STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION, BENEFITS ADMINISTRATION

REQUEST FOR PROPOSALS #31786-00177
AMENDMENT #TWO
FOR TIERED COPAY BENEFIT

DATE: March 12, 2024

RFP #31786-0077 IS AMENDED AS FOLLOWS:

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

EVENT	TIME (central time zone)	DATE
1. RFP Issued		February 7, 2024
2. Disability Accommodation Request Deadline	2:00 p.m.	February 12, 2024
3. Pre-response Conference	10:00 a.m.	February 13, 2024
4. Notice of Intent to Respond Deadline	2:00 p.m.	February 14, 2024
5. Written "Questions & Comments" Deadline	2:00 p.m.	February 20, 2024
6. State Response to Written "Questions & Comments"		March 12, 2024
7. Written "Questions & Comments" Round 2 Deadline	2:00 p.m.	March 19, 2024
8. State Response to Written "Questions & Comments" Round 2 ***NOTE: Vendors may submit no more than five (5) questions to the State in the 2nd round of Written Questions and Comments.**		April 2, 2024
9. Response Deadline	2:00 p.m.	April 9, 2024
10. State Opening of Cost Proposals		April 11, 2024
11. Cost Proposal Analysis		April 11, 2024 – May 9, 2024
12. State Completion of Technical Response Evaluations		May 3, 2024
13. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	1:00 p.m.	May 23, 2024
14. End of Open File Period		May 30, 2024
15. State sends contract to Contractor for signature		June 3, 2024

16. Contractor Signature Deadline	2:00 p.m.	June 7, 2024

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.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
General	1.	Member services representatives shall be Dedicated to the Plans. A Contractor may be allowed, by the State In Writing, to use a Designated call unit (as opposed to a Dedicated call center). **Would the decision for designated versus dedicated be based on final enrollment count?**	The State will base a decision upon a combination of factors including, but not limited to, final enrollment count.
General	2.	Since the RFP indicates that plan design will be developed post contract award, is there a specific plan design you would like for us to assume when putting together the medical savings guarantee?	The State intends to establish a plan design that falls into the “silver” marketplace level.
General	3.	For urgent pre-certification or concurrent review decisions, the Contractor shall make the decision within twenty-four (24) hours of receipt of the request; For urgent pre-certification or concurrent review decisions: **Clarify "pre- cert". Also, please clarify business hours vs. calendar hours.**	Pre-certification in this instance refers to an admission and twenty-four hours is calendar hours, not business hours.
General	4.	For urgent PA decisions, the Contractor shall make the decision within seventy- two (72) hours of receipt of the request. **Does urgent = expedited? Also clarify business hours vs. calendar hours.**	Yes, urgent means expedited, and seventy-two hours is calendar hours, not business hours
General	5.	For non-urgent pre-certification or PA decisions, the Contractor shall make the decision within seven (7) calendar days of receipt of the request. **Does urgent = expedited?**	Yes, urgent means expedited.
General	6.	**It is unclear what constitutes a violation based upon the information provided. Please clarify what constitutes a violation that would subject [REDACTED] to the PG.**	The State does not understand the question. Please provide clarification in written questions and comments round 2 and include a contract reference. This clarification does not

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			have to count toward the five-question maximum.
General	7.	m. The Contractor shall maintain a current record of compliance with appointment access standards, including monitoring activities, findings, and corrective actions and shall provide a report upon request by the State. xx-BDM: Deviation **Would the State amend the requested reporting requirements so that a report of the terms outlined will not be necessary as we do not release survey results externally?**	See response to question #6
General	8.	**Can The State please provide utilization files for provider disruption that include TINs as well as NPIs.**	See revised Appendix 7.12 and 7.13.and amendment item #26
General	9.	**Can The State please provide a Zip Code/Count file based on covered employees instead of members.**	See revised Appendix 7.2 and amendment item #26 below.
General	10.	Question from the Business Associate Agreement re: De identification of PHI **Does the State agree that the Contractor may de-identify PHI received or created by Business Associate under the Business Associate Agreement in accordance with the Privacy Rule, which de-identified information does not constitute PHI, and is not subject to the Business Associate Agreement?**	The HIPAA BAA does not discuss de-identifying PHI. Please clarify and provide contract reference in written questions and comments round 2. This clarification does not have to count toward the five-question maximum.
RFP 1.1.2	11.	1.1.2. The maximum liability for the resulting contract will be determined through the best evaluated cost proposal and estimated cost associated with this service. The maximum liability will exceed one dollar ($1.00). **How is liability defined?**	The maximum liability is determined by the winning respondent's cost proposal, and it is the maximum amount the State will pay the contractor over the life of the contract.
RFP 3.6	12.	If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal	

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		must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information. NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it. **Would the State agree that any change in the services to be provided under the administrative services agreement (ASA) would be mutually agreed to in writing, prior to implementation? We would notify the State of our additional costs to provide such services. If the parties are unable to agree to a new fee, [REDACTED] shall have no obligation to provide the change in service, and the State may terminate the contract.**	All costs should be incorporated into your RFP Cost Proposal response. The State intends to sign the *pro forma* contract listed in the RFP, and the Contractor is responsible for delivering all services and requirements listed in the *pro forma* contract. Any requested changes to the contract should be submitted during written questions and comments.
RFP 4.4	13.	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. **We would agree that neither party can assign this contract, or any rights or obligations under this contract, to anyone without the other party's written consent. Notwithstanding, we need the ability to assign this contract, including all of our rights and obligations, to our affiliates; to an entity controlling, controlled by, or under common control with us; or a purchaser of all, or substantially all of our assets, subject to notice to the customer of the assignment. We need this discretion in the utilization of our sister companies. We cannot agree to have one customer have veto power over our business choice to assign the arrangement to a sister company because that business decision affects our entire book of business. Will the State agree to allow [REDACTED] po choose subcontractors without prior identification and approval from the State?**	The State does not agree to modify these terms, however, the State is only interested in review and prior approval of those subcontractors who the Contractor intends to use to deliver/provide services for this contract, not every subcontractor with whom the company contracts.
RFP 4.4.2	14.	If a Respondent intends to use subcontractors, the response to this RFP	

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		must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.12). **The majority of the services we provide are performed by [REDACTED] personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.** **Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us. Will the State agree to modifying the terms to allow [REDACTED] to choose subcontractors without prior identification and approval from the State?**	See response to question #13
RFP 4.4.3	15.	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. **Will the State agree to modifying the terms to allow [REDACTED] to choose subcontractors without prior identification and approval from the State?**	See response to question #13
RFP 4.4.4	16.	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. **Will the State agree to modifying the terms to allow [REDACTED] to choose subcontractors without prior identification and approval from the State?**	See response to question #13
RFP 4.4.5	17.	Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract. **We will be responsible for services provided by our subcontractors to the same extent that we would have**	The State agrees that the Contractor shall be responsible for services provided by its subcontractors to the same extent that they would have been had the Contractor performed those services without the use of the

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		been had we performed those services without the use of a subcontractor. Would the State be agreeable to modifying the terms to identifying that we will be responsible for services provided by our subcontractors to the extent that we would have been had we performed these services?	subcontractor. The State does not agree that to modify the contract language.
RFP 4.10	18.	The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts. **This is not applicable to the services we are proposing to provide to the customer. Our agreements are not traditional construction or goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs. Would the State be agreeable to removing these requirements from the contract as it is not applicable to our services?**	The State does not agree to remove these requirements. The language referencing the "completion of all services" and "services rendered" does apply in this case.
RFP Question A.3	19.	Provide a current bank reference indicating that the Respondent's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months. **Will the State accept our most current bank reference dated October 31, 2023, from J.P. Morgan Chase?**	The State does not agree. The bidder must a provide bank reference as described in RFP question A.3.
RFP Question A.4	20.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months. **Will the State accept credit references dated October 4, 2023, as those our are most recent references?**	The State does not agree. Please provide credit references as described in RFP question A.4.

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RFP Question A.12	21.	Provide written confirmation that the Respondent will obtain National Committee for Quality Assurance (NCQA) Health Plan Accreditation at a level of 3.5 - 5 stars on or before December 31, 2025 (or a later date as specified by the State) and shall maintain it thereafter, as referenced in Contract Section A.22.I. Rather than relying on maternity and cardiology/cardiac surgery Centers of Excellence (COEs), would the State be open to leveraging [REDACTED] unique plan design for these two conditions? Our variable copays, which are based on our proprietary ranking of providers, render a "COE effect" for our customers by essentially providing all members with guidance and incentive to use the highest-quality providers in their respective geography.	The State does not understand the connection between the contract reference and the question. A similar question was asked and answered in question #52. Please clarify in written questions and comments round 2. The clarification does not have to count toward the five-question maximum.
RFP Question B.12	22.	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 subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP. **The majority of the services we provide are performed by [REDACTED] personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.** **Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us. Will the State agree to**	See response to question #13

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		modifying the terms to allow [REDACTED] to choose subcontractors without prior identification and approval from the State?	
RFP Question C.10	23.	On Page 34 of the RFP, item C.10 under staffing indicates that the Account Executive and Account Manager should be dedicated. Section A.3.c and A.5.g of the Pro Forma contract appears to indicate they should be designated. **Can you clarify if these roles should be designated or dedicated? Would the State be open to these roles being designated vs dedicated based on the final plan enrollment?**	The Account Executive and Account Manager shall be designated. Please see updated RFP. See amendment item #27 below.
Pro Forma A.3.e	24.	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. One thousand dollars ($1,000) for each Business Day for each late deliverable and/or milestone leading up to and by Go-Live. This 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. Measured, reported, reconciled and assessed no later than three (3) months after Go-Live **Please clarify what the milestones are that we'd be measured against to be able to assess feasibility/risk.** **With an understanding of milestones, we would be able to better assess feasibility and risk of penalty.**	The Contractor develops the implementation plan and defines tasks and milestones. Any deliverable outlined in the contract as a report, file, process, etc. that is noted as due on or before Go-Live falls under this metric. Any milestone that is identified in the contract or by the Contractor in their implementation plan that could or does delay Go-Live falls under this metric.
Pro Forma A.4	25.	Section A.4 of the Pro Forma states: 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. **Please confirm this is acceptable: Contractor may comment on plan provisions and applicable laws, but cannot provide legal advice to the State, the State will need to consult with its own legal counsel on the impact of laws and rules on the Plan.**	The State agrees this is acceptable.

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Pro Forma A.4	26.	Section A.4 of the Pro Forma states: The Contractor shall cooperate with the State in analyzing the impact of proposed legislation on the operation of the Contract. Unless otherwise directed by the State, the Contractor shall respond In Writing with a summary of Plan impact, section by section impact, and cost breakdown analysis to all inquiries from the State regarding responses to proposed legislation within forty-eight (48) hours of the State's request. The Contractor shall defer to the State's interpretation of the applicability of proposed legislation to the State Plans. The Contractor's analysis shall include legislation that is not directly applicable to the State Plan but which may indirectly affect the Contract by increasing the cost of Contractor's operations. **Please confirm this is acceptable: Contractors may comment on plan provisions and applicable laws, but cannot provide legal advice to the State, the State will need to consult with its own legal counsel on the impact of proposed legislation on the Plan.**	The State agrees this is acceptable.
Pro Forma A.6.c	27.	The Contractor shall provide and maintain a national provider network for this Contract that provides high quality, cost effective behavioral health services and includes a full spectrum and adequate number of behavioral health Network Providers that meet the required geographic and service access to Members primarily located throughout the State of Tennessee. The Contractor's behavioral health provider network shall include appropriately licensed and credentialed behavioral health practitioners, including, but not limited to, psychiatrists, including addiction psychiatrists, Advanced Practice Psychiatric Nurses -board certified, licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed and/or board certified applied behavioral analysts, substance abuse professionals (SAPs), and drug and alcohol counselors representative of the culture, race, sex and age of the population to be served. The Contractor's network shall also include a sufficient selection of licensed and credentialed programs and facilities (acute, residential, intensive outpatient, detoxification facilities and other necessary programs and services) in the network to provide access to Behavioral Health Services. The Contractor's network shall include providers with	The incumbent provider network has 88% board certified psychiatrists and 100% board certified advanced practice nurses for a combined 95.6%. Setting the threshold at a combined 90% seems reasonable considering the current network. Please provide your network statistics as well as any national benchmarks such as the total number of national psychiatrists and the % that are board certified as well as the same metrics for Advanced Practice Nurses and your proposed threshold for consideration during Question and Answer round 2 and the State will take that information under advisement for a potential contract modification.

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		expertise related to domestic violence, eating disorders/body image disorders, applied behavioral analysis, and gambling addiction, as well as substance abuse providers that provide detoxification for adolescents. A combined ninety percent (90%) of all the Contractor's psychiatrist and Advanced Practice Psychiatric Nurses shall be board certified and reported during the quarterly administrative review meetings. **Although the incidence of board-certified psychiatrists and APRNs is quite high, we require board-eligibility rather than board-certification. Would the State be willing to amend the last sentence in this requirement to read "A combined ninety percent (90%) of all the Contractor's psychiatrist and Advanced Practice Psychiatric Nurses shall be board ELIGIBLE and reported during the quarterly administrative review meetings."**	
Pro Forma A.6.n	28.	The Contractor shall maintain a current record of network physicians not accepting Members as new patients and shall provide a report upon request by the State. **Would the State be willing to amend the reporting terms as described? Please see details below.** **Open/closed practice information is displayed in the directory. Customers can request a report from the account management team (AMT) but the report would be a snapshot or download from the directory.**	The State does not agree to change the language. The State considers an accurate and updated online provider directory that lists the provider or practice status as open, accepting new patients, or closed, not accepting new patients, as meeting this requirement with a directory download being sufficient for reporting purposes.
Pro Forma A.6.w	29.	The Contractor shall provide Network Providers with reports and other information regarding their tiered status and any quality and other performance metrics used by the Contractor to set the tier of the Network Provider so the Network Provider can work to improve their tiering status. The Contractor shall be available to meet with the Network Provider as needed to walk through and discuss the reports and other performance information. **Would the State agree to clarify that providers are evaluated based on each service rendered, not assigned to a discrete preferred/non-preferred tier for all services, as is the case in tiered products? See**	Yes, the State agrees that providers are evaluated based upon each service rendered and is not assigned a discrete status. The State

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		the clarification below. **[REDACTED] arrays copays continuously based on provider value, in a similar manner to how members pay different amounts by provider under a coinsurance arrangement. Providers are evaluated based on each service rendered, not assigned to a discrete preferred/non-preferred tier for all services, as is the case in tiered products. We currently meet with providers requesting more information on their provider evaluations on an as needed basis.**	emphasizes our intent that the Contractor provide network providers with reports and other information regarding their tiering status, by service, if necessary, to encourage providers to make behavior changes that could improve their tiering for some or all their services.
Pro Forma A.6.y	30.	The Contractor shall maintain a provider Denied Claim appeals policy and process and shall provide the State with a copy of said process thirty (30) days prior to Go-Live. The Contractor shall provide the State with a list of medical and behavioral health provider Denied Claim appeals every quarter (refer also to Contract Attachment C, Reporting Requirements). The State shall select a random sample of Denied Claim appeals from the report for further review and explanation. The Contractor shall complete a question log based upon the Contractor's documented process regarding the selected Denied Claim appeals. The completed log shall be maintained by the State on record as verification of contractor compliance with internal policy. **In regards to completing a question log, this process would need to be developed with our Account Management Team and internal claims appeals experts as this is not a standard offering. This development could be subjected to an additional cost due to the work efforts that would allow us the ability to execute this. In the event that we would agree to offering this, the State of Tennessee would have the ability to use the information provided how they see fit. Is the State able to provide a more detailed description of the information the State of Tennessee is looking to obtain?**	The State does not agree to modify these terms. All services outlined in the Contract shall be included in the Administrative Fees listed in Contract Section C.3. The State will provide a question log based on the Contractor's documented process for handling denied claims appeals. The purpose of this review is to determine whether the Contractor is following its documented process.
Pro Forma A.6.cc	31.	The Contractor shall identify and sanction medical and behavioral health 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. **Would the State amend the terms to remove the sanctions requirements from the medical and behavioral health networks?**	The State agrees to remove the sanction requirement. Please see amendment item #7 below.

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		Sanctions are not imposed as a result of physician data-sharing information. Gaps in care are addressed with the physicians and other health care professionals and corrective actions are recommended.	
Pro Forma A.6.ii	32.	The Contractor shall report to the State on a monthly basis all transition of care, continuity of care, and unique care exception requests, whether they were granted or denied, and any reason for approval or denial (refer also to Contract Attachment C, Reporting Requirements). **[REDACTED] has the ability to report on transition of care information. Would the State be open to a [REDACTED] standard report?**	The State will consider a standard transition of care report if it provides the information necessary to track member services. If the standard report does not meet the State's expectations, modifications will be required.
Pro Forma A.7.d	33.	The Contractor's Member service representatives shall have access to an application, which allows them to review alternative drug therapies (Formulary status, Generic Drug alternatives available, etc.) and run test Claims for Members who may request this information. **Would the State amend the terms so that running test claims for members who request alternative drug therapies is not required? The State employees who engage with [REDACTED] and [REDACTED] member services will receive information that includes pricing certainty, not just cost estimations. What they see in [REDACTED] is what they will pay.**	The State agrees to remove the requirement to run test Claims. Please see amendment item #8 below.
Pro Forma A.7.h	34.	The Contractor shall have healthcare navigators and advocacy staff to support Members with resources and services, including but not limited to: finding and scheduling appointments with high quality, low cost providers; **While our advocates assist members in finding a health care provider, they do not currently make appointments on behalf of the member. Will the State amend the terms so finding and scheduling appointments for members will not be a required support function by our Member Services staff?**	The State does not agree to change the language. The State seeks a solution for members who are unable to secure appointments in a timely manner. The State would consider an alternative solution if the Member Services staff cannot provide this service.

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Pro Forma A.8.k	35.	At least one (1) month prior to Go-Live, the Contractor shall provide the State information describing in detail the Contractor's appeals process and procedures along with copies of sample determination letters for internal and external appeals. The State reserves the right to review the appeals process and procedures and letters and require changes, where appropriate. **Would the State be agreeable to amending the terms to clarify that required changes would need to be related to regulatory requirements?**	The State agrees to amend the Contract language to allow changes where appropriate to comply and align with regulatory and Plan requirements. Please see amendment item #9 below.
Pro Forma A.8.m	36.	The Contractor shall allow a Member or their authorized representative one hundred and eighty (180) calendar days to initiate an internal appeal following notice of an adverse determination. The Contractor shall provide notice to the Member of all unfavorable internal appeal determinations and advise them of their right to initiate an external appeal within four (4) months of receiving said notice. **Would the State be willing to accept [REDACTED] standard, which is adherence to all Department of Labor rules and regulations?**	The State does not agree. The State follows Tennessee State Law in addition to Federal Law.
Pro Forma A.9.b	37.	The State shall have the option to approve and apply any UM programs and criteria developed by the Contractor, including UM programs performed by a subcontractor or other entity at the time of contract effective date or at any point during the contract claims processing period, and the costs shall be included in the existing Administrative Fees listed in Contract Section C.3. The Contractor will, upon request, provide a complete list of all currently available UM programs to the State and the Contractor will maintain an inventory of the UM programs the State has both selected and not selected. When there is a change (addition, deletion, or other Program change) to the list of the Contractor's available clinical programs, the Contractor will present the opportunity or change to the State within ten (10) Business Days of availability and will provide the State with an updated UM program list and the State's selection inventory at the same time. The State may also "opt-out" of any UM program and will make all final determinations	The State typically accepts the Respondent's standard Utilization Management program during implementation if the program meets the coverage and exclusions outlined in the Plan Documents and the costs for the standard UM program are included in the Administrative Fees outlined in Contract Section C.3. The State retains the ability to opt out of a UM program should it conflict with State coverage or exclusion criteria, other benefit program or design, or does not manage costs, quality, or site of care to the State's expectations.

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		regarding participation in any UM programs. **Would the State be willing to accept [REDACTED] standard Utilization Management program as a whole? Non-standard requirements must be reviewed on a case-by-case basis.**	
Pro Forma A.9.d	38.	The Contractor shall maintain an online publicly accessible library of medical necessity coverage policies and ensure that submitted claims are processed in accordance with published policies. Should these clinical guidelines be revised, the Contractor shall notify the State thirty (30) days prior to the implementation of any major guideline revisions. In addition, the Contractor shall provide an impact analysis of the proposed changes on the program. The State shall have the option to approve and apply any UM programs and criteria developed by the Contractor that replace the oversight or adherence of a published medical necessity coverage policy and the costs shall be included in the existing Administrative Fees listed in Contract Section C.3. **Would the State be willing to discuss changes to the timeline laid out in this requirement? Would the State be open to eliminating the requirement around the impact analysis the requirement around the State approving our utilization management criteria.**	The State is agreeable to extend the notification timeline to sixty (60) days. The State agrees to modify the impact analysis requirement. The State only approves a UM program and criteria if it replaces an existing medical policy this does not include a medical policy update or revision. Please see amendment item #10 below.
Pro Forma A.9.5	39.	The Contractor shall provide both short and long term UM services based on evidence- based formal written clinical guidelines utilized by experienced mental health and substance abuse clinicians for the entire term of the contract. Mental health Utilization Management shall further consist of the following, when appropriate as determined on a case by case basis: Provisions for periodic onsite visits by utilization and case management clinical staff to high volume and non-compliant providers, in order to continually improve the efficiency and effectiveness of these services. **Would the State be willing to accept [REDACTED] standard behavioral health Utilization Management Program?**	The State typically agrees to accept the Respondent's standard behavioral health Utilization Management program during implementation if the program meets the coverage and exclusions outlined in the Plan Documents. The State retains the ability to opt out of a UM program should it conflict with State coverage or exclusion criteria.

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Pro Forma A.9.i	40.	The Contractor shall collaborate with the State and its contractors to develop a discharge planning and notification protocol and process by which the Contactor's Utilization Management staff work with the facility, patient's physicians, PH/W contractor (as requested by the State), patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission. Consistent with this protocol, the Contractor shall ensure that Network Providers complete a written discharge plan (including, for example, the dates of admission and discharge, follow-up care required, secured appointment date and time with an outpatient Network Provider, and current medications) prior to the discharge of any Member who is being discharged from, at a minimum, Inpatient Care. **Would the State consider a buy-up to our existing Discharge Planning program?**	The State does not agree. All services shall be included in the Administrative Fees as outlined in Contract C.3.
Pro Forma A.9.l	41.	The Contractor shall require PA of the following services. Subject to State approval In Writing, the Contractor may require PA of other services. Outpatient high-technology diagnostic imaging, including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET) scans, and nuclear cardiac imaging studies; **Would the State consider eliminating this requirement?** Hospice; **Would the State consider eliminating its prior authorization requirement for hospice?** Non-emergent ambulance transport; **Would the State consider changing this requirement to "Non-urgent AIR ambulance transport"?** Miscellaneous HCPCS codes (including but not limited to all provider	The State agrees to amend Contract language for some of the requested services and to allow for modifications of this list with State approval in writing. See amendment item #11 below.

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		administered J-codes, Q-codes, and C-codes); **Would the State consider eliminating the prior authorization requirement for HCPCS codes under the pharmacy benefit plan, and limiting it to the medical plan?** Electroconvulsive Therapy; **Would the State be willing to remove this requirement?** Psychological Testing; and **Would the State be willing to remove this requirement?** Other services specified by the State, In Writing, or in the Plan Document. **Would the State consider accepting our standard prior authorization program?**	
Pro Forma A.9.o	42.	The Contractor shall disclose and share, In Writing, all Covered Drug PA criteria and procedures and decision trees applicable to the State during plan implementation and within two (2) Business Days of written request from the State at any time during the Term of the Contract at no additional charge. **Would the State be willing to accept [REDACTED] standard prior authorization documentation to meet this requirement?**	The State does not agree.
Pro Forma A.9.q	43.	Unless otherwise directed by the State, the Contractor shall complete ninety-seven percent (97%) of all medical and behavioral health 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: (1) For non-urgent pre-certification or PA decisions, the Contractor shall make the decision within seven (7) calendar days of receipt of the request;	

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		Please clarify the term "non-urgent". Please also indicate if the timeframe specified is seven calendar or seven business days. (2) For urgent PA decisions, the Contractor shall make the decision within seventy- two (72) hours of receipt of the request **Please clarify the term "urgent". Please also indicate if the timeframe specified is 72 calendar or seven business hours.** For urgent pre-certification or concurrent review decisions, the Contractor shall make the decision within twenty-four (24) hours of receipt of the request; **[REDACTED] requests clarification from the State of the term "pre-certification". We also request clarification of the 24-hour timeframe. Is the State referring to business hours or calendar hours?**	The State follows state law. Non-urgent is the equivalent of routine and the timeframe is seven calendar days, not business days. Urgent is defined in TCA 56-61-102 and the timeframe is 72 calendar hours, not business hours. Pre-certification is related to admissions. Prior authorization timeframes, 24 and 72 hours, are calendar hours and not business hours.
Pro Forma A.9.q	44.	The Contractor shall submit to the State, at least two (2) months prior to Go-Live, a copy of all documents describing its UM programs, evaluation methodology, and audit plan and within two (2) Business Days of written request from the State at any time during the Term of the Contract at no additional charge. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its UM program. **Would the State be willing to accept [REDACTED] standard documentation regarding our UM program?**	Yes, if it meets these contractual requirements.
Pro Forma A.9.bb	45.	At the State's request, the Contractor shall provide expert medical opinion services for Members diagnosed with a complex medical condition or surgical interventions such as but not limited to cancer, musculoskeletal, transplant, autoimmune, renal disease, women's health, cardiac/vascular, gastrointestinal. Expert medical opinion services may be provided by the	

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		Contractor or a subcontractor and shall be reimbursed pursuant to Contract Section C.3. Services shall include an assigned Member care coordinator, medical record collection and consolidation, expert medical review by a provider within seven (7) days, provider consultation with the Member and/or Member's authorized representative, provider consultation with the Member's initial/primary provider (if applicable), written expert medical opinion in a Member approved format (mail, secure email, electronic file, etc.), referrals to in-network specialists, and follow-up medical care coordination. Expert medical opinion services shall be available to the Member through the Contractor's call center, website, or mobile application. The Contractor shall administer Member utilization incentive options such as, but not limited to, an enhanced benefit design at the state's request. The Contractor shall also recommend the expert medical opinion service option to any Member calling the Contractor call center requesting benefit information or a PA for a qualifying condition or surgical intervention. **[REDACTED] requests clarification around the timeframe element of this requirement. It isn't clear exactly what the timeframe applies to; and is it seven calendar or business days?**	The expert provider shall review the medical records and provide the written expert medical opinion within 7 business days.
Pro Forma A.9.cc	46.	If implemented, the Contractor shall submit a quarterly expert medical opinion report with information on each case including but not limited to the case type, any diagnosis or treatment changes, referrals to in-network specialists, and any estimated cost savings (refer also to Contract Attachment C, Reporting Requirements). **Would the State be willing to accept [REDACTED] expert medical opinion report in terms of both content and timeframe?**	The State will accept a standard report if it meets all contract requirements. The State does not agree to change the quarterly timeframe.
Pro Forma A.9.hh	47.	Prior to implementing any program or service for which the Contractor receives external funding, the Contractor shall disclose the details of such program and such sources of external funding to the State. The State shall have the authority to opt-out of any such program that the State determines is not in the best interest of its Members. **[REDACTED] requests further clarification of this requirement. Can the State provide an example of the kind of program or service this requirement would pertain to?**	This refers to any type of utilization management program such as retrospective drug utilization review, standard or enhanced fraud, waste, and abuse programs, gaps in care programs, drug savings review, pharmacy advisor, etc.

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Pro Forma A.12.a	48.	The Contractor shall provide specialized behavioral health case management services through its staff who are experienced Master's or PhD level clinicians with a minimum of five (5) years of experience in mental health and/or substance abuse treatment, including two (2) years with mental health and/or substance abuse case management. The Contractor shall provide appropriate clinical supervision of case managers, including medical review of all alternative treatment plans for specific patients. **[REDACTED] currently meets this need with a team of Clinical Advocates for behavioral health, all of whom are master's-level Licensed Clinical Social Workers. Are the below feasible for what the states need?** **1. Licensed Clinical Social Work Clinical Advocates for behavioral health advocacy, treatment decision support, care coordination, benefit navigation and family support. These are master's prepared clinicians. Included in the [REDACTED] product.** **2. Explore [REDACTED] behavioral health case management.**	The State agrees this meets the State's needs.
Pro Forma A.12.c	49.	Case managers shall provide the following services: (1) Patient advocacy, including but not limited to assistance gathering clinical history to ensure appropriate level of care approvals and placement (through provider outreach calls) with a provider and/or facility with the best quality and fit for the Member's clinical needs; (2) Clinical coordination of care and services for high risk Members requiring or admitted to facility-based care; (3) Telephonic, electronic, and onsite visits, when	

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		necessary in order to ensure the quality, effectiveness, and appropriateness of treatment and discharge planning; (4) Consultations with the patient (if clinically appropriate), family and attending provider; (5) Development of alternative treatment plans, where benefit coverage allows flexibility in determining the most clinically appropriate, cost-effective alternative treatment for the Member; (6) Participation, as necessary, in the appeals process; and (7) Coordination of care with other appropriate State contractors. **[REDACTED] case managers are telephonic only. Will the State accept the provisioning of the services listed by telephonic case managers without onsite visits?**	The State agrees. Please see amendment item #12 below.
Pro Forma A.12.h	50.	The Contractor shall provide expanded case management specifically for families with a Member diagnosed with autism, an autism spectrum disorder, or a developmental disorder. The case manager shall work with the family as a whole to ensure engagement with all available services for the diagnosed Member as well as additional family Members. The case manager shall also assist the family with any community resources that may be of assistance to support the diagnosed Member and the family. **[REDACTED] currently has our Clinical Advocates work with families with a member diagnosed with Autism, and Autism Spectrum Disorder (ASD), or a development disorder to ensure they receive the care they need. Will the State allow [REDACTED] to continue managing this need through our Clinical Advocacy team?** **<u>OPTIONS:</u>** **1. Explore expanding GCM to include Autism** **2. Clinical Advocacy can work with these members/families to ensure they receive the care they need.**	The State agrees.

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		3. Explore [REDACTED] Behavioral Health Case Management for Autism	
Pro Forma A.13.b	51.	PCMH or similar program initiatives shall include Collaborative Physical and Behavioral Health Care for all attributed patients. Collaborative care shall at a minimum include a behavioral health screening using an age appropriate nationally recognized tool, discussion with the provider if the screening is positive, and referral to a licensed behavioral health professional or coordinator for follow up. Behavioral health quality metrics shall be included in overall PCMH or similar program measurements and reported to the State in the overall PCMH performance reporting. The Contractor's program shall include NCQA PCMH Distinction in Behavioral Health Integration, URAC Measurement Based Care Distinction, or similar defined measurement parameters, as approved by the State In Writing. **We cannot agree that Behavioral Health quality metrics will be included in the Accountable Care Organization's (ACOs) overall measurements. Will the State agree to the above requirements with the exception of Behavioral Health quality metrics?**	The State does not agree. If the State is paying a care coordination fee per attributed member for a patient centered medical home collaborative care program, the program must include behavioral health quality metrics. If the State is not paying a care coordination fee per attributed member the contract clause does not apply.
Pro Forma A.13.e	52.	The Contractor shall build by December 31, 2025 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. **Rather than relying on maternity and cardiology/cardiac surgery Centers of Excellence, would the State be open to leveraging [REDACTED] unique plan design for these two conditions? Our variable copays, which are based on**	The State agrees and has updated contract language. See amendment item #13 below.

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		our proprietary ranking of providers, render a "Centers of Excellence effect" for our customers by essentially providing all members with guidance and incentive to use the highest-quality providers in their respective geography.	
Pro Forma A.13.c	53.	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. **We cannot agree to notifying or getting approval from a customer for value-based contracting (VBC) implementation. Those programs are a standard part of our network contracting practices. Will the State agree to moving forward without customer notification or prior approval for VBC?**	If the Contractor's value-based initiative includes additional payments by the State on a per attributed member model or similar separate program fee, then the State must be notified and approve any such payment and attribution models. If the Contractor's value-based initiative is a contracting initiative between the Contractor and the provider and no additional program fees are passed on to the State beyond the Administrative Fees listed in C.3., this clause does not apply.
Pro Forma A.13.f	54.	The Contractor shall notify the State of any operations or plans to implement value based payments where such payments are differentiated based on quality and/or efficiency. Examples of such payments include, but are not limited to, provider incentive payments (e.g. pay for performance), enhanced or reduced reimbursement, capitation, and reference pricing. The Contactor shall not implement such value based payments without prior approval In Writing from the State. **We cannot agree to notifying or getting approval from a customer for VBC implementation. Those programs are a standard part of our network contracting practices. Will the State agree to moving forward without customer notification or prior approval for VBC?**	See response to question #53
Pro Forma A.13.g	55.	The Contractor shall report descriptive information and data about its value based payments in sufficient detail to enable the State to make an approval determination as well as adequately monitor the Contractor's program and billings following approval. The information that may be requested shall include, but not be limited to, the following:	See response to question #53

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		(1) The type(s) of arrangements, such as, withholds, bonus, capitation, discretionary billing; (2) The percent of any withhold or bonus the plan uses; (3) The patient panel size and, if the plan uses pooling, the pooling method; (4) The projected financial impact to the plan as a result of the program; and (5) If approved, semi-annual reporting (refer also to Contract Attachment C, Reporting Requirements) on the number of Members served, program specific measurement based outcomes, utilization, and financial impact including any savings as a result of the program. **We cannot agree to notifying or getting approval from a customer for VBC implementation. Those programs are a standard part of our network contracting practices. Will the State agree to moving forward without customer notification or prior approval for VBC?**	
Pro Forma A.2.zz	56.	**Ingredient Cost:** Will be defined for the Contract according to the criteria below: (1) For retail, Ingredient Cost means the lowest of: a. U&C Price b. MAC, where applicable; or c. Mutually agreed upon baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) less all applicable Discounts or other applicable reimbursement amounts negotiated with the participating Retail Pharmacy which adheres to Discount Guarantees, as applicable, and as set forth in this Contract. (2) For brands dispensed via the Contractor's Mail order and Specialty Pharmacies, Ingredient Cost means the Discounted price using the guaranteed Discount percentage set forth in the price schedule(s) of this Contract, based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties. (3) For generics dispensed via the Contractor's Mail Order and Specialty Pharmacies, Ingredient Cost means the lower of the MAC, where applicable, or the Discounted price using the default Discount percentage set forth in the Price Schedule(s), based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties.	NADAC pricing is required in this contract for claims processed at Participating Pharmacies that qualify as a Low Volume Pharmacy, as defined in the contract. Also refer to footnotes 7 and 8 in the Rx Cost Spreadsheet tab in the cost proposal. The State does not maintain a list of Low Volume Pharmacies. Rather the Contractor shall establish a process to allow pharmacies to attest to being a Low Volume Pharmacy as defined in the contract.

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		Ingredient Cost does not include the Dispensing Fee, the Copayment, Coinsurance, Deductibles or sales tax, if any. **We are not aware of any NADAC pricing requirements in TN (also referenced in the context of Low Volume Pharmacies). Please provide list of Low Volume Pharmacies (NCPDPs).**	
Pro Forma A.13.h	57.	(7) Claims processed at Participating Pharmacies where the pharmacy's annual prescription volume is at a level that, if the pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the pharmacy for the enhanced amount of professional dispensing fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual (per Tennessee PC 1070), shall be excluded from the Guaranteed Minimum Average Discounts above and will be priced using National Average Drug Acquisition Cost (NADAC), published by CMS, on the date dispensed. In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will adjudicate with an Ingredient Cost consistent with the network applicable to Participating Pharmacies not qualifying as a Low Volume Pharmacy, unless otherwise excluded based on tab 2. Pricing Requirements. Point solution claims shall be excluded from the Guaranteed Minimum Average Discounts above ***We are not aware of any NADAC pricing requirements in TN and do not currently have the capability to separately administer NADAC pricing at selected pharmacies. Please advise on how the State would like to move forward?***	See the response to question #56.
Pro Forma A.13.h	58.	As directed by the State, the Contractor shall enter into direct contracts, on the State's behalf, for select Point Solutions that fill gaps in the State's current healthcare benefit offerings or help to solve specific challenges. The Contractor shall collaborate with the State during the direct contracting process in the development of fee schedules, standard protocols and measures, claims processing and payment, or other value based payment, semi-annual reporting (if applicable, see also Contract Section A.13.g.5.) and implement any associated Member cost-sharing benefits or incentives (e.g., waiver of cost sharing, etc.). These Point Solutions shall not negatively impact the Contractor's risk of performance or trend guarantees and shall be excluded from guarantee calculations as necessary. Alternatively, should	

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		the Contractor enter into direct contracts for Point Solutions for their greater book of business, the Contractor shall offer, at the State's request, said Point Solutions to the State for implementation, at no additional administrative cost to the State above and beyond program costs. **[REDACTED] accepts the State's definition of "Point Solutions."** **Would the State be willing to allow [REDACTED] to conduct its normal course of business with regard to contracting with Point Solutions, which would not allow any customer involvement in the contracting process or sharing of fee schedules?**	The State agrees that, in addition to any State specific or State requested Point solutions, the Contractor may conduct its normal course of business related to contracting with Point solutions. However, the State may not be enrolled in a Point Solution without granting prior approval. If the State agrees to enroll in a Point solution, the fees to be paid by the State should be transparent to the State and provided to the State upon request.
Pro Forma Contract A.14.j.1	59.	The Contractor shall maintain an average daily ASA of twenty (20) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.14.j.1. **Would an average speed to answer of 30 seconds or less at the team level be acceptable replacement language?**	The State agrees to a thirty (30) second or less average. See Contract Attachment D Service Level Agreement Scorecard explaining the measurement of this metric at the aggregate level as an average over the quarter. Also see amendment items #15 and #16 below.
A.14.j	60.	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 Members 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 as required in Contract Section A.14.j.2. **Our system does not currently track first call resolution. We would propose removing this language. Is this acceptable to the State?**	The State does not agree to this revision. This is a standard call center measure in all our contracts. Please note the option of implementing a post-call phone or web survey.
Pro Forma A.14.e	61.	The Contractor's call center shall, at a minimum, accept calls Monday through Friday 7:00-5:00 CST, except on official State Holidays. **[REDACTED] Member Services is available Monday**	

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		through Friday, 6:00 a.m. to 9:00 p.m. Central time; however, our Clinical Advocates and Case Managers area available 8:00 a.m. to 5:00 p.m. local time. Would the State be able to amend the terms to accommodate our Clinical Advocate and Case Manager hours?	The bidder's member services hours satisfies the contract requirement.
Pro Forma A.14.u	62.	**Request Details:** The Contractors system shall be able to record calls for monitoring and the Contractor shall, at the States request, allow the State, or its authorized representative to review previously recorded calls from a remote location. (Remote location??) **The [REDACTED] has the ability to listen/review member calls for [REDACTED]. The standard process is to review calls when service issues arise and conclude call reviewing once service issues are resolved. Can you expand on the ask and intent for State of? What is done now with the current carrier? What is the intent going forward? We would need to understand the full ask, frequency and volume of calls.**	Please refer to A.14.p for more information. Should an issue arise where the information provided from a call is in question between the member and the Contractor, the State may request a copy of the recording or request the ability to listen to the recording without physically going to the location where the recording is stored. Other Contractors have played member calls during a virtual meeting and have provided transcripts of the calls for further discussion and issue resolution. This is an infrequent occurrence, maybe once or twice a year, and typically a transcript is sufficient for resolution.
Pro Forma A.15.kk	63.	<u>Claims Processing, Payment and Reconciliation</u> The Contractor, or any third party that negotiates and collects Manufacturer Payments allocable to the State, shall provide with each quarterly payment remitted to the State, a report showing the amount of the payment broken down by Plan Group fund (i.e. State Actives, State Retirees, etc.) and further broken down by service or product name, the calendar quarter that the various Manufacturer Payment amounts are attributable and the appropriate codes to identify the service or product (e.g. NDC-11, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). The Contractor shall also provide an annual reconciliation report demonstrating true-up to one hundred percent (100%) no later than one hundred fifty	

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		(150) days after the end of each calendar year. Refer also to Contract Attachment C, Reporting Requirements. **Would the State accept the following rebate reporting? Accompanying the electronic funds transfer (EFT) is a statement that shows rebates collected by date of service month (rebates for claims processed during a specific calendar month) and any interest included in the payment. A Rebate Trend Report detailing the State's actual and estimated rebate information for pharmacy medication rebates is available on a quarterly basis. This report shows the total payment of rebate dollars and any earned interest, as well as utilization history for total, brand and rebate-applicable brand prescriptions. Member month information is also specified in this quarterly rebate trend report**	The State will accept reporting that meets all requirements outlined in the contract. Unless agreed to in writing, all rebate payments will be made by check, not electronic funds transfer (ETF).
Pro Forma A.15.w	64.	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. **Would the State agree to modify the item to specify network claims, instead of all claims, are run through a clinical edit software program as part of the repricing process?**	The State agrees to update Contract language to specify network claims. However, this does not waive the Contractor's responsibility to review and evaluate out of network claims involving the use of current ICD and CPT/HCPCS codes outside of the clinical edit software. See amendment item #17 below.
Pro Forma A.15.z	65.	z. 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 to the Contractor's documented standards. xx-BDM: Deviation **Would the State be agreeable to clarification that [REDACTED] uses a repricing process that does not store network provider information in**	The State understands and agrees that repricing meets this contract clause.

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		our claims system, but rather accepts the information from our repricing partner?	
A.15.cc	66.	The Contractor shall generate and mail an EOB to the Member each time the Contractor processes a medical or behavioral health claim from a provider where the Member cost share 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, 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. xx-BDM: Deviation **Would the State be agreeable to remove the requirement to have out-of-pocket amounts printed on the explanation of benefits (EOB), as this information is available to members digitally or through [REDACTED] Member Services?**	The State does not agree. An Explanation of Benefits is written confirmation post processing of a claim of the member's liability. This document is critical to ensuring a member understands their responsibility and can reconcile their EOB against provider bills to ensure they are not being asked to pay more. Digital information on a member portal or mobile application is preservice information that helps a member make decisions about their provider and care selection before a service is received.
Pro Forma A.15.dd	67.	If a Member receives a covered benefit from a Network Provider, the Network Provider's contract rate shall be used to determine the allowed amount. The Member shall not be responsible for payment in excess of their Copayment amount. If the Contractor determines that a service to be provided to a Member is 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), but the Network Provider proceeds with rendering	

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		the service: (a) The Contractor shall develop an advanced beneficiary notice (ABN) template and shall provide copies of the template to Network Providers; and (b) Network Providers shall require the Member to sign and date such ABNs acknowledging that the Contractor will not cover the cost of services not authorized by the Contractor, prior to rendering non covered services, should the Member choose to receive said services. The Member shall not be responsible for payment to the provider unless the Network Provider can provide a copy of an ABN for the specific services rendered and the date of service, signed by the Member prior to the service being rendered. Providers shall not require Members to sign ABNs for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services provided at an in- network hospital or ambulatory surgical center. **This is a non-standard request and would be a significant project to implement. Would the State consider removing A.15 (dd) from the contract terms?**	The State is willing to work with the Contractor on the implementation of this request to reduce the burden. However, based upon historical member experience the State does not agree to remove this contract language.
Pro Forma A.15.ff	68.	a.The Contractor shall not pay for services that result from a referral prohibited by Section 1877 of the Social Security Act (Limitation on Certain Physician Referrals). **[REDACTED] currently does not have any plans that require or monitor referrals. Would the State consider removing A.15 (ff) from the contract as it is not applicable?**	The State agrees to remove. See amendment item #29 below.
Pro Forma A.15.nn	69.	nn.The Contractor understands that the Plans cannot and do not cover all medical, pharmaceutical, and behavioral health situations. In a case where the benefits are not referenced in the Plan Documents or are not clear, the Contractor shall comply with any applicable policy issued by the State to interpret the Plan Documents. If the benefits are not referenced in any policy or are not clear, the Contractor shall utilize its standard policies in adjudicating claims, and the	

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		Contractor shall advise the State In Writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State. The Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB) in accordance with the regulations promulgated by the Plan Document and Tennessee Department of Commerce and Insurance, Chapter 0780-1-53 Tenn. Comp. R. & Regs. The Contractor shall provide a report of said activities to the State upon request. The Contractor shall provide a weekly report of necessary updates to Member eligibility records regarding coordination of benefits and other payer coverage (refer also to Contract Attachment C, Reporting Requirements). xx-BDM: Deviation **[REDACTED] has the ability to report on COB. Would the State be open to a [REDACTED] standard report?**	The State is agreeable to the Contractor's standard reports and format if the required information is contained within. Modifications may be required to meet Contract requirements.
Pro Forma A.15.pp	70.	The Contractor shall notify the State, in a weekly report, the receipt of any notices from Medicare that Medicare may have made primary payments for services when it should have been the secondary payer for the timeframe from Go-Live through the claims runout period (a Medicare Secondary Payer demand letter). Refer also to Contract Section A.15.eee. and Contract Attachment C, Reporting Requirements. The Contractor shall resolve issues as to whether Medicare is the primary or secondary payer within thirty-one (31) days of receiving the demand letter. **Would the State be agreeable to eliminating the reporting requirement in as the process is manual? Please see below for clarification.** **These claims are handled manually and manual checks are**	The State does not agree to this revision. Other Contractors meet this reporting and process requirement via a simple weekly email.

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		issued. We would have to introduce a manual report and reporting process.	
Pro Forma A.15.qq	71.	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 **Would the State be agreeable to eliminating this requirement?**	The State does not agree to this revision.
Pro Forma A.15.rr	72.	The Contractor shall implement a process to identify all Claims paid on behalf of a Member affected by a retroactive termination during the period of retroactivity. The Contractor shall notify the State within thirty (30) calendar days of a retroactive Member termination and assist the State in the recovery of impacted Claims. **Would the State be willing to amend the terms so [REDACTED] shall notify the State within 60 calendar days of a retroactive member termination as opposed to the 30 calendar days that has been proposed?**	The State does not agree to modify these terms.
Pro Forma A.15.ww	73.	The Contractor's provider agreements shall include the maximum recoupment periods permitted under Tenn. Code Ann. § 56-7-110 and 56-7-3103. **Would the State accept our standard participation agreement practices as follows?** **Our participation agreements generally allow both pre-payment and post-payment audits. With respect to overpayments, our agreements will generally allow the recoupment of overpayments. Some contracts limit recoupments of overpayments to 12 months after payment, except in cases in which the provider prevented discovery of the overpayment through fraud, abuse or refusal to timely cooperate in an audit.**	The State agrees to updated contract language. See amendment item #18 below.

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Pro Forma A.15.fff	74.	The Contractor shall process all the State's Claims on the same platform and shall not transition the State from the Claims adjudication platform that they are implemented onto during the Term without prior approval In Writing by the State. **We are planning to change the [REDACTED] claims system from [REDACTED] legacy platform to the [REDACTED] claims platform, [REDACTED], in the 2025-2026 timeframe. Will the State concede to this transition without written approval?**	The State agrees to updated contract language. See amendment item #33 below.
Pro Forma A.21.a	75.	The State contracts with a contractor to provide certain population health services, including wellness, weight management, and chronic condition 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: (1) Inclusion of population health and wellness information in its Member handbook (see Contract Section A.17.c.), including the toll-free telephone number to contact the PH/W contractor. (2) Inclusion of the PH/W contractor's telephone number on the back of the Member identification card (see Contract Section A.17.j.). (3) Inclusion of population 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 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	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Members. (4) Accepting and maintaining data from the PH/W contractor in a manner and format and at a frequency specified by the State. **[REDACTED] requests further clarification so we can understand the full scope of this requirement. Would the State be willing to pay additional fees for data feed development if necessary?**	All services outlined in the Contract shall be included in the Administrative Fees listed in Contract Section C.3.
Pro Forma A.22.l	76.	The Contractor shall obtain Health Plan Accreditation at a level of 3.5-5.0 stars by NCQA. If the Contractor is NCQA accredited as of Go-Live, the Contractor shall maintain such accreditation throughout the term of this Contract and submit a copy of report card performance of accreditation annually by October 20th (refer also to Contract Attachment C, Reporting Requirements). If the Contractor is not NCQA acdcredited, or is not currently accredited at the required level, for its products as of Go-Live, the Contractor shall obtain such accreditation by October 20, 2025 (or a later date as specified by the State) and shall maintain it thereafter. Failure to obtain and maintain accreditation may result in liquidated damages as specified in Contract Attachment B, Performance Guarantees. **Would the State agree to remove the requirement to achieve NCQA accreditation by 2025? [REDACTED]** uses NCQA and URAC accredited case management teams to perform their case management, but Surest does not have NCQA Health Plan Accreditation at this time. **[REDACTED]** plans to achieve accreditation in 2026.	The State is willing to change the requirement from 2025 to 2026.See amendment item #20 below.
Pro Forma A.24.a	77.	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.	The State is agreeable to the Contractor's standard reports and format if the required information is contained within. Modifications may be required to meet Contract requirements.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		[REDACTED] has the ability to provide reports in Excel, as well as other formats that are appropriate for the content. Would the State be open to [REDACTED] standard report formats by report?	
Pro Forma A.24.b	78.	The Contractor shall provide the State access to its internal client financial reporting system, including program and fiscal information regarding Members served, payable amounts, services rendered, claim level data etc. and the ability for said personnel to develop and retrieve reports. The Contractor shall provide training in and documentation on the use of this mechanism no later than two weeks prior to Go-Live. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees no later than two weeks prior to the Go-Live date. Additional or replacement users may be added at any time at the State's request. **[REDACTED] does not currently open it's reporting systems to external users to create and develop their own reports, but has an externally facing reporting portal on the analytic roadmap for 2025 that would provide access to a number of various reporting needs. Until that time, [REDACTED] does have the ability to pull ad hoc reports based upon defined requirements that are mutually agreed upon.**	The State is agreeable to this proposed solution. See amendment item #21 below.
Pro Forma A.24.c	79.	The Contractor shall provide requested State employees with access to the Contractor's enrollment system no later than two weeks prior to Go-Live, unless otherwise approved by the State In Writing. Additional or replacement users may be added at any time at the State's request. Access shall include the ability to do real-time updates to the Contractor's enrollment records. **[REDACTED] does not currently open it's reporting systems to external users to create and develop their own reports, but has an externally facing reporting**	The question references reporting, yet the requirement is related to eligibility and enrollment updates. The State

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		portal on the analytic roadmap for 2025 that would provide access to a number of various reporting needs. Until that time, [REDACTED] does have the ability to pull ad hoc reports based upon defined requirements that are mutually agreed upon.	may be agreeable to a proposed alternative solution. Please provide relevant details for real-time eligibility and enrollment updates in round 2 written questions and comments. This clarification does not have to count toward the five-question maximum
Pro Forma A.24.d	80.	The Contractor shall train the requested State staff (and any additional or replacement users) regarding access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to Go-Live. Such training may be delivered remotely or in-person. **[REDACTED] does not currently open it's reporting systems to external users to create and develop their own reports, but has an externally facing reporting portal on the analytic roadmap for 2025 that would provide access to a number of various reporting needs. Until that time, [REDACTED] does have the ability to pull ad hoc reports based upon defined requirements that are mutually agreed upon.**	The State is agreeable to this proposed solution. See amendment item #28 below.
Pro Forma A.24.i	81.	Contractor shall ensure that its reporting system available to state staff allows for pulling Claims data by, at a minimum, various dates, groups, plan types, Member ID (Edison ID) and can be broken down by product name, Pharmacy name, address, city and state, the NDC of the product, and GPIs 2 through 14 (code and description) that applies to the product, as well as provide the Pharmacy-submitted drug cost, net plan paid amount, and any Member Cost Share **[REDACTED] does not currently open it's reporting systems to external users to create and develop their own reports, but has an externally facing reporting portal on the analytic roadmap for 2025 that would provide access to a number of various reporting needs. Until that time, [REDACTED] does have the ability to pull ad hoc reports based upon defined requirements that are mutually agreed upon.**	The State is agreeable to this proposed solution. See amendment item # 31.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma A.24.e	82.	At the State's request, the Contractor shall provide reporting specific to the activity and outcomes associated with all the UM tools and programs provided by the Contractor. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request. **[REDACTED] has the ability to report on utilization management outcomes. Would the State be open to [REDACTED] standard reports?**	The State is agreeable to the Contractor's standard reports and format if the required information is contained within. Modifications may be required to meet Contract requirements.
Pro Forma A.25.j	83.	i. The Contractor shall establish and maintain systems and processes to receive all appropriate and relevant data from entities and contractors providing services to Members, including contractors under contract with the State (e.g., EAP contractor, PH/W contractor, the HSA/FSA contractor) and integrate such data into Contractor's systems and processes as appropriate no later than one (1) month prior to Go-Live at no additional cost to the State. xx-BDM: Deviations **As an alternative to the timeframe requirement of "one (1) month prior to Go-Live," would the State be willing to accept the timeframes spelled out in our implementation plan? Additionally, would the State be willing to accept [REDACTED] qualification that the information accepted from third-party vendors would be contingent on the format and timing of the information that's coming from the State's contractors under contract with the State.**	The State cannot agree to an unspecified timetable. Please provide the proposed timeframe for consideration in written questions and comments round 2. This clarification does not have to count toward the five question maximum. The State agrees that a contingency on third-party data exists and will be considered when evaluating Contractor compliance with timelines set forth in the Contract.
Pro Forma A.25.l(2)	84.	The Contractor shall ensure that all medical and behavioral claims processed for payment have financial fields, valid NPIs, individual social security numbers, the complete most recent International Classification of Diseases codes and Current Procedural Terminology-4/HCPCS codes (and when applicable, updated versions of each). The file submitted to the	

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		State's current health care DSS contractor should contain data elements consistent with industry standards, such as those contained on the Uniform Bill-04, Center for Medicare and Medicaid Services 1450 and Center for Medicare and Medicaid Services 1500 forms and their successors. The Pharmacy claims data shall include GPI, GCN, Pharmacy Provider ID, NDC or NDC 11, individual social security numbers, and all payment sources and amounts for all prescription drug claims. The Contractor shall add data as required by the State's DSS contractor and/or the State for the purpose of processing claims data. The State has final approval for all file layouts. **Would the State be willing to accept medical and behavioral claims data in [REDACTED] industry-standard file format?**	The State does not agree to this request.
Pro Forma A.25.l(3)	85.	All Claims data shared with the DSS contractor shall include all payment sources and amounts such that the total Claim nets out to zero after the Member Cost Share and plan cost share. This shall include any third-party payments, and any adjustments to the Contractor's file to include all relevant fields shall be at the Contractor's expense. **Would the State be willing to accept claims data shared with the DSS contractor in our industry-standard file format?**	The State does not agree.
Pro Forma A.25.l(6)	86.	The Contractor shall provide the data without any restrictions on its use and shall not change the file layout or content without prior approval In Writing. **Would the State agree to remove this clause from the pro forma, as [REDACTED] does not release data of this kind without business justification or an understanding of how the data will be used? Please refer below for an explanation of our standard practices. We exchange data with third-party benefit administrators and data warehouses on behalf of many customers. Data extracts are available to all self-funded customers where there are more than**	The State does not agree to remove this clause from the pro forma contract. The State Health Plan is a HIPAA covered entity and the State complies with HIPAA privacy and security laws with regard to its data.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		300 subscribers, subject to our clear understanding of how data will be used and the application of a minimum necessary standard described below. Customer-specific detail data extracts are available in a format developed for data warehouse partners and may be released one time, or on a fixed released schedule (monthly, quarterly, annually). We typically charge customers directly for these extracts. Data released is pre-defined, based on a combination of system platform, customer funding, intended business use and intended recipient. **We will provide minimum necessary data to perform the intended business justification. We would request the minimum necessary data elements with descriptions provided and notation of which are required versus optional. A member of our team will then review and provide a recommendation. Data release must be to a vendor we have experience with, that has acceptable levels of Information Security and Cyber or Errors and Omission Insurance. If the vendor is not an organization to which we have released data to in the past, then we may need to go through a vendor-vetting process which would require additional time. If our format is not compatible with your partners, we may be able to customize it, depending on the required layout. We evaluate HIPAA regulation compliance, protection of [REDACTED] proprietary information, data accessibility, intended use and recipient when considering requests for custom content or layout. If the requested changes are possible, additional programming and maintenance charges will apply.** **Data we consider network proprietary business information requires additional networks, senior level management and financial underwriter approval; if this is requested, we may request additional details as to why we should consider the data release and how each data element is utilized. Specifically, any combination of provider, services, and financial information may require such review. If the requested changes are possible, additional programming and maintenance charges may apply. Additionally, this level of detail will require a stricter non-disclosure agreement (NDA) around permissible and prohibited uses.**	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Customers are required to execute appropriate documents authorizing any data release, specifying the intended business use and designating authorized recipients. Legal criteria for data release, content and/or layout of data files will vary depending on the funding arrangement. Third-party data recipients are required to execute legal agreements documenting the permitted use of the data and acknowledging that the data is solely to be used for that specific customer. We use our own encryption program when sending claims data to recipients outside of our email system. Recurring files will be released no later than the 25th of the month after the close of the prior month.	
Pro Forma A.25.k	87.	The Contractor shall provide transmittal of claims data via secure medium at a frequency and format determined by the State to any additional third parties including the State's PH/W contractor, EAP contractor, HSA/FSA contractor or others as identified by the State at no additional cost to the State **[REDACTED]** cannot agree to fund the work of third party contractors without full disclosure of the scope and cost; would the state be willing to remove this provision from the contract?	The State does not agree to revision. This requirement is for the Contractor to share a claims data file with other State Contractors. The State does not know the cost to the Respondent for this requirement.
Pro Forma A.25.l	88.	The Contractor is responsible for the fee charged by the DSS contractor to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor shall pay during the term of this contract all applicable fees as assessed by the State's DSS contractor related to any data format changes or additions, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor shall also pay all applicable fees related to any DSS contractor efforts to correct Contractor data quality errors that occur during the term of this contract. **[REDACTED]** cannot agree to fund the work of third party contractors without full disclosure of the scope and cost; would the state be willing to remove this provision from the contract?	The State agrees to remove. See amendment item #22 below.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro forma contract A.27.h	89.	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: A pre-and/or post implementation audit to review, at a minimum, whether the Contractor's adjudication system is configured according to the State's benefit design at contract Go-Live and in subsequent years if benefit changes are made; An operational audit focusing on, at a minimum, staffing, customer service capabilities, TPA audit programs, and claims administration; and Any follow-up audits if significant deficiencies, as determined by the State, are noted. **We will offer HITRUST, SOC 1 (type II) and post adjudicated claims audits – is this acceptable to the State?**	Please provide specific redlines to the contract language and the State will review. This clarification does not have to count toward the five question minimum. .
Pro Forma A.30	90.	The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State. **Would the State amend the contract to remove the terms under A.30 (a) as this is not applicable to the services we are proposing to provide? Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.** **Correction or reperformance of services under warranty requirements are typically specific to companies that provide tangible goods and materials or construction companies. Our agreements are not traditional goods agreements and are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.**	The State does not agree to remove these terms. This is standard language in all contracts and does apply.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma C.1	91.	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. **Would the State amend the contract to remove the terms under C.1 as this is not applicable to the services we are proposing to provide? This is not applicable to the services we are proposing to provide to the customer. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.**	The State does not agree to remove these terms. This clause is included in every contract and is applicable, as it defines the maximum amount payable to the Contractor for the delivery of the contracted services.
Pro Forma C.3.d(1)	92.	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 cannot agree. The only way for us to administer claim reimbursement is via a bank account that we will open on behalf of the State. The account is charged when payments cash (not when they are issued) and reimbursements are requested accordingly. Would the State agree to amend the terms so that the State will maintain separate bank accounts with [REDACTED] to pre-fund an account?**	The State will not pre-fund an account. However, the State will open separate bank accounts that the Contractor will ACH debit for funding purposes in accordance with Contract Section C.3.
Pro Forma C.3.d(2)	93.	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 amount to be transferred or withhold the amount of any overpaid funding from another funding transfer. **Funding is expected in full, upon request. The State can**	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		review claims on the daily reporting but cannot short-fund the bank account under any circumstance. Will the State agree amend C.3 (d2) to comply with our terms?	The State does not agree to modify these terms.
Pro Forma C.3.d(3)	94.	The Contractor acknowledges that funding for Claims Payments shall be adjusted in full consideration of the Contract Scope of Service requirement that the Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB); see Contract Section A.15.oo. **We utilize a pay and pursue model. Will the State agree amend C.3 (d3) to comply with our terms?**	The State will not modify the contract language. However, the State does agree to a pay and pursue model if the coordination of benefits (COB) information is not known or not loaded in the Contractor's adjudication system at the time of claims processing.
Pro Forma A.9.L	95.	In section A.9.L., it states a PA shall be required for certain services. **Is Non-urgent Air Ambulance transport sufficient to fulfill the Non-emergent ambulance transport requirement? Please provide the Miscellaneous HCPCS Codes. Please specify what "other services specified by the State, in writing or in the Plan document" consist of?**	The State does not agree this will be sufficient to fulfill this requirement. In addition to air ambulance, non-emergent ground ambulance services shall be prior authorized to ensure medical necessity. The State does not define miscellaneous HCPCS codes. The State does not have a list of other services specified by the State at this time. The State monitors new treatments and procedures coming into the market and developing utilization patterns that may indicate a need for prior authorization in the future.
Pro Forma A.14.a	96.	Section A.14.a of the Pro Forma contract indicates that the Contractor should have a dedicated toll free number for the State. **Due to the capabilities of our intelligent call routing system to link members to the appropriate member service team and plan, we do not build out dedicated toll free numbers.** **Would it be acceptable to the State to remove this language?**	The State has updated Contract language to consider a dedicated call tree as an alternative. See amendment item #14 below.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma A.15	97.	Section A.15 of the Pro Forma states: 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. **Will the State agree to an error standard for repayment of unrecovered overpayments, the Contractor is not liable for repayment of the error unless it was grossly negligent or, in the aggregate, did not meet industry standards?**	The State does not agree to this request.
Pro Forma A.15	98.	Section A.15 of the Pro Forma States: 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. **Will the State agree to an error standard for repayment of unrecovered overpayments, the Contractor is not liable for repayment of the error unless it was grossly negligent or, in the aggregate, did not meet industry standards?**	The State does not agree to this request.
Pro Forma A.15.a and A.15.g	99.	The Contractor shall correctly adjudicate claims in accordance with the plan design and State approved covered benefits, see Contract section A.15.a. and A.15.g. One hundred dollars ($100) per occurrence (defined as an individual claim) plus the actual costs incurred of the incorrectly processed claim. This includes any administrative costs incurred by the Contractor or State to correctly reprocess claims or reimburse members and the plan for any overpayment. Plan design information must be accurate as to not cause confusion or financial hardship to Members. This assessment and amount take into account the States increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries. Reported after each occurrence. Measured, reconciled and assessed quarterly. **Our system does not track this metric so we would propose removing this language. Would this be acceptable to the State?**	The State does not agree to this request. When an incident occurs and the Contractor's system is identified as not processing claims in accordance with the plan design and State approved covered benefits, all impacted claims shall be identified, reprocessed, and the Contractor shall be assessed the performance guarantee accordingly.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma A.15.l	100.	The Contractor shall submit to the State, at least one (1) month prior Go-Live, a summary of its methodology for conducting internal claims audits, including audits to determine claims payment, processing, and financial accuracy and claims payment turnaround. The State reserves the right to review the methodology and request changes, where appropriate. The Contractor shall notify the State In Writing at least thirty (30) days in advance of any significant changes to its methodology. The State reserves the right to review the change and request changes, where appropriate. **Would the State agree to clarify that we will provide an overview of our internal claims audit process to the State and not allow a full audit of our internal audit methodology? Additionally, would the State agree to clarify that [REDACTED] would review requested changes but is not required to make changes the State requests. Additionally, would the State agree to remove the written notification requirement of any significant changes to our methodology?**	The State does not agree to modify these terms. The intent is to review the Contractor's methodology for conducting internal claims audits, not perform a full audit. The State will discuss with the Contractor any concerns the Contractor may have with the State's request and may revise its request based on these discussions. The State does not agree to remove the written notification requirement of any significant changes to the Contractor's methodology.
Pro Forma A.15.p.1	101.	The claims management system shall automatically adjudicate no less than eighty percent (80%) of clean claims, i.e., without recourse to manual or other calculation methods external to the system, as required in Contract Section A.15.p.1. **Given that there are many factors that can interfere with auto-adjudication rate, especially since plan design has not been determined which could affect the level of manual intervention or other calculations methods that might need to happen external to the system, we would propose removing this metric. Would this be acceptable to the State?**	The State does not agree to this revision.
Pro Forma A.15.p.3	102.	Financial accuracy shall be ninety- nine percent (99%) or higher as required in Contract Section A.15.p.3. **We do not track financial accuracy and would propose replacing this metric with dollar accuracy at 99%. Would this be acceptable to the State?**	The State does not agree to this revision.
Pro Forma A.15.p.5	103.	Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher as required in Contract Section A.15.p.5. **We would propose changing this to 97%. Would this be acceptable to the State?**	The State does not agree to this revision.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma A.15.p.6	104.	The Contractor shall complete ninety- five percent (95%) of all claim adjustments within seven (7) calendar days, as required in Contract Section A.15.p.6. **We would propose 85% of member adjustments in 5 business days. Would this be acceptable to the State.**	The State does not agree to this revision.
Pro Forma A.19	105.	A.19. Pharmacy f. The Contractor shall implement changes to the Formulary, Step Therapy, PA, and other clinical edit requirements within forty-five (45) Business Days of the State's approval or request. Additional time, beyond thirty (30) Business Days, may be granted with the State's prior approval In Writing. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify Pharmacy Providers and affected Members In Writing at least forty-five (45) days prior to the implementation, unless the State requests a shorter notification time. The State must provide prior approval In Writing for all Pharmacy Provider and Member notifications **Would the State accept the following member and pharmacy provider notification?** We notify affected members of negative changes to the PDL (for example, drugs moving to a higher tier or drugs moving to an exclusion category) approximately 30 days in advance of the implementation date through: • **Targeted Engagement:** Includes written communication with information on covered prescription and over-the-counter (OTC) lower cost alternatives to discuss with their physicians. Members may also receive outbound calls (live calls or IVR) to inform them of select coverage changes. • **Website:** Through myuhc.com and our mobile app, members may view and compare plan-specific pricing and coverage for brand-	While these notifications appear to be appropriate, the State cannot agree to specific communications or notifications until they have been reviewed and approved. This work will take place during the contract implementation phase. See amendment item #19 below.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		name and generic medications at Home Delivery Pharmacy or through a retail pharmacy. This convenient tool educates on cost savings afforded by generics and alternative treatment options that cost less. • **Employee Articles and Flyers:** Provides templates for distribution in company newsletters or posted on intranet sites. • **Digital Alerts:** Digital alerts are available to members through our member portal allowing visibility before the formulary changes are made. Emails are sent to members that receive a disruption mailing directing them to the member portal for the change in their formulary. Our participating network pharmacies are contractually required to support our PDL. Pharmacists access PDL and benefit information in real-time through the claims adjudication system. We notify pharmacists of updates that may cause disruption or questions at the point of service through online messaging. In addition, we communicate PDL changes through our broadcast fax system. We communicate, through email and printed mailings, to participating pharmacies for updates that: • Impact a large number of members • Affect dispensing requirements • Are unique (for example, a generic is moved to Tier 3 while the brand is in Tier 1 or Tier 2) The Contractor shall send Member and prescriber notification letters at least 45 days in advance of formulary updates to advise Members and their prescribers of any change that negatively impacts the Member once the formulary changes. The Member and prescriber letters shall indicate the formulary change date, the Member's currently used medication(s) and the soon-to-be formulary alternatives. The State shall not be billed for these letters, and they shall be included in the monthly Administrative Fee paid to the Contractor.	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Would the State accept the following member and prescriber notification? We notify affected members of negative changes to the PDL (for example, drugs moving to a higher tier or drugs moving to an exclusion category) approximately 30 days in advance of the implementation date through: • **Targeted Engagement:** Includes written communication with information on covered prescription and over-the-counter (OTC) lower cost alternatives to discuss with their physicians. Members may also receive outbound calls (live calls or IVR) to inform them of select coverage changes. • **Website:** Through myuhc.com and our mobile app, members may view and compare plan-specific pricing and coverage for brand-name and generic medications at Home Delivery Pharmacy or through a retail pharmacy. This convenient tool educates on cost savings afforded by generics and alternative treatment options that cost less. • **Employee Articles and Flyers:** Provides templates for distribution in company newsletters or posted on intranet sites. • **Digital Alerts:** Digital alerts are available to members through our member portal allowing visibility before the formulary changes are made. Emails are sent to members that receive a disruption mailing directing them to the member portal for the change in their formulary. **We communicate PDL updates to physicians through multiple channels, including:** • **Physician Network Bulletin:** Sent monthly, includes information about the PDL, program updates and other pertinent pharmacy information. • **Online:** Provides access to the PDL through physician website, UHCProvider.com, and e-prescribing vendors.	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		• **Physician Administrative Guide:** Sent annually, it includes basic information on how to contact us, the claims process, prior authorization requirements and network participation guidelines. • **Letters/Faxes:** Explains our rationale on PDL or clinical program updates with high member impact. • **E-prescribing Tools:** Provides convenient access to current tier status and lower-tier options. • **PreCheck MyScript:** Provides real-time coverage or status of a medication and alternative treatment options. • **Outbound calls:** Targeted communications by our internal team for select changes.	
Pro Forma A.19	106.	A.19. Pharmacy (7) If the Contractor supports an AWP-based pricing strategy: i. For Claims processed at Participating Pharmacies that do not qualify as a Low Volume Pharmacy: The Contractor shall use the post-settlement AWP for this Contract's pricing terms. ii. For Claims processed at Participating Pharmacies that do qualify as a Low Volume Pharmacy: The Contractor shall use NADAC for this Contract's pricing terms. A) In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will adjudicate with an Ingredient Cost consistent with the network applicable to Participating Pharmacies not qualifying as a Low Volume Pharmacy. ***Is the Suggested Definition allowable from the State****: We are not aware of any NADAC pricing requirements in TN and do not currently have the capability to separately administer NADAC pricing at selected pharmacies*	NADAC pricing is required in this contract for claims processed at Participating Pharmacies that qualify as a Low Volume Pharmacy, as defined in the contract. Also refer to footnotes 7 and 8 in the Rx Cost Spreadsheet tab in the cost proposal.
Pro Forma A.25	107.	Section A.25 of the Pro Forma states: The Contractor shall recognize that the medical, behavioral, and Pharmacy claims data transmitted pursuant to the provision of this Contract is owned by the State of Tennessee. **Please confirm that the State agrees the Contractor has a proprietary interest in all paid claims data and such data is not owned by the State.**	The State does not agree to this request.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma A.25	108.	Section A.25 of the Pro Forma states: Within sixty (60) days of notice of termination of this Contract, the Contractor shall transfer to the State all required data and records necessary to administer the plan(s)/program(s), subject to state and federal confidentiality requirements. The Contractor shall also share at least one (1) year of historical data with the State's new vendor(s) at the Term of this contract. The transfer shall be made electronically via secure medium, in a file format to be determined based on the mutual agreement between the State and the Contractor. **Please confirm that the historical data is limited to the customary industry standard data and not all records maintained under the Agreement.**	The State does not confirm.
Pro Forma A.26	109.	Section A. 26 of the Pro Forma states: 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. **Please confirm that information ownership is limited to documents created specifically for the State and does not include paid claims data or any Contractor intellectual property.**	See the response to question #107 concerning the State's ownership rights to claims data. Excluding claims data, the State agrees that its information ownership is limited to documents created specifically for the State.
Pro Forma A.26.i.	110.	Section A.26 of the Pro Forma states: Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences. **Is the State open to other standards? The Contractor has numerous systems and the unsuccessful attempt lock out logic can vary by system**	See amendment item #23
Pro Forma A.26	111.	Section A.26 of the Pro Forma states: The Contractor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be mutually agreed upon by the Contractor and the State.	

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		Please confirm that testing and audit can be based on Contractor's methodology. As these systems support our entire book of business, we do not alter our methodology for each customer.	The State does not agree to this request.
Pro Forma A.27	112.	A.27. Audit Authority a. Pharmacy Rebate audits can include, but are not limited to, review and examination of Manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with Pharmacy Manufacturers, and Program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. To the extent that the Contractor contracts with a separate Group Purchasing Organization (GPO) in connection with Rebates or Manufacturer Payments for the State, the State may (a) directly confirm the existence of contract(s) between the Contractor and such third-party GPO (I.e., view the contract introduction, recitals, and signature block) and (b) audit all aspects of such contract with the establishment of applicable third-party confidentiality agreement(s), if any, as reasonably required by the GPO. Upon request by the State, or its Designated authorized independent auditor, the Contractor shall provide full disclosure of Rebates and Manufacturer Payments received by the Contractor, its Affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line-item detail by NDC or NDC-11 and line-item detail by pharmaceutical Manufacturer showing Actual Cost remitted and other related Claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from Go-Live, January 1, 2025, until the termination of Benefits shall be included in any kind of Pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment assigned by the State (or lack thereof), Spread or differential	

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		between drug tier Copayments, or any kind of utilization. **Would the State accept the following rebate audit terms?** The State's third-party auditor will have access to rebate manufacturer contracts whether those contracts are held directly or indirectly through a GPO arrangement upon execution of a non-disclosure agreement (NDA). Audits of rebate manufacturer contracts are allowed, provided that (i) a third party auditor approved by Optum Rx must be utilized; (ii) The State' pays its own costs associated with the audit; (iii) all audits are subject to confidentiality obligations required of Optum Rx in its third party contracts; and (iv) rebate audits include no more than The State's top 10 pharmaceutical manufacturers or those rebate manufacturer contracts comprising of 75 percent of The State's rebate spend, whichever is less.	The State of TN is willing to comply with the request for confidentiality agreements and/or non-disclosure agreements (NDAs) for third-party auditors. See amendment item #32. The State will not accept the additional rebate audit terms. See pro forma contract Section A.27.h for additional information on audit terms.
	113.	**Authorized Generic:** a drug that is marketed, sold or distributed in the United States as a Generic Drug version of a Brand Drug where the authority for such marketing, sale and or distribution is based upon a Manufacturer's New Drug Application (NDA) or Biologic License Application (BLA) for the associated Brand Drug. Also, the Authorized Generic is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repacking the listed drug for use in institutions) than the Brand Drug. Authorized Generics will be identified using MediSpan Multisource Code of "M" (co-branded product) with a Brand Drug Code of "B" (Branded Generic Name). ***Is the Suggested Definition allowable from the State****: Authorized Brand Alternative Drug: A drug with a unique NDC that is the bioequivalent of a Brand Drug that is under patent and which is manufactured by the patent holder or affiliate or a third party under a license, whether or not identified as a Brand Drug or Generic Drug by the manufacturer or a Pricing Source.*	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.
	114.	n. **Brand Drug:** an FDA approved drug, or a drug that is Designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its	

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		licensee, set forth in Medi-Span's National Drug Data File (MS) as a Brand Drug identified by all of the products meeting at least one of the following criteria: (1) Brand Name code of "T" and Multisource Code "M" (2) Brand Name code of "B" or "T" and Multisource Code of "N" (3) Brand Name code of "B" or "T" and Multisource Code "O" and a DAW code of 0, 1, 2, 7, 8, or 9 For the avoidance of doubt, Brand Drugs shall also include brand name vaccines, supplies, medical devices, kits, diabetic supplies, OTC products, and test strips. ***Is the Suggested Definition allowable from the State****: Contract definition (adjudication):* *Brand Drug: A single-source or multi-source prescription drug product as designated by the Medi-Span Prescription Pricing Guide (with supplements) or other available data resources that identify as a Brand product.* *Reconciliation definition:* *Brand Drug: An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee , set forth in Medi-Span's National Drug Data File as a brand drug identified by all of the products meeting at least one of the following criteria:* *Medi-Span Multi-Source Code ("MSC") is equal to M, O, or N.*	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.
Pro Forma A.2.mm	115.	mm. **Generic Drug:** an FDA approved drug, or a drug that is Designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File (MS) as a Generic Drug identified by all products meeting at least one of the following criteria: (1) Brand Name code of "G" for all Multisource Codes (M, N, O, and Y) (2) Multisource Code of "Y" (3) Multisource Code of "M" with a Brand Drug Code of "B" (Authorized Generic) (4) "O" with a DAW code of 3, 4, or 6 (5) Multisource Codes (M, N, O, and Y) with a DAW code of 5 (House Generic).	

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		For the avoidance of doubt, Generic Drugs shall also include generic vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips. ***Is the Suggested Definition allowable from the State:*** Contract definition (adjudication): Generic Drug: A prescription drug product, whether identified by its chemical, proprietary or non-proprietary name, that is therapeutically equivalent and interchangeable with a Prescription Drug having an identical amount of the same active ingredient(s). For purposes of this Agreement, the Generic Drug determination is made based upon factors including indicators included in the Medi-Span Prescription Pricing Guide (with supplements) or other available data resource that identify as a Generic product. Reconciliation definition: Generic Drug: An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File as a generic drug identified by all products meeting at least one of the following criteria: Medi-Span Multi-Source Code ("MSC") is equal to Y.	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.
Pro Forma A.2.pp	116.	pp. **Guaranteed Minimum Manufacturer Payment or Rebate Guarantee:** the minimum Rebate per Rx by dispensing channel. The performance will be calculated for the annual period using the following formula for each dispensing Channel independently, then summed: 'The calculation of the Annual Rebate Guarantee Amount will be [Rebate Guarantee] multiplied by [total Rx count minus the exclusions as identified by the State in Contract Section A.15.ii. and C.3.p.]. **We do not see exclusions in A.15.ii or C.3, is the State able to provide?**	This information is in contract section A.19.y. See amendment item #30
Pro Forma A.2.kkk	117.	kkk. **Manufacturer Administrative Fees ("MAF"):** fees for services rendered to Pharmaceutical Manufacturers in relation to administrative duties in connection with	

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		aggregation, allocating, collecting, and invoicing for Rebates. Manufacturer Administrative Fees are considered inclusive of "rebate Administrative Fee(s)," "formulary Administrative Fees," "GPO fees" or any other fee paid to Contractor, Contractor's Affiliate, or their Subcontractor(s),or a GPO in relation to administrative duties in connection with the collection of Manufacturer Payments, excluding fees retained by the GPO for Contractor's participation in the GPO. ***Is the Suggested Definition allowable from the State***: Manufacturer Administrative Fees: The administrative fees paid by drug manufacturers to [REDACTED] for [REDACTED] provision of Rebate administration services.	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.
Pro Forma A.2.mmm	118.	mmm. **Manufacturer Payments:** any and all compensation, financial benefits and remuneration Contractor, Contractor Affiliates, Subcontractor, or a GPO, receives from a Pharmaceutical Manufacturer, that is in any way attributable to the State's Claims and/or utilization, including but not limited to, Discounts; credits; Rebates, regardless of how categorized; market share incentives, chargebacks, commissions, Inflation Protection adjustments or payments, access fees, MAF, and administrative and management fees. Manufacturer Payments also include any fees received for sales of utilization data to a Pharmaceutical Manufacturer. For avoidance of doubt, Manufacturer Payments excludes Other Pharmaceutical Manufacturer Revenue that is not in any way attributable to the State's Claims and/or utilization. ***Is the Suggested Definition allowable from the State***: Is the state able to remove reference to GPO.	The state does not agree to this revision.
Pro Forma A.2.sss	119.	sss. **NADAC:** The National Average Drug Acquisition Cost. NADAC represents a national pricing benchmark, published by CMS, that is reflective of actual invoice costs that pharmacies pay to acquire prescription and over-the-counter drugs. It is based upon invoice cost data collected from retail community pharmacies and reflects actual drug purchases. ***Is the Suggested Definition allowable from the State****: NADAC pricing is n/a (referenced in the context of Low Volume Pharmacies).*	See response to question #56.

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Pro Forma A.2.cccc	120.	cccc. **Pass Through Transparent Pricing:** ***Is the Suggested Definition allowable from the State****: Definition "full pass through (100%) of the Contractor's contracted rates with Participating Pharmacies" is problematic and not administrable*	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.
Pro Forma A.2.rrr	121.	rrrr. **Rebate(s):** All revenue received by the Contractor and any Contractor Affiliates (including Rebate aggregators or any similar contracted entities) from outside sources related to the Plan's utilization or enrollment in programs also known as Total Manufacturer Value. Also, the amounts paid to the Contractor, Contractor Affiliates, or a GPO, (i) pursuant to the terms of an agreement with a Pharmaceutical Manufacturer pursuant to the terms of a Rebate contract, negotiated directly or indirectly with a pharmaceutical company by Contractor, Contractor Affiliates, or a GPO, (ii) in consideration for the inclusion of such Manufacturer's drug(s) on the Formulary, and (iii) which are directly or indirectly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescriptions by Members. This includes but is not limited to: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite Pharmacy Claims, low day supply Claims, Generic Drug Claims, Biosimilar Drugs, Formulary access fees, service fees, Manufacturer Administrative Fees and marketing grants from Pharmaceutical Manufacturers, wholesalers and data warehouse contractors, Discounts, credits, Inflation Protection, charge backs, commissions, and any fees received for sales of utilization data to a pharmaceutical Manufacturer. Rebates do not include purchase Discounts (e.g., prompt pay Discounts) from mail and specialty products, the value of drug Manufacturer coupons, or the value from any other patient assistance programs. ***Is the Suggested Definition allowable from the State****:* *Rebate: Any discount, Manufacturer Administration Fees, price protection amounts, price concession or other remuneration United 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 during the Term. Rebate does not include any discount, price concession, Manufacturer Administration Fees, or other direct or indirect remuneration United or a group purchasing organization receives from a Drug Manufacturer for direct purchase of a Prescription Drug or for*	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.

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		the provision of any product or service or tool, including analytical services used in the review of data.	
Pro Forma A.2.bbbb	122.	bbbbb. **Specialty Drugs:** Certain pharmaceuticals, biotech or biological drugs, that are used in the management of complex or genetic disease that meet at least one of the first two criteria (1 and 2) and all the last three criteria (3-5) in order to be placed on your Specialty Drug list: (1) Produced through DNA technology or biological processes (2) Targets a complex disease caused by a combination of genetic, environmental and lifestyle factors (3) Unique handling, distribution, and/or administration requirements such that the drug cannot be safely dispensed from a Mail Order Pharmacy (4) Requires a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training is required (5) Are not a device, supply, medical food, or durable medical equipment. Lastly, only newly FDA-approved and launched drugs, and drugs not on the market as of January 1, 2025, may be considered for addition to the Specialty Pharmacy drug price list after this date, unless the Specialty Pharmacy gains access to a previously unavailable Limited Distribution Specialty Drug. ***Is the Suggested Definition allowable from the State****: Specialty Drug: A Prescription Drug that has at least three (3) of the following criteria: (a) a biotechnology product or exhibit gene therapy technology; (b) FDA designated orphan or ultra-orphan status; (c) any formulation of drug that is high-cost as defined by the CMS Specialty cost threshold; (d) drugs requiring focused, in-depth member education and/or adherence monitoring and/or side effect management and/or injection preparation/administration education; I drugs that require specialized storage control or other specific shipping/handling requirements; (f) infusion or healthcare administered injectable drugs professionally administered by a healthcare professional or in a healthcare setting (but excluding supplies or the cost of administration); or (g) therapy requiring management and/or care coordination by a healthcare provider specializing in the member's condition; or (h) managed as part of an*	The State does not accept the proposed definition and will not agree to the edit(s). The original definition will stand.

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		existing specialty therapeutic program. Specialty Drugs shall not include any Prescription Drugs that: (x) require nuclear pharmacy sourcing; (y) are preventive immunizations (e.g., influenza, DTP); or (z) are administered only in the inpatient setting.	
Pro Forma A.27	123.	**A.27. Audit Authority** **Is the State agreeable with the following statements?** We are agreeable to an audit provision that, upon minimum of 60 days notice, affords [customer] or a mutually acceptable entity the opportunity to audit us once per calendar year to determine whether medical claims are being administered in accordance with benefit plan requirements under our administrative services agreement (ASA). We permit annual claim processing audits that are consistent with generally acceptable auditing standards, such as a statistically valid, random sample audit that employs acceptable sampling and audit methodologies where the audit firm is not paid on a contingency basis and does not include electronic/data mining audits that are used for purposes of recovery discovery. Our audit provision provides for the following: ■ The time, place, type, duration and frequency of the audit are reasonable and agreed to by the parties. The information reviewed relates to paid claims for the calendar year in which the audit is conducted and/or the immediately preceding calendar year (up to 18 months), during the term of the ASA, and at any time within six months following its termination. ■ The parties pay for their own audit costs. In addition, [customer] will pay us for any unanticipated costs we incur, a reasonable per-claim cost for any audit exceeding five business days for direct claim review or for claim sample sizes exceeding the allowable scope, any costs of an audit after termination, and any costs associated with more than one audit per year as approved by [REDACTED]. ■ A mutually agreeable third party may be allowed or designated to conduct the audit. ■ The audit will be conducted pursuant to agreed-upon confidentiality commitments. ■ We will be given a reasonable opportunity to review and comment on any audit conclusions	The State does not agree.

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Pro Forma A.28	124.	Section A.28 of the Pro Forma states: The Contractor shall assist the State in complying with all requirements of the Consolidated Appropriations Act of 2021, and Transparency in Coverage rules including Prescription Drug Data Collection (RxDC) reporting requirements at no additional cost to the State. The Contractor must provide, at no additional cost to the State, copies of all data that the Contractor provides to CMS each year to meet their portion of the RxDC reporting requirements (e.g., files D3-D8 and the prescription drug portion of the narrative response). **Please confirm that the Contractor is only required to assist with CAA requirements that are directly related to services the Contractor is providing to the State. For example, Contractors do not perform Mental Health Parity testing for Plans and Plans are responsible for ensuring their Plans are complaint, so Contractor can't confirm that the State's Plan's non-quantitative treatment limitations are compliant. We can, though, cooperate with the State in its performance of MHPAEA testing.**	The State does not agree. The State expects the Contractor to provide RxDC reporting per the Contract requirements. The State's current behavioral health contractor performs a MHPAEA review and testing but does not attest to compliance. As behavioral health and medical are combined in this contract the State expects the Contractor to provide MHPAEA review, testing, and the outcomes to the State.
Pro Forma A.29	125.	Section A.29 of the Pro Forma states: Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract. **Please confirm that possession (ie. ownership) is limited to documents created specifically for the State and does not include claims data or any Contractor intellectual property.**	See the response to question #109.
Pro Forma A.29	126.	Section A.29 of the Pro Forma states: If Contractor fails to provide the goods or services as warranted, then Contractor will re- provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services.	

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		Please confirm that in the context of claims administration and related services, this only applies to physical goods, documents etc. that the Contractor is providing.	The State does not confirm. This applies to any good or service required in the contract.
	127.	Section c: The State shall perform a quarterly review for potential duplicate claims payments to ensure the Contractor's claim edits are identifying duplicate claims and correcting any overpayments. Any duplicate claims identified as questionable by the State shall be submitted to the Contractor for further research. The Contractor shall respond within thirty (30) days of notification with additional claim detail to confirm or deny duplicate claims. Any confirmed duplicate claims shall be reprocessed to reimburse the State. Is the State agreeable with the following statements? We are agreeable to an audit provision that affords [customer] or a mutually acceptable entity the opportunity to audit us once per calendar year to determine whether medical claims are being administered in accordance with benefit plan requirements under our administrative services agreement (ASA). We permit annual claim processing audits that are consistent with generally acceptable auditing standards, such as a statistically valid, random sample audit that employs acceptable sampling and audit methodologies where the audit firm is not paid on a contingency basis and does not include electronic/data mining audits that are used for purposes of recovery discovery. Our audit provision provides for the following: ■ The time, place, type, duration and frequency of the audit are reasonable and agreed to by the parties. The information reviewed relates to paid claims for the calendar year in which the audit is conducted and/or the immediately preceding calendar year (up to 18 months), during the term of the ASA, and at any time within six months following its termination. ■ The parties pay for their own audit costs. In addition, [customer] will pay us for any unanticipated costs we incur, a reasonable per-claim cost for any audit exceeding five business days for direct claim review or for claim sample sizes exceeding the allowable scope, any costs of an audit after termination, and any costs associated with more than one audit per year as approved by [REDACTED]. ■ A mutually agreeable third party may be allowed or designated to conduct	The State does not agree to any of the statements.

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		the audit. ■ The audit will be conducted pursuant to agreed-upon confidentiality commitments. ■ We will be given a reasonable opportunity to review and comment on any audit conclusions	
Pro Forma C.3.x	128.	In Section C of the Pro Forma, it states: The Contractor shall reimburse, when necessary and appropriate, monies to plan Members when an overpayment has occurred by the Member. **Will the State agree to an error standard for repayment of unrecovered overpayments, the Contractor is not liable for repayment of the error unless it was grossly negligent or, in the aggregate, did not meet industry standards?**	The State does not agree modify these terms. The State's expectation is that the Contractor will reimburse monies owed to plan Members when an error is found in the Contractor's adjudication system and/or an error cannot be re-processed by the Contractor's adjudication system.
Pro Forma C.15	129.	In Section C of the Pro Forma it states: Compensation Disclosure. All sources of indirect or transactional payment or compensation to the Contractor and any and all PBM Affiliates including GPOs, as a result of or in connection with the State's business, must be disclosed to the State In Writing. The Contractor, and any and all PBM Affiliates, including GPOs, shall submit an annual disclosure detail statement of all such sources of revenue, within sixty (60) days prior to the end of the year for the subsequent calendar year. The annual disclosure detail statement shall be updated and submitted to the State within sixty (60) calendar days of any changes throughout the year. **Contractor agrees to make all compensation disclosures as required by law. Does this meet the obligations of this provision?**	This request does not meet the State's requirement and maintains the Compensation Disclosure requirements as written.
Pro Forma C.1	130.	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.	

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		This is not applicable to the services we are proposing to provide to the customer. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs. **How is liability defined?**	See responses to question #11 and #91.
Pro Forma C.3.g	131.	Section C.3. g. of the Pro Forma contract, requires that during the term of the contract the average, aggregate reimbursement for all Specialty Drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed: Plan Year 2025 ASP + 28% Plan Year 2026 ASP + 26% Plan Year 2027 ASP + 26% **Is the ASP guarantee limited to services received within the state of TN? or would out of state infusion services also apply to the ASP guarantee?**	Out of State infusion services also apply to the ASP guarantee.
Pro Forma C.3.g	132.	Section C.3. g. of the Pro Forma contract, requires that during the term of the contract the average, aggregate reimbursement for all Specialty Drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed: Plan Year 2025 ASP + 28% Plan Year 2026 ASP + 26% Plan Year 2027 ASP + 26% **Please confirm that ASP would be defined as CMS ASP (the rates published quarterly by CMS). If this is not correct, please provide the correct definition.**	The State confirms that ASP is defined as the rates published quarterly by CMS.
Pro Forma C.3.g	133.	Section C.3. g. of the Pro Forma contract, requires that during the term of the contract the average, aggregate reimbursement for all Specialty Drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed: Plan Year 2025 ASP + 28% Plan Year 2026 ASP + 26% Plan Year 2027 ASP + 26%	

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		Are the current vendors administering custom direct vendor contracts for the State to be in compliance with this requirement or does the current plan document have max benefit language in terms of what providers will be reimbursed for items falling within this category? Please provide any details around the current arrangements that are in place to ensure compliance with this requirement.	The State's current contractors have created their own contracting process to comply with this requirement. The State does not define the contracting approach.
Pro Forma C.3.k	134.	k. The Contractor will calculate the achieved Discounts with the following formula: [1 minus (total Discounted Ingredient Cost, excluding Dispensing Fees and penalties due to DAW Claims and prior to application of Copayments, of applicable prescription drug Claims for the measurement period) divided by total AWP for the measurement guarantee period]. Both the Discounted Ingredient Cost and the AWP will be calculated as of the date of adjudication. Discounted Ingredient Cost will always be the lowest of the post settlement, reconciled AWP Discount, MAC or U&C adjudication methodology. **What would "penalties due to DAW Claims" include?**	DAW claim penalties (also called member-pay-the-difference) may be applied when either the prescriber (DAW-1) or the member (DAW-2) requests a higher-cost/higher-tier product when there is a lower-cost/lower-tier alternative also available on formulary. DAW penalties come in the form of higher member cost share amounts, where, in addition to the member cost share for the higher-tier product requested, they will also be charged the difference between the actual post-discount costs of the two products, respectively.
Pro Forma C.30	135.	C.30 Confirm that all costs associated with any utilization management, payment optimization, affordability solutions and any other program or mechanism utilized by you or a subcontractor to ensure evidence based services are being provided at the optimal place of service with clinical oversight and compliance with medical policies and guidelines are included in the administrative fees as proposed in the cost proposal and are not charged to the state in any other cost, capitation, or other payment model. **How is "optimal place of service" defined?**	Optimal place of service refers to utilization management processes to direct or redirect care to a lower cost quality place of service when that place of service can still meet the medical needs of the member, i.e. infusion center vs. Hospital, ambulatory surgery center vs. Hospital outpatient department, etc.
Pro Forma D.4	136.	In Section D of the Pro Forma it states: Subject to Funds Availability. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special,	

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		incidental, consequential, or any other damages of any description or amount. **Please confirm this applies solely to the act of the State exercising the termination right; it does not eliminate other State contractual obligations or Contractor remedies under the agreement.**	The State confirms this is correct.
Pro Forma D.7	137.	In Section D of the Pro Forma it states: Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. **As the Contractors subcontracts for its entire book of business, is the State willing to limit the right to approve subcontractors to those that are only solely providing Services for the State?**	No, the State is interested in providing review and prior approval to all subcontractors who the Contractor intends to use to deliver/provide services for this contract, not every subcontractor with whom the company contracts.
Pro Forma D.19	138.	In Section D of the Pro Forma it states: Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys' fees, court costs, expert witness fees, and other litigation expenses for the State to enforce the terms of this Contract. **Is the State willing to indemnify the Contractor for the 1) State's breach of the agreement, or 2) the States design and operation of its Plan?**	The State will not agree to this request.

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Pro Forma E.7.a.2	139.	In Section E of the Pro Forma it states: The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 or 140-3 (current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Contractor shall provide installation and maintenance support at no cost to the State. **Is encryption using AES-256 acceptable? For security purposes, is the State willing to allow the Contractor to control access to the encryption keys, as they rotate regularly?**	See amendment item #25 below.
Pro Forma E.7	140.	In Section E of the Pro Forma it states: The State shall approve the SOC audit control objectives. **Please confirm that SOC audit and control objectives can be based on Contractor's methodology. As these systems support our entire book of business, we do not alter our methodology for each customer.**	The State would need to know what the vendor's methodology is to confirm if the SOC audit and control objectives are acceptable. Please provide a response in Round 2 Written Questions and Comments.
	141.	SOC 2 Type II Audit **We do not produce SOC 2 Type II. SOC2 type information security is covered by both the HITRUST certification and SOC1 Type II report. Is this acceptable to the State?**	Please provide contract reference and suggested redlines in Written Questions and Comments round 2. The State wanted to point out that Attachment C, item #43 requires a SOC 2 Type 2 report. This clarification does not have to count toward the five-question maximum.
Pro Forma E.7.a.3	142.	In Section E of the Pro Forma it states: The Contractor shall provide proof of current ISO certification **Is HITRUST certification acceptable in lieu of ISO certification?**	HITRUST certification is acceptable in lieu of ISO. See amendment item #34

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
Pro Forma E.7.a.3	143.	In Section E of the Pro Forma it states: 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 or Subcontractor. **Please confirm that SOC corrective action plans can be based on Contractor's methodology and requirements. As these systems support our entire book of business, we do not create corrective action plans for each customer.**	The State would need to know what the vendor's corrective action plan is to confirm if it is acceptable. Please provide this information in Round 2 written questions and comments.
Pro Forma E.7.a.4	144.	In Section E of the Pro Forma it states: The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment. **As there are security issues with a customer performing penetration tests and vulnerably assessments on a Contractor processing environment, please confirm that the tests completed by Contractor and its vendor are sufficient.**	In round 2 written questions and comments, please clarify if bidder accepts one of the following options. **Option 1:** Contractor shall allow a mutually agreed upon 3rd party to perform the penetration testing and vulnerability assessments per NIST 800-115 (penetration testing definition). **Option 2:** Contractor shall provide a letter of attestation that the penetration testing and vulnerability assessments per NIST 800-115 have been performed annually and any material weaknesses have been remediated.
Pro Forma E.7.b	145.	In Section E of the Pro Forma it states: The Contractor and all data centers used by the Contractor to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology- solutions/sts-security-policies.html.	The contractors' policies and procedures on their own is not sufficient. The State could substitute NIST or HITRUST policies in lieu of EISP. Please confirm in round 2 written

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		As we have extensive security policies and procedures for our entire book of business, please confirm that compliance with Contractor information security policies is sufficient.	questions and comments if this is acceptable.
Pro Forma E.7.d(2)	146.	In Section E of the Pro Forma it states: The Disaster Recovery Test shall use actual State Data Sets that mirror production data **We conduct these tests with book of business data, please confirm that is sufficient.**	The State does not agree to this request.
Pro Form E.7.c	147.	In Section E of the Pro Forma it states: Comptroller Audit Requirements. Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Contractor and all Subcontractors **As Contractor, we have audit rights with our subcontractors. Please confirm if the Contractor audits of its subcontractors are sufficient.**	The State declines to make any change to the contract language.
Contract Attachment B, PG #19	148.	**It is unclear what is meant by "($19,000) per incident basis violation until resolved." What constitutes an incident and if there is an incident what impact does the time to reach a resolution have on the PG?**	The State assumes the bidder is referring to Performance Guarantee #19. An incident is a breach that impacts 500 or more members. Breach is defined in the Guarantee section. A breach is to be reported after each occurrence and measured, reconciled, and assessed quarterly.
Contract Attachment C	149.	As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted via secure electronic medium, in a format approved or specified by the State, and shall be of the type and at the frequency indicated below. The reports shall be used by the State to assess the medical TPA performance and utilization, as well as reconcile any liquidated damages and Service	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Level Agreements. The State reserves the right to modify reporting requirements as deemed necessary to monitor the Public Sector Plans. The State will provide the Contractor with at least ninety (90) days' notice prior to implementation of a report modification. Unless otherwise directed by the State, the Contractor shall submit reports as follows: 1. Weekly reports shall be submitted by Tuesday of the following week; 2. Monthly reports shall be submitted by the 15th of the following month; 3. Quarterly reports shall be submitted by the 20th of the following month; 4. Semi-Annual Reports shall be submitted by the 20th of the following month; Annual reports shall be submitted within sixty (60) days after the end of the calendar year. Note: Any report due on a holiday or weekend will then be due on the following Business Day. **[REDACTED] has the ability to generate reports on a weekly, monthly, quarterly, semi-annual, and annual basis. The cadence of reporting may vary by report type, data type, data availability, and data refresh cycles. Based upon the [REDACTED] standard reports proposed in the following section, would the State be open to discussion of cadence for each report based upon the [REDACTED] standards?** Reports shall include: **Geographic Access Report**, submitted quarterly in compliance with contract section A.6.j. **[REDACTED] has the ability to report on providers by geography. Would the State be open to a [REDACTED] standard report?** **Provider Denied Claim Appeals Report,** submitted	The State is generally agreeable to the Contractor's standard reports and format if the required information is contained within. Modifications may be required to meet Contract requirements. Certain reports must be submitted in the State's requested format such as: Geographic Access Report Provider Denied Claim Appeals Claims SLA and KPI Metrics Pharmacy Claims Metrics The State cannot provide an example of the Transparency Tool Report. For

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		quarterly in compliance with contract section A.6.y. **[REDACTED] has the ability to report denied claims that have been appealed, would the state be open to a [REDACTED] standard report?** **Continuity of Care and Unique Care Exception Report**, submitted monthly in compliance with contract section A.6.ii. **[REDACTED] has the ability to report on transition of care information. Would the State be open to a [REDACTED] standard report?** **Appeals Report**, submitted quarterly in compliance with contract section A.8.g. **[REDACTED] has the ability to report on appeals. Would the State be open to a [REDACTED] standard report?** **UM Program List and Selection Inventory**, submitted semi-annually in compliance with contract section A.9.c. **[REDACTED] has the ability to report on appeals. Would the State be open to a [REDACTED] standard report?** **Therapeutic Substitution and Generic Drug Dispensing Results Report**, submitted annually in compliance with contract section A.9.s. **[REDACTED] has the ability to report on drug substitutions and generics. Would the State be open to a [REDACTED] standard report?** **Prior Authorization and Utilization Management Report**, submitted quarterly in compliance with contract section A.9.u. **[REDACTED] has the ability to report on prior authorizations and utilization management reviews. Would the State be open to a [REDACTED] standard report?** **Telehealth Utilization Report**, submitted quarterly in compliance with contract section A.13.i.	this product it would be a report demonstrating the utilization and searches by members on the member portal and mobile application. A standard report would be considered. See Question #76 related to NCQA Accreditation and reporting.

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		[REDACTED] has the ability to report on telehealth and virtual care. Would the State be open to a [REDACTED] standard report? **Diabetes Prevention Program Outcomes Report**, submitted quarterly in compliance with contract section A.13.j. **[REDACTED] has the ability to report on diabetes programs. Would the State be open to a [REDACTED] standard report?** **Call Center Statistics**, submitted in compliance with contract section A.14.k. **[REDACTED] has the ability to report on call center metrics. Would the State be open to a [REDACTED] standard report?** **Claims SLA and KPI Metrics Report,** submitted quarterly in compliance with contract section A.12.p.(1-6). **[REDACTED] has the ability to report on claims SLA. Would the State be open to a [REDACTED] standard report?** **Pharmacy Claims Metrics Report,** submitted quarterly in compliance with contract section A.12.q.(1-3). **[REDACTED] has the ability to report on pharmacy claims key metrics. Would the State be open to a [REDACTED] standard report?** **Coordination of Benefits Report**, submitted weekly in compliance with contract section A.15.oo. **[REDACTED] has the ability to report on COB. Would the State be open to a [REDACTED] standard report?** **Recoveries Reports**, submitted monthly in compliance with contract section A.15.qq. **[REDACTED] has the ability to report on recoveries. Would the State be open to a [REDACTED] standard report?**	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Denied Claims Report, submitted quarterly in compliance with contract section A.15.aaa. **[REDACTED] has the ability to report on denied claims. Would the State be open to a [REDACTED] standard report?** **Pended Claims Report,** submitted monthly in compliance with contract section A.15.bbb. **[REDACTED] has the ability to report on pended claims. Would the State be open to a [REDACTED] standard report?** **Member Engagement Plan**, submitted two months prior to the annual enrollment before Go- Live and annually thereafter in compliance with contract section A.16.a. **[REDACTED] has the ability to report on member engagement. Would the State be open to a [REDACTED] standard report?** **Marketing and Communications Report,** submitted quarterly in compliance with contract section A.16.a.(2). **[REDACTED] has the ability to report on marketing and communications programs. Would the State be open to a [REDACTED] standard report?** **Transparency Tool Report,** submitted quarterly in compliance with contract section A.16.g.(6). **Is the State able to provide this to us?** **Wellness Activity Completion,** submitted at the request of the State in compliance with contract section A.21.c. **[REDACTED] has the ability to report on wellness activities. Would the State be open to a [REDACTED] standard report?** **NCQA Health Plan Accreditation Certification,** in compliance with contract section A.22.l. **Would the State agree to remove this requirement to achieve NCQA accreditation by 2025? [REDACTED] uses**	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		NCQA and URAC accredited case management teams to perform their case management, but [REDACTED] does not have NCQA Health Plan Accreditation at this time. [REDACTED] Slans to achieve accreditation in 2026. **Ad-Hoc Reports,** in compliance with contract section A.24.g. **[REDACTED] has the ability to provide ad hoc reporting based upon requirements gathered and agreed upon per request. Would the State be open to a [REDACTED] standard process?** **Daily or Weekly Enrollment File Error Report,** submitted within one (1) Business Day of receipt of the daily or weekly enrollment file in compliance with contract section A.25.e(3). **[REDACTED] is able to submit data extracts of claims to CMS for data matching purposes. Would the State be open to a [REDACTED] standard report?** **Local Government CMS Data Match Report**, submitted monthly in compliance with contract section A.25.h. **[REDACTED] is able to produce claims extracts and would be willing to work with the State on other data extract needs. Would the State be open to a [REDACTED] standard process?** **Other Reports,** as specified in this Contract. **[REDACTED] has the ability to provide ad hoc reporting based upon requirements gathered and agreed upon per request. Would the State be open to a [REDACTED] standard process?**	
Contract Attachment C	150.	**CONTRACT ATTACHMENT C** **REPORTING REQUIREMENTS** 18. **Rebates and Manufacturer Payments Report**, submitted quarterly, no later than sixty (60) days following the end of each quarter, in compliance with contract section A.15.kk an C.3.p.	

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		Rebates are standardly paid/reported with a 100 day lag (request 100 days) (7) Claims processed at Participating Pharmacies where the pharmacy's annual prescription volume is at a level that, if the pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the pharmacy for the enhanced amount of professional dispensing fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual (per Tennessee PC 1070), shall be excluded from the Guaranteed Minimum Average Discounts above and will be priced using National Average Drug Acquisition Cost (NADAC), published by CMS, on the date dispensed. In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will adjudicate with an Ingredient Cost consistent with the network applicable to Participating Pharmacies not qualifying as a Low Volume Pharmacy, unless otherwise excluded based on tab 2. Pricing Requirements. Point solution claims shall be excluded from the Guaranteed Minimum Average Discounts above ***We are not aware of any NADAC pricing requirements in TN and do not currently have the capability to separately administer NADAC pricing at selected pharmacies. Please advise on how the State would like to move forward?***	The state does not agree to change this requirement. See response to question #56
Contract Attachment D, KPI #1	151.	One hundred percent (100%) of expedited appeals for urgent care, not involving a third-party review, shall be decided within seventy-two (72) hours, as required in Contract Section A.8.f.1. **We would propose an alternate metric of 95%, measured quarterly. This would apply to member liability appeals only at Customer Level. Is this acceptable to the State?**	This metric is measured quarterly. The State does not agree to a lower metric. Please review T.C.A. 56-61-109. Establishment of written procedures for expedited review of urgent care requests of grievances involving adverse determination.
Contract Attachment D, KPI #26	152.	The level of overall customer satisfaction, as measured annually by the CAHPS Member Satisfaction survey(s) required by Contract Section A.7.q., shall be equal to or greater than eighty-five percent (90%) in the first year of the Contract, and shall be equal to or greater than ninety percent (95%) in all subsequent year(s) within the contract term. If the Contractor fails to meet the requirement. $20,000 if requirement is missed.	The State is unaware of any availability issues with the CAHPS Survey. If the CAHPS survey is not available or the Contractor has a preferred equivalent survey the State would consider an alternative survey that meets the State's goal of

RFP SECTION		QUESTION / COMMENT	STATE RESPONSE
		CAHPS Survey is currently unavailable, would it be acceptable to use the UES post-member call survey for this requirement?	measuring Member Satisfaction with the Contractor.

3. **Delete RFP Section 1.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted).**

1.1. Statement of Procurement Purpose

The State intends to secure one self-funded contract with a Third Party Administrator (TPA) for a broad Preferred Provider Organization (PPO) network for medical, behavioral health, and pharmacy benefits (pharmacy may be carved out at the State's request) servicing all ninety-five (95) Tennessee counties statewide as well as nationally for Members residing or traveling outside of the state. The TPA shall provide access to an existing (current) high-quality cost effective broad commercial network that meets the state's access requirements. The State intends to procure a contract with a TPA who has a current tiered copay only benefit design, which is applied to all providers in a broad national network, that is currently in place with other large self-funded employers. This contract and benefit design shall include all medical and behavioral healthcare services as well as pharmacy services (unless the State requests to carve out pharmacy). The tiered copay only benefit design sets member copay ranges, beyond a preferred and non-preferred status, for ALL national provider and specialist office visits, healthcare services including surgeries and procedures, admissions, behavioral healthcare services, and pharmacy benefit services based upon the quality and cost of the providers, facilities, pharmaceuticals, healthcare services and outcomes. Cost and quality data must be displayed online in a transparent, customer friendly way that is easily accessible by members. Members pay a copay for all services covered by this contract up to a maximum out of pocket amount. Copays and the maximum out of pocket amounts will be finalized by the State after the award of the contract during implementation.

The State will select the best evaluated proposal resulting in a single contract. The TPA shall provide network administration, utilization management, claims adjudication, call center services, and benefits communication materials for Members approved to receive this benefit. While all three Insurance Committees may choose to offer this product to their plan Members, it is possible that the benefit will be offered to select groups initially. Additional groups may be added during the contract term at the Insurance Committees direction. The Contractor shall perform all services described in the Scope of Services of the pro forma contract (RFP Attachment 6.6).

4. **Delete RFP Question C.1 through C.2 in their entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted).**

	C.1	Provide a brief description of your copay only plan design program that tiers ALL providers, specialists, facilities, pharmacies, and services using cost and quality data including the name, how long has it been offered, number of tiers, how the tiers/copays work by provider, facility, pharmacy, and service including episodic care like surgeries, procedures, and admissions?		5	

	C.2	Is medical, behavioral, Rx, and clinical care data fully integrated in your proposed tiered copay program plan including all providers, facilities, pharmacies, and services?		5	

5. **Delete RFP Question D.3.1 through D.3.3 in their entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted).**

	D.3.1	**Medical Provider Disruption Analysis.** Using the provider listing in Appendix 7.13 and following the instructions on tab 1 (Utilized Providers), indicate the tier or out of network status of the providers listed, related to the		**4**	

		proposed network as of the proposal date. Summarize the information in Table 2. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.13 to the Evaluation team.**			
	D.3.2	**Behavioral Provider Disruption Analysis.** Using the behavioral provider listing in Appendix 7.12 and following the instructions on tab 1 (Utilized Facilities) and tab 2 (Utilized Providers), indicate the tier or out of network status of the providers listed, related to the proposed network as of the proposal date. Summarize the information in Table 2 of each tab. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.12 to the Evaluation team.**		**5**	
	D.3.3	**Retail-30 Pharmacy Disruption Analysis.** Using the pharmacy listing in Appendix 7.14 and following the instructions on tab 1 (Utilized Pharmacies), indicate the tier or out of network status of the pharmacies listed, related to the proposed retail-30 network as of the proposal date. Summarize the information in Table 4. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.14 to the Evaluation team.**		**4**	

6. **Delete *Pro Forma* Contract section A.1.c in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    c. The Contractor shall administer a Preferred Provider Organization self-funded medical benefit design option using a tiered Copayment design with no Deductible, to be agreed upon by the State In Writing. The plan design shall assign different Copayments based upon the tier status of every provider, specialist, facility, pharmacy, and service based upon quality and cost data analytics. Tiering shall extend beyond a two-tier preferred and non-preferred status and include tiered Copayments for all provider specialties, facilities, pharmacies, and services. Episodic care such as surgeries, procedures, and admissions shall also be tiered based upon the cost and quality of the provider and facility in the episode and shall be bundled so that the Member Copayment includes all services rendered by all providers and facilities. The Contractor shall offer an online platform clearly presenting the Member's Copayment options for every provider, facility, and service, which shall be based on underlying cost and quality data. The Contractor shall administer this benefit design option inclusive of behavioral health benefits with the same Copayment and tiering of providers, facilities, and services. At the State's request pharmacy services shall also be administered, with the same tiered Copayment design by both formulary and pharmacy. However, the State reserves the right to carve out pharmacy benefits at any time. If carved out, the respective pharmacy, not including medical specialty, contract requirements will not apply.

7. **Delete *Pro Forma* Contract section A.6.cc in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    cc. The Contractor shall identify medical and behavioral health 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.

8. **Delete *Pro Forma* Contract section A.7.d in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    d. The Contractor's Member service representatives shall have access to an application, which allows them to review alternative drug therapies (Formulary status, Generic Drug alternatives available, etc.) for Members who may request this information.

9. **Delete *Pro Forma* Contract section A.8.k in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

    k. At least one (1) month prior to Go-Live, the Contractor shall provide the State information describing in detail the Contractor's appeals process and procedures along with copies of sample determination letters for internal and external appeals. The State reserves the right to review the appeals process and procedures and letters and require changes, where appropriate to comply and align with regulatory and Plan requirements.

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

    d. The Contractor shall maintain an online publicly accessible library of medical necessity coverage policies and ensure that submitted claims are processed in accordance with published policies. Should these clinical guidelines be revised, the Contractor shall notify the State sixty (60) days prior to the implementation of any major guideline revisions. In addition, the Contractor shall provide an impact analysis of any major guideline revisions that may have a significant impact on utilization or cost trends. The State shall have the option to approve and apply any UM programs and criteria developed by the Contractor that replace the oversight or adherence of a published medical necessity coverage policy and the costs shall be included in the existing Administrative Fees listed in Contract Section C.3.

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

    l. The Contractor shall require PA of the following services. Subject to State approval In Writing, the Contractor may require PA of other services or remove a service from this list with supporting evidence.

        (1) Outpatient high-technology diagnostic imaging, including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET) scans, and nuclear cardiac imaging studies;
        (2) Home health services (including home infusion);
        (3) Private duty nursing;
        (4) Inpatient rehabilitation services (including pulmonary and cardiac);
        (5) Non-emergent ambulance transport;
        (6) Miscellaneous HCPCS codes when administered in a medical setting (including but not limited to all provider administered J-codes, Q-codes, and C-codes);
        (7) Chemotherapy;
        (8) Radiation therapy;
        (9) Outpatient surgical procedures with documented medical policy criteria, including those performed at ambulatory surgery centers (does not apply to screening colonoscopy or provider office procedures);
        (10) Genetic Testing;
        (11) Specialty Drugs dispensed through the medical or Pharmacy benefit;
        (12) Applied Behavioral Analysis;
        (13) Transcranial Magnetic Stimulation; and
        (14) Other services specified by the State, In Writing, or in the Plan Document.

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

c. Case managers shall provide the following services:

(1) Patient advocacy, including but not limited to assistance gathering clinical history to ensure appropriate level of care approvals and placement (through provider outreach calls) with a provider and/or facility with the best quality and fit for the Member's clinical needs;
(2) Clinical coordination of care and services for high risk Members requiring or admitted to facility-based care;
(3) Telephonic and electronic visits, to ensure the quality, effectiveness, and appropriateness of treatment and discharge planning;
(4) Consultations with the patient (if clinically appropriate), family and attending provider;
(5) Development of alternative treatment plans, where benefit coverage allows flexibility in determining the most clinically appropriate, cost-effective alternative treatment for the Member;
(6) Participation, as necessary, in the appeals process; and
(7) Coordination of care with other appropriate State contractors.

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

e. The Contractor shall build by December 31, 2025 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, and gene therapy. 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.

14. Delete *Pro Forma* Contract section A.14.a in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

a. The Contractor shall operate a call center that uses a toll-free telephone number Dedicated to the Plans as the entry point for Members contacting the Contractor. At the request of the Contractor, in lieu of a Dedicated toll-free telephone number, the State may approve a dedicated call tree including all prompts and branches, In Writing.

15. Delete *Pro Forma* Contract section A.14.j in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

a. The Contractor's call center shall meet each of the following performance standards (refer also to Contract Attachment D, SLA Scorecard):

(1) Daily ASA of thirty (30) seconds. After answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.
(2) 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.

(3) Telephone Service Factor of 90-20, meaning 90% of calls are answered within 20 seconds.

(4) Open call/inquiry closure rate of 90% within five (5) Business Days.

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

6.	Average Speed of Answer	The Contractor shall maintain an average daily ASA of thirty (30) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.14.j.1.	30 second average	30 Sec Avg or less 30.1 – 35.9 Sec Avg 36 - 40.9 Sec Avg 41 Sec Avg or greater	8 6 4 0	

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

w. The Contractor shall use a clinical edit software program that automatically evaluates all network 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.

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

ww. The Contractor shall pursue claims up to the maximum recoupment periods permitted under Tenn. Code Ann. § 56-7-110 and 56-7-3103.

19. Delete *Pro Forma* Contract section A.19.f in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

f. The Contractor shall implement changes to the Formulary, Step Therapy, PA, and other clinical edit requirements within forty-five (45) Business Days of the State's approval or request. Additional time, beyond forty-five (45) Business Days, may be granted with the State's prior approval In Writing. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify Pharmacy Providers and affected Members In Writing at least forty-five (45) days prior to the implemenatation, unless the State requests a shorter notification time. The State must provide prior approval In Writing for all Pharmacy Provider and Member notifications.

20. Delete *Pro Forma* Contract section A.22.l in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

l. The Contractor shall obtain Health Plan Accreditation at a level of 3.5-5.0 stars by NCQA. If the Contractor is NCQA accredited as of Go-Live, the Contractor shall maintain such accreditation throughout the term of this Contract and submit a copy of report card performance of accreditation annually by October 20th (refer also to Contract Attachment C, Reporting Requirements). If the Contractor is not NCQA accredited, or is not currently accredited at the required level, for its products as of Go-Live, the Contractor shall obtain such accreditation by October 20, 2026 (or a later date as specified by the State) and shall maintain it thereafter.

Failure to obtain and maintain accreditation may result in liquidated damages as specified in Contract Attachment B, Performance Guarantees

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

a. The Contractor shall provide the State access to its internal client financial reporting system, including program and fiscal information regarding Members served, payable amounts, services rendered, claim level data etc. and the ability for said personnel to develop and retrieve reports. The Contractor shall provide training in and documentation on the use of this mechanism no later than two weeks prior to Go-Live or within one month of the system becoming operational. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees no later than two weeks prior to the Go-Live date or within one month of the system becoming operational. Additional or replacement users may be added at any time at the State's request. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

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

l. Decision Support System

(1) The Contractor shall transmit medical, behavioral, and Pharmacy 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 31786-00177 Appendix 7.20 "DSS Standard Claims Layout" and Appendix 7.24 "DSS_File_Format_RX" 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) calendar 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.

(2) The Contractor shall ensure that all medical and behavioral claims processed for payment have financial fields, valid NPIs, individual social security numbers, the complete most recent International Classification of Diseases codes and Current Procedural Terminology-4/HCPCS codes (and when applicable, updated versions of each). The file submitted to the State's current health care DSS contractor should contain data elements consistent with industry standards, such as those contained on the Uniform Bill-04, Center for Medicare and Medicaid Services 1450 and Center for Medicare and Medicaid Services 1500 forms and their successors. The Pharmacy claims data shall include GPI, GCN, Pharmacy Provider ID, NDC or NDC 11, individual social security numbers, and all payment sources and amounts for all prescription drug claims. The Contractor shall add data as required by the State's DSS contractor and/or the State for the purpose of processing claims data. The State has final approval for all file layouts.

(3) All Claims data shared with the DSS contractor shall include all payment sources and amounts such that the total Claim nets out to zero after the Member Cost Share and plan cost share. This shall include any third-party payments, and any adjustments to the Contractor's file to include all relevant fields shall be at the Contractor's expense.

(4) Claims data provided to the DSS contractor shall meet the quality standards detailed in Contract Attachment D, SLA Scorecard as determined by the State's DSS contractor. The Contractor shall not withhold any processed claims data from the file submission.

(5) To the extent that the Contractor receives electronic lab results for laboratory tests performed by contract providers, the Contractor shall transmit these lab results to the State's DSS contractor in a mutually agreed upon format. The Contractor shall transmit the 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.

(6) The Contractor shall provide the data without any restrictions on its use and shall not change the file layout or content without prior approval In Writing.

(7) The Contractor shall recognize that the medical, behavioral, and Pharmacy claims data transmitted pursuant to the provision of this Contract is owned by the State of Tennessee.

23. Delete *Pro Forma* Contract section A.26.i in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

i. System and Information Security and Access Management Requirements

(1) The Contractor's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

i. Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;
ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities and the ability to create, change or delete certain data (global access to all functions shall be restricted to specified staff jointly agreed to by the State and the Contractor);
iii. Restrict unsuccessful attempts to access system functions, with a system function that automatically prevents further access attempts and records these occurrences; and.
iv. Ensure that authentication credentials are not passed in clear text or otherwise displayed or presented.

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

This Contract shall be effective on July 1, 2024 ("Effective Date") and extend for a period of seventy-two (72) months after the Effective Date ("Term"). This provides for 6 months of implementation, forty-eight (48) months of service delivery to Members, and 18 months of runout. The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

25. Delete *Pro Forma* Contract section E.7.a(2) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

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, **AES-256,** or 140-3 (current applicable version) validated encryption technologies. Upon request, the Contractor shall provide the State with a copy or set of the Confidential State Data that can be decrypted.

26. Delete and add the following appendices and renumber any subsequent sections as necessary:

Delete

Appendix 7.12 Behavioral Provider and Facility Disruption
Appendix 7.13 Medical Provider Disruption Analysis
Appendix 7.14 Pharmacy_Network Discruption_Analysis
Appendix 7.2 TN_Zip_Code_Counts

Add

Appendix 7.12 Behavioral Provider and Facility Disruption v2
Appendix 7.13 Medical Provider Disruption Analysis v2
Appendix 7.14 Pharmacy_Network Discruption_Analysis v2
Appendix 7.2 TN_Zip_Code_Counts v2

27. Delete RFP Question C.10 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

	C.10	Identify the designated account management team you propose to work on this account (pending State approval). Provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management including the estimated number of hours per week. Indicate whether the person who will fill each position is already employed by your firm or whether they will be recruited upon Contract award. If the person(s) are already employed, provide a brief resume to include their title, role, work history, education (if applicable), and length of time with your company. At a minimum, the positions should include: i. Account Executive (Designated) – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and overseeing contractual services. ii. Account Manager (Designated) – Responsible for providing daily operational support, member support, as well as strategic planning and analysis. iii. Operations Manager – Responsible for all benefits set up and claims operations. iv. Enrollment Analyst – Responsible for all 834 file loads and enrollment corrections/updates. v. Reporting Analyst – Responsible for all reporting including Ad-Hoc requests. vi. Medical/Clinical Program Director – Responsible for all UM, Case Management, and other clinical support. vii. Licensed Chief Pharmacist – responsible for clinical pharmacological advice in the review and development of benefits and UM viii. Member Services Manager – Responsible for all call center and customer service functions.		3	

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

d. The Contractor shall train the requested State staff (and any additional or replacement users) regarding access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to Go-Live. Such training may be delivered remotely or in-person. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

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

ff. Intentionally left blank

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

pp. Guaranteed Minimum Manufacturer Payment or Rebate Guarantee: the minimum Rebate per Rx by dispensing channel. The performance will be calculated for the annual period using the following formula for each dispensing Channel independently, then summed: 'The calculation of the Annual Rebate Guarantee Amount will be [Rebate Guarantee] multiplied by [total Rx count minus the exclusions as identified by the State in Contract Section A.19.y.].

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

i. Contractor shall ensure that its reporting system available to state staff allows for pulling Claims data by, at a minimum, various dates, groups, plan types, Member ID (Edison ID) and can be broken down by product name, Pharmacy name, address, city and state, the NDC of the product, and GPIs 2 through 14 (code and description) that applies to the product, as well as provide the Pharmacy-submitted drug cost, net plan paid amount, and any Member Cost Share. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

32. **Delete *pro forma contract* section A.27.l in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

a. Pharmacy Rebate audits can include, but are not limited to, review and examination of Manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with Pharmacy Manufacturers, and Program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. To the extent that the Contractor contracts with a separate Group Purchasing Organization (GPO) in connection with Rebates or Manufacturer Payments for the State, the State may (a) directly confirm the existence of contract(s) between the Contractor and such third-party GPO (I.e., view the contract introduction, recitals, and signature block) and (b) audit all aspects of such contract with the establishment of applicable third-party confidentiality agreement(s), which may include non-disclosure agreements (NDAs), if any, as reasonably required by the GPO. Upon request by the State, or its Designated authorized independent auditor, and upon completion of confidentiality agreement(s) or non-disclosure agreements (NDAs) as required by the Contractor or as required by the Contractor's third party Rebate contracts, the Contractor shall provide full disclosure of Rebates and Manufacturer Payments received by the Contractor, its Affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line-item detail by NDC or NDC-11 and line-item detail by pharmaceutical Manufacturer showing Actual Cost remitted and other related Claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from Go-Live, January 1, 2025, until the termination of Benefits shall be included in any kind of Pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment assigned by the State (or lack thereof), Spread or differential between drug tier Copayments, or any kind of utilization.

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

fff. The Contractor shall process all the State's Claims on the same platform and shall not transition the State from the Claims adjudication platform that they are implemented onto during the Term without prior notification In Writing to the State.

34. Delete *pro forma contract* section E.7.a.3 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

3. The Contractor and the Contractor's processing environment containing Confidential State Data shall either (1) be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (2) 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") Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide proof of current ISO or HITRUST certification or FedRAMP authorization for the Contractor and Subcontractor(s),or provide the State with the Contractor's and Subcontractor's annual SOC Type II audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor. 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 or Subcontractor.

   If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any material changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

   No additional funding shall be allocated for these certifications, authorizations, or audits as these are included in the Maximum Liability of this Contract.

35. Delete RFP #31786-00177 Release #2 in its entirety and replace with RFP #31786-00177 Release #3. Revisions of the original RFP document are emphasized within the new release. **Any sentence or paragraph containing revised or new text is highlighted.**

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