but the State intends

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			Member identification card (see Contract Section A.14.j.). Inclusion of behavioral health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members as requested and approved by the State. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's Members. Accepting and maintaining claims and accumulator data from the EAP/BHO in a manner, format, and frequency specified by the State. The Contractor shall also share medical claims data and claim amounts with the EAP/BHO for the purpose of allowing the TPA Contractor and the EAP/BHO to routinely track Member out of pocket maximums and for enhanced care management of Members. Is the data mentioned above from the EAP/BHO vendor designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	for the TPA to share limited medical claims data going forward on a monthly basis.
		111.	Regarding the following statement in the Proforma …The State contracts with a contractor to provide certain population health services, including wellness, weight management, and disease management. The Contractor is not responsible for the provision of these population health services. However, the Contractor is responsible for coordinating with the PH/W contractor as necessary to ensure that Members receive appropriate population health services. Coordination by the Contractor shall include the following: Inclusion of population health and wellness information in its member handbook (see Contract Section A.14.c.), including the toll-free telephone number to contact the PH/W contractor. Inclusion of the PH/W contractor's telephone number on the back of the member identification card (see Contract Section A.14.j.). Inclusion of population health benefits information in the Contractor's annual	

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			enrollment materials and welcome packets for distribution to Members as requested and approved by the State. Such materials shall include website information, toll-free member service number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's Members. Accepting and maintaining data from the PH/W contractor in a manner and format and at a frequency specified by the State. Is the data from the PH/W vendor designed to be integrated into the benefits (for example, out of pocket maximum) as well as integrated into clinical programs? Can you clarify what the states desired/current frequency is for the transfer of this information?	The PH/W vendor will not be receiving accumulator files from the TPA. The TPA sends limited medical claims data to the PH/W contractor on a monthly basis for verification of completed incentives. See Appendix 7.17 for a basic file template. At this time the PH/W contractor does not send any wellness information to the TPA for integration of PH/W information into its clinical programs however, the State could request data sharing as needed for wellness program operations.
A.19.g		112.	The Contractor shall adopt and implement evidence-based clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. Any provision of the Plan Documents and any guideline, protocol, or pathway in State law shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.15.) shall contain all such guidelines, protocols, or pathways that are applicable to the Plans. Is it acceptable with the State based on this provision that the Contractor will provide all information as stated except any provisions that are proprietary based on contracts with external vendors. However, if there is a denial based on a provision that is proprietary, the information can be shared based on processes in place for appeals.	The State agrees that any provisions that are proprietary based on contracts with external vendors may be provided to the State upon request if not posted on the Contractor's website.

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A.19.c.		113.	The Contractor shall establish a quality assurance committee comprised of qualified medical experts, including adequate representation of medical specialties, which shall meet according to Contractor program policies and procedures. The quality assurance committee shall be responsible for evaluating the quality of care provided by Network Providers. Any person employed by the Contractor who identifies a potential quality of care issue involving a Network Provider shall submit it for investigation by the quality assurance committee. The committee shall promptly investigate any potential quality of care issues. Will the State consider modifying "any employee of the Contractor" to be "any employee of the Contractor with appropriate expertise…"?	The State does not agree to this revision
A.21.g.		114.	Please confirm: Should contract reference A.21.g (7) reflect Contract Attachment D, Service Level Agreement Scorecard?	The State confirms. Please see Amendment item #22 below.
A.22.l.		115.	The Contractor shall transmit medical claims data to the State's current health care DSS contractor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 31786-00148 Appendix 7.10 "DSS Vendor File format" or in a mutually agreed upon format. The data feed(s) shall be provided at no additional charge to the State. The Contractor shall transmit the claims data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State, until all claims incurred during the term of this Contract have been paid. Refer also to Contract Attachment B, Liquidated Damages Please confirm who the State's DSS vendor is. Please also provide a copy of the current/requested file layout.	IBM Watson is the State's current DSS vendor. The current file layout is included as Appendix 7.10 "Decision Support System File format".
A.23.f.		116.	Information Ownership. All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. The Contractor is expressly prohibited from sharing or publishing State information	The State does not agree that the contractor has a proprietary interest in or ownership of claims information and data provided to the State under the

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			and reports or releasing such information to external entities, Affiliates, parent company, or subsidiaries without the prior written consent of the State. Further clarification regarding the scope of ownership and prohibition on disclosure is requested. For example, we recognize the State's interest in owning information (including data, documents and reports referencing that information) as well as the State's interest that the information not be shared or published externally. Practically speaking, much of the information the State will receive, particularly claims data with provider payment information, is proprietary to, and owned by, the carrier. Additionally, we require the ability to disclose information (i) internal to our enterprise for purposes of data analytics, development/enhance of products, etc., and (ii) externally to our advisors (e.g., auditors and attorneys) for our operations. We look forward to working through these issues with the State in a manner that meets both parties' needs, such as with licensures for use of information, agreed upon limited exceptions to the prohibition on use/disclosure, etc.	contract but the State has modified the language. Please see Amendment item #23 below.
A.24.h.		117.	The Contractor shall fund the following audits which shall be conducted by a qualified organization or representative chosen by the State and the scope of the audit shall be defined by the State: 1.A pre-implementation audit to review, at a minimum, whether the Contractor's adjudication system is configured according to the State's benefit design; 2.An operational audit focusing on, at a minimum, staffing, customer service capabilities, TPA audit programs, and claims administration; and 3.Any follow-up audits if significant deficiencies, as determined by the State, are noted. Would the State consider limiting the Contractor's payment for audits by third parties to two audits per year? Alternately, would the State consider limiting the Contractor's payments for	The State does not agree to this revision

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			audits by third parties to a total of $100,000 per year?	
C.1		118.	Regarding the following statement Proforma Section C.1: Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract. Please confirm whether the State intended the Maximum Liability amount to be specific to administrative services fees, exclusive of claims dollars.	The maximum liability amount is specific to administrative services fees, exclusive of claims dollars.
C.3		119.	The state seeks to transition as much appropriate outpatient Specialty Drug dispensing as possible to our carved-out PBM or for those Specialty Drugs that are physician- administered to the most clinically appropriate cost effective site of care such as, physician's offices or home health from hospital inpatient and outpatient settings which tend to have higher costs. The state recognizes that some dispensing of Specialty Drugs will continue through the medical benefit, but seeks to reimburse providers for the provision of Specialty Drugs via our TPAs of these contracts on an ASP+ model. Refer to Contract Section C.3.g. Is it the State's intent to carve specialty medications out of the physician outpatient setting and have them handled directly by the PBM?	It is not the State's intent to carve out specialty medications from the physician's office to the State's PBM contractor.
		120.	In regards to Specialty Drugs would the state be willing to separate billing and remittance of recoveries (to the customers funding account) as these are usually handled independently?	The State does not understand this question as written and needs further clarification as to the context and intent in order to respond. Please clarify in Round 2 of the Questions and comments.
C.3.d		121.	Section C.3.d of the Proforma states "the transfer of said funding to the Contractor for claims payments shall be effected at least weekly by ACH debit	Yes, this is correct.

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			from the Contractor to a designated State bank account". To clarify, does this mean that you would like us to pull funds from your designated bank account in order to fund the claims?	
		122.	Is the State open to daily funding for claims payments instead of weekly?	Yes, daily funding is acceptable as the contract language says at least weekly but does not limit to weekly.
		123.	Is the State's claims funding coming from a single State bank account to the Contractor?	No.
		124.	Please provide some detail around the current State claims funding process and bank account set up.	Currently, the State has a designated bank account for each carrier, plan, product, region, and network that the Contractors ACH Debit for claims issued. Under the current benefit design, the minimum number of bank accounts each Contractor would have is 66. The Contractor will initiate the ACH Debit to the correct bank accounts at least weekly. Unless there are unforeseen issues, the ACH Debit is routinely settled the next banking business day.
C.3.d.1		125.	In the Proforma Section C.3.d.1 states "The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account." We will need to maintain a separate bank account that we own, on behalf of the State. This is the account that the State funds when claim payments are charged. Is this acceptable to the State? This is the systematic way we have of managing claim funding and reporting specific to the State's claims. Is the State open to considering a cashed basis instead of issued?	The Contractor is expected to ACH Debit the issued claims from the bank accounts designated by the State. The State will not fund to a Contractor's bank account. The State will not consider paying on a cash basis rather than an issued basis. Please refer to the State's response to question #30.
C.3.d.2.		126.	In the Proforma Section C.3.d.2. states " The State reserves the right to review documentation either before or after the transfer of funding for claims payments and, as the State may deem appropriate, to adjust the funding	It is very rare that the State would short fund a payment. The State or its designated auditors would be more likely to review documentation after a payment has been made and

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			amount to be transferred or withhold the amount of any overpaid funding from another funding transfer." Please elaborate on the circumstances under which the State decides to short fund or dispute the claims funding and the frequency that this occurs.	request reimbursement for any improper payments found.
		127.	In our standard process for handling escheatment, if a check is determined to be non-negotiable after a period of 12 months, we will send a report to the State so they can perform the appropriate filing or reimburse the member directly. In a cashed based arrangement, there are no funds to return to the customer when a check is aged. In an issue-based arrangement, the aged checks are credited to the claim benefit account, net with other issued payments and voids. Is this acceptable to the State? If this is not your current escheatment process, can you please describe the current process.	This is not acceptable to the State. The uncashed checks are considered unclaimed property for State of Tennessee purposes. Unclaimed property is intangible (uncashed check) or tangible property in which there has been no activity generated or contact with the owner for a one-year or longer period—at which point, it becomes unclaimed or abandoned. The bank account from which the check was issued is controlled by the Contractor. The Contractor is considered a business holding the unclaimed property or holder. A Holder must: 1. Identify potential unclaimed property, 2. Perform due diligence – attempt to locate the owners, 3. Report and remit the unclaimed property to the State's Unclaimed Property Division under the Department of Treasury.
C.3.g.		128.	Regarding Section C.3.g of the Proforma, we propose to amend this section based on our current contracted arrangements for Specialty Drug reimbursements.	The State cannot agree to this request due to lack of detail and proposed solution.
C.11		129.	In the Proforma Section C.11 Can you please provide a copy of the "Authorization Agreement for Automatic Deposit Form" discussed in Section a?	It appears this question is referencing C.14.a. Please see Appendix 7.14,
D.5.		130.	We request to change the number of days to 60.	The State does not agree to this revision.
D.6		131.	We request to change the number of days to 60.	The State does not agree to 60 days but has modified the language.

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				Please see Amendment item #25 below.
D.6		132.	If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor materially violates any 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. 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. Please Confirm: May we suggest language be added to include a cure period.	See the State's response to question #131.
D.7		133.	The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract. Like all large health plan administrators, we obtain the assistance of subcontractors and it would not be feasible to seek approval for all of carrier subcontractors. Please confirm this is acceptable? Please confirm approval to assign to a subsidiary or corporate affiliate without obtaining further permission	The State does not confirm. All carrier subcontractors must be approved by the State. The State confirms approval to assign to a subsidiary or corporate affiliate without obtaining further permission.
D.32		134.	"Contractor shall provide the COI ten (10) business days prior to the Effective Date and again thirty (30) calendar days	The State does not agree but has modified the language.

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			before renewal or replacement of coverage." Insurance carriers often have not provided quotes to us within 30 days of the expiration of the current policies. It is not impossible to provide a new COI 30 days before renewal or replacement of coverage. We can however, agree to provide a COI 30 days after renewal or replacement of coverage.	Please see Amendment #39 below.
D.32.a.		135.	We request that the limit be changed to per claim.	The State has modified the language. Please see Amendment #39 below.
E.4		136.	Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract. Please Confirm: Is it acceptable if the Contractor is required to disclose certain information for accreditation or other internal purposes?	Refer also to question #46. The State confirms and reiterates the following prohibited uses marketing, advertising, or expanding non-State business relationships or for any pecuniary gain.
E.7, second paragraph		137.	The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise	Question 1: The State declines to revise the contract language. The State has a standard notification requirement of 24 hours for all vendors. Question 2: All potential disclosures shall be reported to the State. HIPAA defines disclosure as: the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information. A contractor could have a breach in security without confirmation that PHI was disclosed. The State wants to know about such events.

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			available at law. The obligations set forth in this Section shall survive the termination of this Contract. Please Confirm: Is the State agreeable to revise the timeline to 72 hours. Sometimes it is difficult to obtain enough information to know what to report. We can commit to ongoing updates as additional details become available. SECOND QUESTION: It would be difficult and very subjective to report on "potential disclosures" - every action could be considered potential –we could possibly be bombarding the State with every event that hits our various systems.	
E.8.a.		138.	With respect to the Proforma section E.8.a.(2), are you willing to revise as follows: The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption algorithms ~~technologies.~~"	The State agrees to modify the language. Please see Amendment item #27 below.
E.8.a.3		139.	With respect to the Proforma sectionE.8.a.(3) , we do not permit customers to perform tests and assessments on our environment; however, we will share summary results of internal and 3rd party tests and assessments. Given this fact, we propose the following revision: "The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment."	The proposed language is the same as the current contract language. The State has modified this language. See the State's response to question #140.
E.8.a.3		140.	Current language: The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security	The State agrees to modify the language. Please see Amendment item #27 below.

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
			weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment. Due to confidentiality and privacy concerns, will the State consider revisions to the ProForma language as follows: The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment. The Contractor shall commission an independent third party to perform the risk assessment which must include penetration testing and vulnerability assessments. The Contractor shall provide the results of the third party testing to the State.	
E.8.a(4)		141.	Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State. The Contractor shall maintain a duplicate set of all records relating to this Contract in	The State does not understand as the respondent's question seems more applicable to Section E.8.d instead of E.8.a(4). Please clarify your question and suggested redlines

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			electronic medium, usable by the State and the Contractor for the purpose of Disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation. Would the following language be acceptable…Our Business Continuity and Disaster Recovery program meets or exceeds industry standards. [REDACTED] has an Industry leading backup and data recovery program that includes multi-site, near real-time recovery and data replication. Data is also offsite backed up to an offsite location within our infrastructure. We fully replicate the data for retention in all our data center environments. In addition, timeline data is stored in our systems and we maintain history using full and incremental backups	in Round 2 of Questions and Comments.
E.8.b(1)		142.	With respect to Proforma section E.8.b(1) Vendor has its own policies and standards. It is extremely challenging to agree to a policy that will likely change over time without knowing now, what those future changes may be. If there are specific concerns in this regard, Vendor is willing to discuss and have the State review a summary of its policies, which constitute best practices within our industry.	The State would be willing to review the State's current policy against current Contractor activities to ensure compliance. The State would also be willing to review the language and the Contractor's policies and standards once the contract is awarded.
E.8.d.2		143.	"Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives: Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: one (1) hour. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences	The State does not agree to this revision. The State would also like to direct potential respondents to contract Section E.8.4. It states that the Contractor shall maintain a set of all records, stored separate from the originals. These records are to be updated, at minimum, on a daily basis and retained for at least sixty (60) days.

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
			associated with a break in business continuity: seventy-two (72) hours. Would the State be agreeable to an RPO of 24, 12, or 8 hours in lieu of one hour?	
		144.	The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide the State with the Contractor's and Subcontractor's annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor and in addition to periodic bridge reports as requested by the State, see Contract Attachment D. The Contractor shall submit corrective action plans or mitigation to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor. Please confirm if the following is acceptable with the state… Subcontractors who will be managing protected/confidential information are subjected to a Vendor Information Security Risk Assessment (VISRA) by [REDACTED]'s Enterprise Information Security Team prior to engaging in subcontractors services and exchange of data. This VISRA is to assess our supplier/partner's control environment and overall security posture before customer data is exchanged. Suppliers must adhere to an adequate framework of Information Security policies, standards, and controls while under contract with or providing services to [REDACTED] and they must acknowledge their responsibility for safeguarding [REDACTED]'s information technology systems and information assets through [REDACTED]'s Master Service and Business Associate Agreements. In addition independent	The State does not agree to this revision. The State is willing to review the language and the Contractor's policies and standards once the contract is awarded.

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
			attestation of a service provider's security practices and process controls may be accepted in place of a [REDACTED] assessment given the attestation provides sufficient evidence (e.g., current Statement on Auditing Standards 70 Type II, its equivalent, and/or a BS7799 Certification, and/or an ISO270002 or HITRUST Certification). Acceptance of such attestations must be assessed and approved by [REDACTED]'s Information Risk Management organization. We ask you remove subcontractors from this language.	
E.8.e.		145.	The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type II audit. The SOC audit control objectives shall include all five trust services principles. The Contractor shall provide the State with the Contractor's and Subcontractor's annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor and in addition to periodic bridge reports as requested by the State, see also Contract Attachment C, Reporting Requirements. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor. [REDACTED] has adopted the Health Information Trust Alliance (HITRUST) Common Security Framework (CSF) rather than the SOC2 reports. SOC2 has a very board range of uses; however, the HITRUST CSF framework was developed in collaboration with healthcare and security professionals to address the security needs of the healthcare industry. Would the State be willing to accept our HITRUST?	The State does not agree to this revision. The State is willing to review the language and the Contractor's policies and standards once the contract is awarded.

<table>
<tr><th>RFP SECTION</th><th>PAGE #</th><th></th><th>QUESTION / COMMENT</th><th>STATE RESPONSE</th></tr>
<tr><td>E.8.e. SOC reports</td><td></td><td>146.</td><td>The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants (“AICPA”) for a System and Organization Controls for service organizations (“SOC”) 2 Type II audit. The SOC audit control objectives shall include all five trust services principles. The Contractor shall provide the State with the Contractor’s and Subcontractor’s annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor and in addition to periodic bridge reports as requested by the State, see also Contract Attachment C, Reporting Requirements. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor.

Would the State consider alternative reports that illustrate carrier has excellent privacy and security programs in place other than a SOC2 that has all five principles?
Since this contract begins in June, 2021 and current SOC runs January 2021 through September 30, 2021 with a bridge letter, is it acceptable that we implement the new five Principals for the Plan year 2022?</td><td>The State does not agree to any revisions.

The State is willing to review the language and the Contractor’s policies and standards once the contract is awarded.

If awarded the contract, the Contractor would need to provide its current SOC report and then transition to a SOC report including the new five Principals for the Plan year 2022.</td></tr>
<tr><td>Liquidated Damages</td><td></td><td>147.</td><td>Please confirm: Are Contractors required to have both NCQA and URAC accreditation? NCQA is the more stringent accreditation.
<table><tr><th colspan="2">16. URAC Accreditation</th></tr><tr><td>Guarantee</td><td>The Contractor shall su accreditation certificatio</td></tr><tr><td>Assessment</td><td>Twenty thousand dolla</td></tr></table></td><td>Please refer to question # 60.</td></tr>
</table>

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
			Justification: This accreditation sets out minimum standards that a Contractor must ut in a utilization management program to receive NCQA accreditation. This assessment and amount take into account the State's increased oversite and managemer the Contractor without this accreditation. Measurement: Measured, reported, reconciled and assessed annually.	
Liquidated Damages Item 1		148.	Should the Justification section start with the sentence "The Project Implementation Plan" rather than "This"?	The State has modified the language. Please see Amendment item #28 below.
Liquidated Damages Item 4		149.	Should this be A.11.b.?	The State has modified the language. Please see Amendment item #29 below.
Liquidated Damages Item 15		150.	The Contractor shall submit a copy of their NCQA's Credentials Verification Organization certification as specified in Contract Section A.6.m. and NCQA Health Plan Accreditation at a level of 4 or more stars as specified in Contract Section A.19.l. Is the State willing to accept our full Health Plan Accreditation certificate and not one specific to CVO since credentialing falls under NCQA? Our NCQA Health Plan includes both UM, Credentialing and so much more. Within the Health Plan accreditation we are also audited on Quality, Network Management, Population Health Management, and Member Experience. Therefore the NCQA Health Plan accreditation is more comprehensive.	See the State's response to question #52.
Liquidated Damages, HIPAA 500+		151.	Please clarify that carriers are only required to pay the assessments when HIPAA requires notification of the breach. There are exceptions to HIPAA's breach notification requirements that are often available, but not noted by the terms. Simply put, an incident might be a HIPAA breach, but HIPAA doesn't always require the plan to notify members of the breach. If HIPAA provides an exception to the breach notification requirement, then members will never know of the breach and there will be no need to field inquiries from members, set up a toll free number, etc.	An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors: 1. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
				2. The unauthorized person who used the protected health information or to whom the disclosure was made; 3. Whether the protected health information was actually acquired or viewed; and 4. The extent to which the risk to the protected health information has been mitigated. Benefits Administration's HIPAA Compliance Officer will review vendor risk assessment of breach and will provide final determination regarding breach notification. The business associate agreement outlines that Benefits Administration has the final determination of notification. If the breach involves any unsecured protected health information, then notification is required. Unsecured protected health information is protected health information that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology
Contract Attachment C		152.	Regarding the following statement in the Proforma: As directed by the State, the Contractor shall report to the PH/W contractor those Members who complete state specified wellness activities to earn incentives and/or requirements delivered by the Contractor such as, but not limited to, case management, preventive screenings, or other programs/activities. Refer also to Attachment C, Reporting Requirements. Can the State specify the requirements that are currently in place and being reported on as well as provide a sample report and the frequency?	Please see the response to Question #37. The current incentive file is shared with the PH/W contractor monthly with delivery on or before the 20th of the month. Please see Appendix 7.17 .
Contract Attachment C		153.	Reporting Requirements, Contract Attachment C, Episodes Report, in compliance with contract section A.10.b.(8). Should the reference be to Section A.10.b.9?	The State has modified the language. Please see Amendment item #12 below.

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
Contract Attachment C		154.	Value Based Payments Report, In compliance with contract section A.10.j.(5). Should the reference be to Section A.10.k.5? (based on the fact there are two "b" items in this section?	The State has modified the language. Please see Amendment item #12 below.
Contract Attachment C		155.	Value Based Payments Report, In compliance with contract section A.10.j.(5). Would you consider annual or semi-annual reports? The rationale is when we talk reported outcomes, financial impact we usually need a year of time to measure impact upon (usually three months isn't enough to gauge impact).	Yes. Please see Amendment #15 below.
Contract Attachment C		156.	Telehealth Utilization Report, submitted quarterly in compliance with contract section A.10.l.. Should the reference be to Section A.10.m? (based on the fact there are two "b" items in this section?	The State has modified the language. Please see Amendment item #12 below.
Contract Attachment C		157.	Diabetes Prevention Program Outcomes Report, submitted quarterly in compliance with contract section A.10.m. Should the reference be to Section A.10.n? (based on the fact there are two "b" items in this section?	The State has modified the language. Please see Amendment item #12 below.
Contract Attachment C		158.	ASP Specialty Drug Reconciliation Report. submitted annually in compliance with contract sections A.16.f and C.3.f of this contract and will be validated by the State's actuarial consultant. Should this reference C.3.g?	Yes. Please see Amendment item #35 below.
Service Level Agreement Scorecard		159.	It appears that KPI's numbered 1-10 are all quarterly reports and that those only will be included in the Service Level Agreement Scorecard and used in the Quarterly Calculation At Risk Performance Payment. The other 10 KPI's listed in Attachment D have a flat dollar At Risk Performance Payment. Is there a difference in the last 10 items and/or would those be considered a Performance Guarantee with Liquidated Damages like those listed in Attachment B?	The first ten KPIs listed in Contract Attachment D will be reviewed and assessed quarterly based on the total score. The other ten KPIs are a flat-based SLA which are assessed based on the occurrence.
Service Level		160.	PA and UM Evaluation. Should the contract reference be A.9.i?	Yes. Please see Amendment item #36 below.

RFP SECTION	PAGE #		QUESTION / COMMENT	STATE RESPONSE
Agreement Scorecard				
Service Level Agreement Scorecard		161.	Unauthorized Usage of Information Should this reference Contract Section A.4.l.?	Yes. Please see Amendment item #37 below.
Service Level Agreement Scorecard		162.	Should the contract language reference Contract Attachment D, Service Level Agreement Scorecard since Attachments B and C were already referenced in section A.21.a.?	Yes. Please see Amendment item #21 below.
Service Level Agreement Scorecard item 10		163.	Distribution of Ongoing Member ID Cards/Welcome Packets Please confirm this may be tracked at our Book-of-business level; otherwise it would require a manual process.	The State does not agree.
Service Level Agreement Scorecard, Efficient Network Provider/Facility Network Accessibility		164.	Are reports semi-annual or quarterly? The language indicates we will be assessed quarterly, but it also mentions semi-annual report. Also, if a deficiency is found and there are no providers in the area to contract with, will the PG/LD be reviewed and waived?	Please see Amendment item #31 below. If an area of deficiency is identified and no licensed provider is available to be contracted in the specialty in question the State will consider waiving the LD with sufficient documentation.
Service Level Agreement Scorecard, Enrollment Set-Up		165.	As required in Contract Section A.22.d., enrollment information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to Go-Live. Since enrollment information availability by 12/1 is solely dependent upon when enrollment files are received from the State, please confirm any unexpected delays in receipt of files from the State would allow for additional time for online availability.	The State confirms.

3. Delete RFP Section C.51 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

	C.51	Provide your 2019 appeal processing outcomes for your Tennessee fully insured book of business. Appeals / CY 2019 Expedited within 72 hours / % Preservice within 30 days / % Post service within 60 days / %		5	

4. Delete RFP Section D.1, Part 1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

TECHNICAL PROPOSAL & EVALUATION GUIDE

NOTICE: Section D, Part 1 is applicable to the currently established **Efficient** statewide network option the Respondent elects to offer. The proposed network must meet access standards defined in Contract Attachment B in the pro forma contract.

Complete and address the Technical Proposal & Evaluation Guide – Section D.1 for the currently established Efficient statewide network

SECTION D, PART 1: NETWORK. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 1. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will, then, multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 1 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Provider Network Management The State is seeking an Efficient network, as referenced in Section D Part 2, in both quality and cost. In addition to the Efficient network the State may decide to offer a Broad network, referenced in Section D Part 2, choice to Members at an additional premium cost. Answer the following questions only as they relate to your **Efficient** network.					
	D.1.1.	Define if all of your networks are managed by your company or if you subcontract any portion of your network from another organization. If you subcontract, please provide information about the subcontracted network.		**6**	
	D.1.2	Describe your network provider services including provider training, technical assistance, and how quality standards are communicated and enforced.		**6**	
	D.1.3	Describe your approach to provider network management to ensure your network maintains high quality high performing providers at a reasonable cost. Include your approach to involuntary termination as necessary.		**10**	
Provider Network Development The State is seeking an Efficient network in both quality and cost. In addition to the Efficient network the State may decide to offer a Broad network choice to Members at an additional premium cost. Answer the following questions only as they relate to your **Efficient** network.					
	D.1.4	Describe your approach to network development (including physician profiling		**6**	

<table>
<tr><td></td><td></td><td>and hospital profiling), maintenance (including the standard period of provider agreement renegotiation and renewal), and provider credentialing.</td><td></td><td></td><td></td></tr>
<tr><td></td><td>D.1.5.</td><td>Describe your approach to developing high performance or tiered networks and your plans to expand or develop high performance networks in Tennessee.</td><td></td><td>8</td><td></td></tr>
<tr><td></td><td>D.1.6</td><td>Describe the quality measures and cost criteria used to identify high performing providers and how those providers are identified to encourage member utilization.</td><td></td><td>10</td><td></td></tr>
<tr><td colspan="6">Provider Network Turnover</td></tr>
<tr><td></td><td>D.1.7</td><td>Detail the voluntary and involuntary network provider turnover rate for the Efficient network in Tennessee, as referenced in Section D Part 2, you are proposing for this account (calculated as the number of provider agreements terminated divided by the total number of provider agreements at the start of that calendar year) for CY 2019 and CY 2020 for hospitals, PCPs, and specialists.

<table><tr><td></td><td colspan="2">CY 2019</td><td colspan="2">CY2020</td></tr><tr><td></td><td>Vol.</td><td>InVol.</td><td>Vol.</td><td>InVol.</td></tr><tr><td>Hospitals</td><td></td><td></td><td></td><td></td></tr><tr><td>PCPs</td><td></td><td></td><td></td><td></td></tr><tr><td>Specialists</td><td></td><td></td><td></td><td></td></tr></table></td><td></td><td>4</td><td></td></tr>
<tr><td colspan="6">National Provider Network</td></tr>
<tr><td></td><td>D.1.8.</td><td>Describe your currently established national network you are proposing to use for this contract, including the provider and facility participation that enrolled members will access if they live out of state or are traveling.</td><td></td><td>5</td><td></td></tr>
<tr><td></td><td>D.1.9</td><td>Describe any limitations regarding your national network including, but not limited to, less competitive pricing arrangements, utilization management/prior authorizations, provider quality management, member access, and level of claims data available.</td><td></td><td>5</td><td></td></tr>
<tr><td colspan="4">The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.</td><td>Total Raw Weighted Score:
(sum of Raw Weighted Scores above)</td><td></td></tr>
<tr><td colspan="4">Total Raw Weighted Score

Maximum Possible Raw Weighted Score</td><td>X 5
(maximum possible score) = SCORE:</td><td></td></tr>
<tr><td colspan="6">State Use – Evaluator Identification:</td></tr>
<tr><td colspan="6">State Use – Solicitation Coordinator Signature, Printed Name & Date:</td></tr>
</table>

5. **Delete RFP Section D.2 heading in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):**

NOTICE: Section D, Part 2 is applicable to the currently established **Efficient and Broad** network options the Respondent elects to offer. All proposed networks must meet access standards defined in Contract Attachment B in the pro forma contract.

Complete and address the Technical Proposal & Evaluation Guide – Section D.2.1 through D.2.6 for the Efficient network option and D.2.7 through D.2.12 for the Broad network option.

6. **Delete pro forma contract section A.2.r. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):**

r. Dedicated: Wholly assigned to the State and this contract without supporting additional clients or other non-State contracts.

7. **Delete pro forma contract section A.4.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 collaborate and assist with questions regarding effective dates, benefits, cost-sharing and cessation of coverage as requested by the State, Members, and providers.

8. **Delete pro forma contract section A.4.c. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):**

The Contractor shall keep the State apprised (through such methods as policy briefs, white papers, client communications, etc.) of any new or recently discovered federal or state laws, rules or policies that may impact the Plans. The Contractor shall collaborate with the State on any recommended actions in order to comply with such laws, rules or policies.

9. **Delete pro forma contract section A.4.n. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):**

The Contractor shall notify the State, within three (3) Business Days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plan, or benefits, including but not limited to, file and data sharing between contractors. (Refer to Attachment D, SLA Scorecard.) The situation shall be researched and resolved in a timeframe mutually agreed upon with the State.

10. **Delete pro forma contract section A.6.m in its entirety (any sentence or paragraph containing revised or new text is highlighted):**

The section has been deleted and the subsequent numbering updated.

Contract Attachment C:
Item 2: **Provider Denied Claim Appeals Report,** submitted quarterly in compliance with contract section A.6.o.

Item 3: **Continuity of Care and Unique Care Exception Report**, submitted monthly in compliance with contract section A.6.x.

11. Delete pro forma contract section A.7.n. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Unless otherwise directed by the State, the Contractor shall conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey. The Contractor shall contract with a contractor that is certified by NCQA to perform CAHPS surveys, and the contractor shall perform the CAHPS adult commercial survey. The Contractor shall report the results of the survey to the State by July 20 of each calendar year (refer also to Contract Attachment D, Service Level Agreement and Attachment C, Reporting Requirements). The level of overall customer satisfaction shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term. Based upon the results of the survey, the Contractor shall also develop an action plan to correct problems or deficiencies identified through this activity and deliver said action plan with the CAHPS survey results. The State reserves the right to review the action plan and require changes, where appropriate.

12. Delete pro forma contract section A.10.b in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Corrected the duplicate subsection b and updated subsequent headings and references including:

Contract Attachment C:
Item 9: **Episodes Report**, in compliance with contract section A.10.b.(9).

Item 10: **Value Based Payments Report,** Semi-annually in compliance with contract section A.10.k.(5).

Item 11: **Telehealth Utilization Report,** submitted quarterly in compliance with contract section A.10.m.

Item 12: **Diabetes Prevention Program Outcomes Report,** submitted quarterly in compliance with contract section A.10.n.

13. Delete pro forma contract section A.10.e. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall receive prior approval In Writing from the State for any Member attribution model and associated program payments in a PCMH, Accountable Care Organization, or any other similar model.

14. Delete pro forma contract section A.10.i. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall build by December 31, 2022 and maintain a network of Centers of Excellence for treatment or surgical interventions including but not limited to: bariatric surgery (COE use required), orthopedic surgery, oncology/cancer surgery, cardiology/cardiac surgery, gene therapy, and maternity. The criteria for Centers of Excellence shall be developed by the Contractor and limited to facilities that adhere to the highest standards of patient safety and quality care. As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence and/or shall provide incentives to Members to use Centers of Excellence for the specified services (including but not limited to lower Member cost sharing for procedures performed at such facilities). Additionally, the Contractor shall provide health navigators to direct Members to these facilities when medically appropriate.

15. Delete pro forma contract section A.10.k.(5) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

If approved, semi-annual reporting (refer also to Contract Attachment C, Reporting Requirements) on the number of Members served, program specific outcomes, and financial impact of the program.

16. Delete pro forma contract section A.10.m. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall offer to Members at least one web based diabetes prevention program option based upon the Center for Disease Control's Diabetes Prevention Program including, but not limited to, Member and provider outreach and education. The Contractor shall be able to vary provider program payments based on Member participation and outcomes and must be billed as a claim. The Contractor shall submit a quarterly Diabetes Prevention Program outcomes report that includes the cumulative enrollees, enrollees by program stage, total weight loss, average weight loss by program stage, enrollees by weight loss range (below 0%, 0-3%, 3.01-5%, 5.01-7%, 7.01-10% and 10.01%+) and starting BMI (<25,25-29, 30-34, 35-39 and 40+) (refer also to Contract Attachment C, Reporting Requirements).

17. Delete pro forma contract section A.12.t. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall not knowingly pay for preventable events and conditions, *e.g.*, hospital-acquired conditions and preventable surgical errors that are identified as non-payable by Medicare. In addition, as directed by the State, the Contractor shall not pay for other preventable events and conditions that are identified as non-payable by other federal or state payers. At the State's request, the Contractor shall provide a report of these Denied Claims and the avoided charges to the State. If it is later determined that a payment has been made for a preventable event or condition, the Contractor will reverse the payment or recoup the payment from the provider.

18. Delete pro forma contract section A.13.c. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall, in consultation with the State, develop and disseminate Member information and communication materials. All materials must have approval In Writing by the State prior to distribution (refer also to Attachment D, Service Level Agreement). Contractor shall ensure that all Member materials and other communications meet any state or federal regulatory compliance (e.g., Civil Rights Compliance), if applicable. The Contractor shall develop all materials in conformance with the style, formatting and other related standards developed by the State and its marketing staff.

(1) Materials could include, but are not limited to, Member handbooks, provider directories, identification (ID) cards, welcome packets, letters, brochures, fliers, webinars, website copy, website images, mobile app and app content, social media content, PowerPoints, training materials, marketing materials specific to Plan or agency and videos.

(2) Marketing/segmenting: Contractor may offer or suggest marketing and communications based on segmentation of population (e.g., demographics, geography, etc.). Contractor may provide data to address paths and barriers to engagement.

(3) The Contractor shall, upon request by the State, personalize materials and digital communications.

(4) Contractor shall provide, upon request by the State, marketing and communications samples of how they introduce Plan options to Members and continually drive engagement and utilization of preferred services.

(5) The Contractor shall use graphics to communicate key messages to populations with limited literacy, limited health plan literacy or limited English proficiency. The

Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

(6) The Contractor shall provide text and graphics, if applicable, for the State's communication to Members.

(7) As part of its submission to the State, the Contractor in consultation with the State, shall specify how the materials will be distributed.

19. Delete pro forma contract section A.13.i. 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 the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials (refer also to Attachment D, Service Level Agreement). The State has and retains the ability to edit and customize all communication pieces distributed by the Contractor, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters or correspondence. The Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements.

20. Delete pro forma contract section A.13.0. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

At the State's request and upon sufficient notice, the Contractor shall notify Members, In Writing, of any benefit, Plan or program changes no less than thirty (30) Business Days prior to the implementation of the change.

21. Delete pro forma contract section A.21.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 submit all reports in a mutually agreeable electronic format (*e.g.*, Microsoft Word or Microsoft Excel), of the type, at the frequency, and containing the detail described in Contract Attachment C, Reporting Requirements. As appropriate, reporting shall continue during the claims runout period. Refer also to Contract Attachment D, SLA Scorecard.

22. Delete pro forma contract section A.21.g(7) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report within the specified timeframe (see Contract Attachment D, Service Level Agreement).

23. Delete pro forma contract section A.23.f. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Information Ownership. All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. All contract related information retained by the Contractor including but not limited to, communications and files related to plan members, shall be made available to the State upon request. The Contractor is expressly prohibited from sharing or publishing State information and reports or releasing such information to external entities, Affiliates, parent company, or subsidiaries beyond the extent

necessary to perform the duties outlined within this contract without the prior written consent of the State, which consent will not unreasonably be withheld.

24. Delete pro forma contract section A.23.i(10) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor shall conduct a security risk assessment at least annually and communicate the results to the State in compliance with Contract Attachment E. The first report shall be provided one (1) month prior to Go-Live and annually thereafter (refer also to Contract Attachment C, Reporting Requirements). The risk assessment shall also be made available to appropriate state and federal agencies. At a minimum the assessment shall contain the following: identification of loss risk events/ vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 - 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR §164.308(a)(6)).

25. Delete pro forma contract section D.6. 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.

26. Delete pro forma contract section D.18 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Limitation of Contractor's Liability. The Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to one times the total Paid Claims, as defined in Contract Section A.2., that have processed throughout the one year of contract performance immediately preceding the breach. If the breach occurs in the first year of the contract, the calculation will be based on processed claims from the beginning of contract performance until the date of the breach, prorated to equal one year and as may be amended, 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.

27. Delete Pro Forma Contract Section E.8.a in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

E.8. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

a. "Confidential State Data" is defined as data deemed confidential by state or federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

(1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

(2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption algorithms.

(3) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall commission an independent third party to perform the risk assessment which must include penetration testing and vulnerability assessments. The Contractor shall provide the results of the third party testing to the State.

(4) Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State. The Contractor shall maintain a duplicate set of all records relating to this Contract in electronic medium, usable by the State and the Contractor for the purpose of Disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation.

(5) In accordance with the timeframe for audits listed in Contract Section D.11 and in consultation with the State , the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) Business Days after destruction.

(6) Contractor must enter into a Business Associate Agreement (BAA) with the State. See Contract Attachment E.

28. Delete Pro Forma Contract Attachment B, #1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

1. Implementation	
Guarantee	The Contractor shall complete all tasks, deliverables, and milestones included in the project implementation plan, as required in Contract Section A.3.e. necessary to install the program by Go-Live.
Assessment	One thousand dollars ($1,000) for each Business Day for each late deliverable and/or milestone leading up to and by Go-Live.
Justification	The Implementation Plan is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.

29. Delete Pro Forma Contract Attachment B, #4 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

4. Call Center Operational	
Guarantee	The Contractor's call center shall be fully operational no later than the date specified in Contract Section A.11.b.
Assessment	Ten thousand dollars ($10,000) for every Business Day beyond the deadline that the call center or other system is not operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.

30. Delete Pro Forma Contract Attachment B, #6 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

6. Plan Design	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design and State approved covered benefits, see Contract section A.12.a.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) for each incorrectly processed claim.
Justification	Plan design information must be accurate as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.

31. Delete Pro Forma Contract Attachment B, #11 Measurement row in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled, and assessed quarterly.

32. Delete Pro Forma Contract Attachment B, #12 Measurement row in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled, and assessed quarterly.

33. Delete Pro Forma Contract Attachment B, #17 Assessment row in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours; 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours; 4. Executive Director's time and work estimated at eighteen (18) hours; 5. Department attorney time including legal review estimated at thirty (30) hours; 6. Service Center staff time and work answering Member questions/concerns estimated at one-hundred (100) hours; 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.

34. Delete Pro Forma Contract Attachment C, #2 NCQA Credentials Verification Organization Certification in its entirety (any sentence or paragraph containing revised or new text is highlighted):

The section has been deleted and the subsequent numbering updated.

35. Delete Pro Forma Contract Attachment C, #26 Unauthorized Usage of Information in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

ASP Specialty Drug Reconciliation Report, submitted annually in compliance with contract sections A.16.f and C.3.g. of this contract and will be validated by the State's actuarial consultant.

36. Delete Pro Forma Contract Attachment D, KPI #1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

1.	PA and UM Evaluation	The Contractor shall complete ninety-seven percent (97%) of all prior authorizations and utilization management decisions within the timeframes specified in Section A.9.i.	97%	97% or greater 95.0-96.9% 93.0-94.9% Less than 93%	10 8 6 0	

37. Delete Pro Forma Contract Attachment D, KPI, Unauthorized Usage of Information in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Unauthorized Usage of Information	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain as stated in Contract Section A.4.l.	If the Contractor uses data without prior approval	$50,000 per incident.

38. Delete Pro Forma Contract Section A.15.q in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

The Contractor may include a mobile application for use by Members with prior approval In Writing by the State. The Contractor must agree to and adhere to all security measures as it relates to Member data. The Contractor must provide a secure web-based application that requires only a web-browser and an Internet connection.

39. Delete Pro Forma Contract Section D.32 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance

Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI fifteen (15) Business Days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The Parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. 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 or its insurer, 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.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance
    1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).
    The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per claim. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.
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) 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.

    2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:
        i. The Contractor employs fewer than five (5) employees;
        ii. The Contractor is a sole proprietor;
        iii. The Contractor is in the construction business or trades with no employees;

iv. The Contractor is in the coal mining industry with no employees;
v. The Contractor is a state or local government; or
vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a claims-made basis. If this coverage is written on a claims-made basis, then:
   i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services;
   ii. Insurance must be maintained and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment; and
   iii. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or prior to the Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.
2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) in the aggregate; and
3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession in an amount not less than ten million dollars ($10,000,000) per occurrence or claim and ten million dollars ($10,000,000) annual aggregate, covering all acts, claims, errors, omissions, negligence, infringement of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than ten million dollars ($10,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

40. Add or replace the following as RFP Appendices and renumber any subsequent sections as necessary:

Remove:
Appendix 7.2 Network Access Analysis Instructions
Appendix 7.4 Quest Analytics Sample Reports

Add:
Appendix 7.2 REVISED Network Access Analysis Instructions

Appendix 7.4 REVISED Quest Analytics Sample Reports

New:
Appendix 7.12 Bank Draft Report Template
Appendix 7.13 Musculoskeletal Bariatric Reports
Appendix 7.14 Supplier Direct Deposit Authorization
Appendix 7.15 Subrogation Contractor Requirements
Appendix 7.16 Example Subrogation Reports
Appendix 7.17 Simplified_wellnessactivity_layout
Appendix 7.18 Enrollment Census
Appendix 7.19 Claims_Members by Month and Large Claims
Appendix 7.20 Implementation and Account team surveys
Appendix 7.21 Episodes of Care Data
Appendix 7.22 Welcome Kit information

41. **Delete RFP #31786-00148 in its entirety, and replace with RFP #31786-00148, Release #2.** Revisions of the original RFP document are emphasized within the new release. Any sentence or paragraph containing revised or new text is highlighted.

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