

REQUEST FOR PROPOSALS
(RFP)

ISSUE DATE: September 21, 2012

TITLE: Administrative Services and Fully Insured Health Benefits Plans

Number: OHB13-02

ISSUING AGENCY: Commonwealth of Virginia
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219

PERIOD OF CONTRACT: From July 1, 2013 through June 30, 2016, with three one-year renewal options as described within.

Sealed proposals for furnishing services described herein will be received subject to the conditions cited herein until 2:00 p.m., October 26, 2012.

All Inquiries Must Be In Writing, Include the RFP# in the Subject Line, and Should Be Directed To:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219
e-mail: dan.hinderliter@dhrm.virginia.gov

SEND ALL PROPOSALS DIRECTLY TO THE ISSUING AGENCY ADDRESS SHOWN ABOVE.

Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, § 2.2-4343.1 or against a bidder or Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposals, and to all the conditions imposed therein and hereby incorporated by reference, the undersigned offers and agrees to furnish materials and services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Name And Address Of Firm:

Zip Code: _____

eVA Vendor ID or DUNS #: _____

Fax Number: (____) _____

E-mail Address: _____

Date: _____

By: _____

(Signature In Ink)

Name: _____

(Please Print)

Title: _____

Telephone Number: (____) _____

PRE-PROPOSAL CONFERENCE: A **Mandatory** pre-proposal conference will be held on Monday, October 1, 2012 at 9 a.m. at the James Monroe Building, Conference Rooms C, D and E. (Reference Paragraph 5.9)

1.0 INTRODUCTION

1.1 PURPOSE

The Commonwealth has adopted a phased, integrated Total Population Health Management (TPH) strategic direction for the health plan that includes the following components and tactics for implementation beginning July 1, 2013. Throughout this RFP, TPH services are also referred to as a Wellness Engine. TPH provisions for July 1, 2013 implementation for both plans may include an incented Health Risk Questionnaire (HRQ) and BMS participation. Furthermore, additional plan design features and tactical components will be added in future phases depending on circumstances, vendor capabilities, population health priorities and plan design feasibility.

The purpose of this Request for Proposals (RFP) is to secure an administrator for the statewide standard PPO health benefits program for the Commonwealth of Virginia and The Local Choice (TLC). This statewide standard PPO health benefits program anticipates relatively few changes to the plan design of the current statewide PPO programs. Individual submissions may be made for Medical/Surgical including vision and hearing, Prescription Drug, Behavioral Health (also referred to as MISA throughout this document) including EAP services, Dental, and Flexible Benefits under Section 125. However, the Commonwealth prefers a bundled submission for Medical/Surgical, Prescription Drug, Behavioral Health, Dental, and Flexible Benefits. Flexible Benefits encompass Flexible Spending Account Administration. The rating criteria will include a mechanism for evaluating Offerors' demonstrated ability to deliver multiple and integrated products, including but not limited to those above, through a bundled offering. The TLC program is an optional health benefits program administered by the Department of Human Resource Management (DHRM) for political subdivisions of the Commonwealth. Please note that Flexible Benefits will not be included in the TLC program. Also, please note that one statewide health benefit plan must be offered. Less than statewide plans may also be offered under this RFP, if they meet the criteria described in Section 2.2 below.

The medical/surgical vendor administers the current vision and hearing plan. Offerors are to submit a similar combined arrangement.

Concurrent to this RFP, the Commonwealth is releasing an RFP (OHB13-03) for a Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA). This CDHP RFP will include, under the Medical/Surgical product, a requirement for a robust Wellness Engine. The successful Offeror(s) for the PPO plan will be required to integrate with the Wellness Engine chosen under the CDHP RFP.

Also concurrent to this RFP, the Commonwealth is releasing an RFP (OWC13-01) that includes a pharmacy component for the State Workers' Compensation Program. The Commonwealth prefers that the Offeror for the Prescription Drug product under this PPO RFP be capable of managing Prescription Drug benefits for the State Workers' Compensation Program in a manner that produces a net benefit to the Commonwealth without harming either the State Employee Health Program or the Workers' Compensation Program.

The entire PPO plan, with the exception of the Wellness Engine as described above, is being procured through this RFP (See paragraph 1.3).

The objectives of the programs are to provide better than average benefits administered in a very cost-effective manner with excellent service to enrollees, so that state agencies and participating local jurisdictions can recruit and retain high quality employees.

1.2 BACKGROUND

The Department of Human Resource Management (the Department) is authorized to administer the state employee health benefits program. The program is delivered through approximately 219 state agencies to some 102,000 active, full-time employees, retirees not eligible for Medicare, and extended coverage (COBRA) enrollees, and to the dependents of these enrollees. Agencies distribute program materials, assist employees in applying for coverage or changes in coverage according to rules developed by the Department, payroll-deduct employee premiums (with some exceptions), post eligibility information onto the Benefits Eligibility System (BES), and otherwise assist employees in accessing the program's benefits. Participants who do not receive pay from which to deduct premiums (e.g., some retirees and COBRA participants) will be billed by the selected Offeror for the Medical/Surgical product. To support employees and agencies' benefit personnel, the Department operates Employee Direct (E-Direct) which is a web-based system through which employees may make enrollment and coverage changes without the use of paper forms.

The Department also has the responsibility for administering a health benefits program, The Local Choice (TLC), which is offered to localities statewide as a replacement option to other health benefits program choices. Any local government, school district, political subdivision, etc. may join this program. Presently there are 317 member groups covering approximately 50,000 employees, retirees and their covered dependents. In addition to the plans offered above to State employees, the Department offers a choice of benefit designs to TLC member groups. Currently, the choices of plans include PPO, High Deductible Health Plan (HDHP) and HMO plans with some utilizing coinsurance rather than co-payments and deductibles. The successful Offeror for each product listed above will also be responsible for administering these TLC plans.

The Department has developed plans and programs with the advice of consultants, vendors, employees and others, and has delivered benefits through Contractors, either insurers or third party administrators. The coverages currently available may be found on the state employees' web site: www.dhrm.virginia.gov/employeebenefits.html and on The Local Choice web site: www.thelocalchoice.virginia.gov.

1.3 GENERAL DESCRIPTION

The Department currently offers two statewide self funded plans, PPOs called COVA Care and COVA Connect, and a regional fully insured HMO. It is anticipated that similar medical/surgical and HMO plans, both regional and statewide and both fully insured and self funded will result from this RFP #OHB13-02. However, the Department plans to offer only one statewide self funded PPO plan effective July 1, 2013. The Department also offers a statewide self funded HDHP, which is not part of this procurement, and plans to

offer another CDHP to be procured separately. The TLC program currently offers five choices under the self-funded plan and is designed around a PPO called Key Advantage. TLC offerings include Key Advantage Expanded, Key Advantage 250, Key Advantage 500 and Key Advantage 1000. In addition, a regional fully insured HMO, as well as an HDHP are available. It is anticipated that there will always be a degree of choice in TLC to better meet the needs of the different groups and to ensure the program remains competitive in the marketplace.

The Department wishes to receive offers for the statewide plan on an Administrative Services Only (ASO), self-insured basis. It wishes to receive offers for less than statewide plans on a fully insured basis. Fully insured offers for less than statewide plans may be considered, but the Department is under no obligation to implement such a plan.

This RFP is divided into sections, such as this numbered Section 1.0, Introduction. A section is one of the principal divisions of this RFP. Within these sections, numbered paragraphs are the second principal division and normally contain the number of the section in which they are located, such as this paragraph numbered 1.3.

It is imperative that Offerors respond to all applicable requirements and complete all applicable schedules and exhibits described in the Form of Response, Section 6. Any Offeror confusion about which sections and/or paragraphs may be applicable to a potential Offeror should be clarified no later than the mandatory Offerors' conference.

This RFP covers Medical/Surgical, Behavioral Health including EAP, Dental, Pharmacy, and Flexible Benefits. For scoring requirements concerning all plans, refer to the Section 6.7 of this RFP. As stated above, the successful Offeror(s) for these PPO products will be required to integrate with the Wellness Engine chosen under the CDHP RFP (OHB13-03). However, the TLC program will not initially incorporate this Wellness Engine.

This RFP also does not address coverage for Medicare Retiree benefits. Benefits for the Medicare Retiree Program, including the Medicare Part D benefit, will be procured at a later date for an effective date on or after January 1, 2014, but not later than January 1, 2016.

1.4 POLICY REGARDING PARTICIPATION OF SMALL, WOMEN, AND MINORITY OWNED BUSINESSES

It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in state procurement activities. The Commonwealth encourages Contractors to provide for the participation of small businesses and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, and other contractual opportunities. Submission of a report of past efforts to utilize the goods and services of such businesses and plans for involvement on this contract are required. By submitting a proposal, Offerors certify that all information provided in response to this RFP is true and accurate. Failure to provide information required by this RFP will ultimately result in rejection of the proposal.

All information requested by this RFP on the ownership, utilization, and planned involvement of small businesses, women owned businesses, and minority owned businesses must be submitted. If an Offeror fails to submit all information requested, the purchasing agency will require prompt submission of missing information after the receipt of vendor proposals in order for a non-compliance proposal to be considered. (See Exhibit TWO)

1.5 APPENDICES

Appendix 1 is the current standard contract. Appendix 2 contains selected enrollment, cost, workload, demographic and utilization data for state employees. Appendix 3 contains a link to websites for summary description of plans, along with currently used forms, currently offered to state and TLC employees. Appendix 4 gives information regarding the number of enrollees of TLC local employees covered under non-HMO contracts. Appendix 5 contains a description of the state employee eligibility, enrollment and billing system. Appendix 6 contains a description of the eligibility, enrollment and billing procedures and group renewal process for TLC. Appendix 7 contains a link to a website providing the EDI payment procedures that are used for the state employee group. Appendix 8 contains selected information about the Flexible Benefits Program. Appendix 9 contains a proposal checklist.

1.6 ATTACHMENTS

Attachment 1 contains a link to benefit descriptions. Attachment 2 contains critical instructions for the cost schedules and technical questionnaires that must be submitted with a proposal. In electronic form (see 1.8 below), it also contains claim and eligibility data necessary to prepare a proposal. Attachment 3 provides report formats.

1.7 EXHIBITS

Exhibit **One** contains a sample HIPAA Privacy Business Associate Agreement (see paragraph 8.23). Exhibit **Two** contains the Small Business and Business Owned By Women and Minorities report that is required to be submitted under paragraph 6.6.

1.8 ELECTRONIC DATA FILES AND RESPONSE FORMS

Files containing claims, enrollment data and the Attachment 2 schedules that you will need to prepare and submit a proposal are available in electronic form. To obtain these files, please send email to Jim Rogers (james.rogers@aonhewitt.com) and Leah Snider (leah.snider@aonhewitt.com) with copy to Dan Hinderliter (dan.hinderliter@dhrm.virginia.gov) requesting credentials and instructions necessary to download the files from a secure site.

Please note that these files are proprietary and available only to vendors of the services requested by this RFP.

2.0 SPECIFICATIONS, TASKS, AND MANDATORY QUALIFICATIONS

2.1 STATEWIDE PLANS

The Department offers a statewide benefit plan for the state employees program and TLC plans. They are all provided on a self-insured basis. The plans that are currently offered are described on the web sites provided in Section 1.2 above and encompass a variety of plan designs. The Department will continue self-insured arrangements and the Contractor(s) must have the ability to administer multiple plans. The Contractor(s) must be able to assist the Department in changing plan designs during the term of this contract as situations change within the health care industry and/or as required by legislation.

Note: The statewide medical plans include a vision and hearing benefit. The successful Medical/Surgical Contractor will be required to provide these benefits as shown on the schedules of benefits on the Department's Web Site and in Appendix 3.

2.2 LESS THAN STATEWIDE PLANS: HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND PPOS

An Offeror may submit a proposal for a less than statewide plan under these conditions:

- 2.2.1 The plan has a managed care network (HMO; PPO)
- 2.2.2 The plan is licensed and the proposal covers a contiguous service area.
- 2.2.3 Only fully insured options will be considered.

The benefit design for a less than statewide plan is up to the Offeror, but should represent a distinctive choice when compared to the statewide PPO option. More than one option may be proposed.

2.3 PLAN PROVIDER NETWORK

- 2.3.1 The statewide Contractor(s) must offer a statewide network of providers who are expert and practiced and appropriately credentialed. The number of providers should permit employees to access the network for services within the standards described in paragraph 2.4. In addition, there must be provider access for participants who live outside of the state or who live or travel abroad as demonstrated through geo access reports.
- 2.3.2 The Contractor(s) must:
 - 2.3.2.1 ensure that providers continue to meet the Contractor's criteria,
 - 2.3.2.2 ensure that sufficient liability insurance is maintained,
 - 2.3.2.3 ensure that provider contracts continue to remain in force,

- 2.3.2.4 ensure that referral patterns and utilization of services are monitored continually,
 - 2.3.2.5 ensure that sufficient (in the Department's judgment) numbers of credentialed providers are available, and
 - 2.3.2.6 encourage providers to support and utilize electronic health records
 - 2.3.2.7 ensure that providers are using available tools to avoid duplication of services and ensure compliance with medical advice.
 - 2.3.2.8 ensure that the pharmacy benefit provided by the Offeror's PBM offers transparency as outlined in section 2.9.2 below
 - 2.3.2.9 ensure that the health plan's data and reports do not include statements indicating that the data is proprietary, confidential, protected, and/or the property of the Contractor's.
- 2.3.3 The Department will consider local networks for less than statewide plans if the networks are properly credentialed.
- 2.3.4 The Contractor must develop and maintain an on-line, real-time directory of participating providers of services. Real-time is defined as instantaneous electronic information transmission as it is available to the Contractor. Batch processing is not considered real-time. It must be available to all group administrators and must be easily accessible by enrollees on the Contractor's web site (see paragraph 8.15). Additionally, this on-line directory must be capable of being printed, in a printer-friendly format, by group administrators and enrollees. The Contractor shall have and execute a plan for communicating provider changes to affected enrollees. This should include the ability to identify providers outside of the state.

2.4 QUALIFICATIONS FOR OFFERORS

- 2.4.1 All network-based plans shall demonstrate that sufficient access is available as demonstrated by the geo-access response in Attachment 2.
- 2.4.2 All network-based plans shall annually produce and submit a HEDIS (or department approved substitute), including the standard Member Satisfaction Survey, in accordance with the current requirements. This report must be submitted by August 15th for the prior plan year. Please note that currently, and likely going forward, the state employee plan year runs from July 1 through June 30.
- 2.4.3 All network-based plans shall apply for NCQA certification *before* responding to this RFP. If rejected, regardless of the reason, the plan(s) shall re-apply at the earliest time permitted by NCQA.
- 2.4.4 To be awarded a contract, all plans must demonstrate the capability to provide the

claims and eligibility files in a format required by the Department. Such demonstration will consist of submission and approval of a test file in the format provided to finalists. The timing and other logistics involved with this process will be determined during the proposal evaluation and negotiations.

- 2.4.5 All plans must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.
- 2.4.6 The network for the statewide plans shall provide access to participating providers outside of the Commonwealth of Virginia where desired by enrollees.
- 2.4.7 The Medical Surgical Contractor must also provide vision and hearing overages as a buy-up.

2.5 CLAIMS PROCESSING QUALIFICATIONS FOR OFFERORS

- 2.5.1 Process all claims incurred during the life of this contract.
- 2.5.2 Receive, date and control claims within 24 hours of the day received.
- 2.5.3 Verify eligibility of claimant and period of coverage for every claim processed. Pay no claims any participants who are in a claims-hold status. Pay no claims for TLC employees whose premiums are not currently paid. TLC eligibility file must include each dependent by name and number together with the period during which coverage has been in force.
- 2.5.3 Verify eligibility of claimant and period of coverage for every claim processed. Pay no claims for TLC employees whose premiums are not currently paid. TLC eligibility file must include each dependent by name and number together with the period during which coverage has been in force.
- 2.5.4 Examine the licensure and participation status of the provider of services.
- 2.5.5 Determine whether or not the services are covered.
- 2.5.6 Determine that the services provided were medically necessary. For prescription drug this would mean that the drug is covered. The Department would prefer that diagnostic codes and provider names are captured with the claim.
- 2.5.7 Check claims history and prevent duplicate payments or payments that exceed contract limits.
- 2.5.8 Price the services.
- 2.5.9 .Generate and mail a check, as required, and an explanation of benefits (EOB) or denial notice. Please note that, in general, the Department prefers electronic communication where legal and possible. The forms of the EOB and denial notice are subject to the Department's approval, however, as referenced above, the Department prefers an electronic EOB in lieu of a paper EOB if requested by

the participant, otherwise payments and denial notices must be mailed or generated within five business days of the date on which the claim was processed. It is understood that prescription drug claims adjudicated at the point of service do not require an EOB.

- 2.5.10 Deliver a summary paid claim listing to the Department in a form acceptable to the Department every week along with an invoice. Administrative costs are to be billed monthly.
- 2.5.11 Maintain a bank account for paying claims. Reconcile the account and credit interest to the Department when interest on the float exceeds banking charges. The amount of interest will be determined by mutual agreement between Contractor and the Department.
- 2.5.12 Maintain a history of all claims paid. Not less than 18 months of claims history prior to the current calendar year shall be maintained on line.
- 2.5.13 Provide Department's Consultant an electronic file of claims which support the most recent bill – usually weekly. Format will be provided to the finalists to produce a test file as part of the Contractor selection process as described in 2.8.5.
- 2.5.14 Provide, on a schedule to be determined, an electronic claim file to any designated data warehouse(s), and to other vendors as needed to perform integrated disease management services.
- 2.5.15 As requested, provide “real-time” access to claim information to a third party vendor for purposes of performing consolidated customer service, health coaching and patient care coordination. In relation to this paragraph, real-time means instantaneous electronic transfer of information.
- 2.5.16 The successful Offeror for the Medical/Surgical product will be responsible for developing a consolidated Summary of Benefit Coverage (SBC) for each available benefit option. This means that, should the Department select multiple Offerors to administer the PPO (for example, one Offeror for Medical/Surgical, another for Prescription Drug, another for Behavioral Health, another for Dental, another for Flexible Benefits), it will be the responsibility of the Medical/Surgical Offeror to work with all successful Offerors to gather and format information into a consolidated SBC for each option.
- 2.5.17 The Commonwealth of Virginia enacted legislation in April, 2012 which created the Virginia All-Payer Claims Database (APCD). This is in development, however once the requirements for the APCD are promulgated, the Medical/Surgical, Behavioral Health, Pharmacy and Dental Contractors are expected to submit claims in the specified format and at the specified frequency. The Contractor agrees to submit information at the frequency and format approved by the Department.

2.6 PLAN EMPLOYEE INQUIRIES QUALIFICATIONS FOR OFFERORS

Respond correctly and timely to inquiries received by telephone, mail, e-mail or in person as specified in section 2.9 of this RFP.

2.7 BENEFITS ADMINISTRATION QUALIFICATIONS FOR OFFERORS

- 2.7.1 The Contractor shall check the eligibility of claimants before authorizing benefits against the eligibility files that will be supplied by the Department (for State employees) and a central eligibility file (for enrollees of The Local Choice).
- 2.7.2 The Contractor shall develop employee communication materials, which fully and accurately describe, including any companion carve out benefits:
 - 2.7.1.1 the benefits of the program,
 - 2.7.1.2 how the program works,
 - 2.7.1.3 where, how, and when additional information can be obtained,
 - 2.7.1.4 how to access benefits,
 - 2.7.1.5 what to do in an emergency,
 - 2.7.1.6 how to appeal the determination of the Contractor with respect to a denial of benefits for any reason,
 - 2.7.1.7 employee assistance services available,
 - 2.7.1.8 such other information as would be required to meet the standards of a summary plan description as that term is defined in the Employee Retirement Income Security Act (ERISA),
 - 2.7.1.9 develop 2 articles per year for use by the Department in employee communications about various aspects of the plan,
 - 2.7.1.10 develop ancillary communications materials as needed to focus on specific program components, and
 - 2.7.1.11 any communications required to comply with state or federal legislation.
- 2.7.3 Provide a legal defense against all claims arising out of this contract.
- 2.7.4 Hold enrollees and covered dependents harmless with respect to services covered under this contract when such services are furnished by participating providers.
- 2.7.5 Should this PPO offering result in multiple Contractors, each Contractor shall coordinate as closely as possible with the other Administrators under which the

employee is enrolled to integrate customer service, claims processing, disease/case management, data reporting and other services as deemed necessary by the Department.

2.7.6 Participate as requested in HR Conferences, benefits fairs and wellness activities coordinated under the CommonHealth program or through the Department.

2.8 GENERAL MANDATORY QUALIFICATIONS FOR OFFERORS (Please note that in addition to these general mandatory qualifications, there are also mandatory qualifications below in section 2.9 for specific products). The plan must have at least one client requiring similar services as this entire RFP, and include it as a reference as directed in applicable Attachment 2 questionnaires, of 25,000 employees. Public sector clients over 50,000 employees are preferred, and all should be included as references. Additionally, the plan must submit transparent administrative cost detail by service component as requested in the Attachment 2 cost exhibits.

2.8.1 The plan shall demonstrate that the access to participating providers available to employees of the Commonwealth is acceptable to the Department.

2.8.2 A network-based plan shall annually produce and submit an approved Member Satisfaction Survey which includes a question(s) about network adequacy.

2.8.3 The plan must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.

2.8.4 The plan must provide exclusive websites available to state and TLC employees that are available for use by April 1, 2013. If the Contractor is unable to comply with this due date, then the Contractor may offer another solution if it is deemed acceptable by the Department. However, without exception, the Contractor must provide the exclusive websites by July 1, 2013. These websites must be maintained for the duration of the contract.

2.8.5 Before issuing a contract, the plan must submit a paid claims test file containing at least 500 claims in a format that will be provided. The Department will evaluate the test file and may require additional submissions until the format is acceptable. PLEASE NOTE: Standard vendor files are not acceptable to fulfill this requirement.

2.8.6 Proposals should state the Contractor's willingness to accept these standards, and to install the necessary telephone, telecommunications and other systems to ensure adherence to the standards without cost to the Commonwealth. The Contractor must be able to provide the Department with documentation of its performance.

2.8.7 The plan shall cooperate with other vendors and designated consultants in data integration activities.

2.8.8 The Contractor(s) shall work with the Department and other vendors in the creation and distribution of a single, COVA PPO-specific ID card and a single,

TLC ID card. This means that, at a minimum, the single ID card must include all necessary information related the Medical/Surgical, Prescription Drug, Behavioral Health, and Dental benefits. The common TLC card should not be Social Security number. Additionally, the Department would prefer for the single ID card to incorporate all necessary information related to Flexible Benefits, including a debit card magnetic swipe feature. The Department is interested in proposals that incorporate options to address this desire.

2.9. SPECIFIC MANDATORY QUALIFICATIONS BY PLAN

2.9.1 MEDICAL/SURGICAL PLAN

2.9.1.1 Must administer out-of-network option.

2.9.1.2 In addition to those found in section 3.8, the Offeror shall propose any additional plan specific standards of performance by which its performance shall be judged. Specific areas of interest are identified in the Attachment 2 questionnaire. Liquidated damages will be attached to these additional standards through the negotiation process, should the Offeror be selected as a finalist.

2.9.2 PRESCRIPTION DRUG PLAN

2.9.2.1 The plan must be mandatory generic with an option for the member to buy a brand medication, paying the difference in cost plus the brand copay. For certain types of medications, there are maximum limits for the difference in cost plus copay.

2.9.2.2 The plan must include out-of-network option.

2.9.2.3 The successful Offeror must provide, upon request of the Department, all claims-related financial and utilization information relating to the provision of benefits and all other financial and utilization information relating to benefits to covered individuals. This information shall include the nature, type, and amount of all other revenue received in aggregate from pharmaceutical manufacturers or labelers for programs relating to benefits to covered individuals of the State Employee Health Plan as well as the TLC Plan.

2.9.2.4 The plan must be a Statewide Prescription Drug Plan providing both retail and mail service.

2.9.2.5 The Contractor must develop a statewide network of pharmacies which, by contract, agrees to submit claims for subscribers, agrees not to waive co-payments, and agrees to accept the Contractor's allowance (along with any patient co-payments) as payment in full for covered services. Network pharmacies and mail services vendors must include Lesser of Logic to include MAC, Usual and Customary pricing and standard co-payments.

- 2.9.2.6 The Contractor must develop and maintain channels of communications with pharmacies adequate to maintain a high degree of participation and continuity in the network and insure that pharmacies are familiar with the program's requirements.
- 2.9.2.7 The Contractor must develop and execute a plan for conducting field audits of 5% of participating pharmacies each year.
- 2.9.2.8 The Contractor must contract with a pharmacy, licensed to do business in Virginia, to provide mail-order prescription drug services for maintenance and specialty drug prescriptions.
- 2.9.2.9 The Contractor must determine whether or not the drugs are covered. The system should have the capability to exclude certain drugs or classes of drugs and to administer all step therapy and prior authorization requirements as requested.
- 2.9.2.10 The Contractor must check consolidated community pharmacy and mail order pharmacy claims history to determine that the claim does not duplicate in whole or in part a previously paid claim or exceed contract limits.
- 2.9.2.11 The Contractor must price mail order and community claims according to the contract terms. The system should have the ability to handle varying dispensing fees, multiple co-payments, incentives for dispensing generic drugs and limits on payments for drugs which have generic equivalents. COB processing is required.
- 2.9.2.12 Pharmacy claims may be adjudicated at the point of service. However, paper claims submitted by the member must be responded to by the Contractor with an Explanation of Benefits (EOB) explaining the payment. All properly completed manual claims must be processed within 30 calendar days, and 90% of all properly completed claims must be processed within 14 calendar days.
- 2.9.2.13 The Contractor must conduct an ongoing program which reviews the utilization of services, patterns of prescribing, and the actual dispensing of legend drugs under the program.
- 2.9.2.14 The Contractor must provide 24 hour per day pharmacy coverage to respond to emergency calls by enrollees regarding their prescriptions.
- 2.9.2.15 The Contractor shall maintain a file of persons eligible for the prescription drug benefit. This file can be updated from files provided by the Department, or from files provided by the Department's designee.

- 2.9.2.16 The Contractor shall maintain a toll free telephone emergency information line. The line shall be staffed at all times, 24 hours per day including weekends and holidays, by qualified personnel who can provide information to covered individuals and family members, and referrals for emergencies, if necessary. NOTE: Answering machines or tape-recorded messages are not acceptable.
- 2.9.2.17 The Contractor shall check patient history to determine the appropriateness of the prescription in terms of quantity, possible interactions and other related quality issues.
- 2.9.2.18 The Contractor shall employ a sufficient number of licensed pharmacists to fill prescriptions correctly and quickly, and to provide redundancy as a control over quality. Prior to mailing, each prescription must be checked by a pharmacist other than the one who filled the prescription. The Contractor and the Department will develop a mutually agreeable performance standard in this area.
- 2.9.2.19 The Contractor shall contact the patient or physician, as appropriate, to secure generic or therapeutic substitutes or to advise of potentially harmful drug interactions.
- 2.9.2.20 The Contractor shall dispense quickly and accurately, providing the patient with all important information about the drug dispensed and a kit for the next prescription.
- 2.9.2.21 The Contractor shall maintain consolidated retail and mail order claims history files with each prescription interactions, and provide consolidated billing to the Department.
- 2.9.2.22 The Contractor shall review paid claims files to locate and investigate cases of potential fraud and abuse. The Contractor is responsible for developing the criteria used to identify cases, for contacting the beneficiary, pharmacy or prescribing physician, and for all appropriate corrective actions, such as collecting erroneous payments and referring potential fraud cases to appropriate authorities.
- 2.9.2.23 The Contractor must ensure that claims are paid correctly. The claims processing system must have an extensive series of prepayment edits. Claims payments are subject to audit. Erroneous payments must be corrected, overpayments recovered and problems with the claims processing system must be repaired immediately when discovered.
- 2.9.2.24 Mail order prescriptions must be dispensed within seven calendar days of receipt.

- 2.9.2.25 Mail order drugs actually dispensed shall conform to the drugs actually prescribed in every respect. Substitution consistent with the FDA Orange Book is permitted. (The data to be used to evaluate compliance with this standard includes all prescriptions for all programs filled at the facility which dispenses drugs covered under the State plan.)
- 2.9.2.26 The facility must be open to announced and unannounced inspections by the Department and its agents.
- 2.9.2.27 The number of dispensing errors identified at the last quality control checkpoint must be recorded and reported immediately as requested. Also, any dispensing error discovered (by whatever means) after the drug has been mailed must be reported upon discovery in a special incident report to the Department.
- 2.9.2.28 The Contractor must provide definitive replies to 98% of written correspondence within 10 days, and to all written correspondence within 21 days.
- 2.9.2.29 Prescription Drug Telephone Access Timeliness
 - a. Lost calls should not exceed 5% of calls during any week in a calendar month.
 - b. Average telephone holding time should not exceed thirty seconds during any week in a calendar month.
 - c. Access to live Customer Service Representatives should always be viable alternative to IVR access.
- 2.9.2.30 In addition to those found in section 3.9, the Offeror shall propose any additional plan specific standards of performance by which its performance shall be judged. Specific areas of interest are identified in the Attachment 2 questionnaire. Liquidated damages will be attached to these additional standards through the negotiation process, should the Offeror be selected as a finalist.
- 2.9.2.31 The Contractor shall, at the request of the Department, work with the Department to develop a Medication Therapy Management pilot program.
- 2.9.2.32 SPECIFIC PRESCRIPTION DRUG SCHEDULE OF LIQUIDATED DAMAGES

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
prescription	\$100 per day for each late prescription

timeliness

prescription
dispensing

\$1,000 for every instance in which scripts are not checked by a pharmacist other than the dispenser

- 2.9.3 BEHAVIORAL HEALTH PLAN – The benefits to be offered are referenced in Appendix 3 and the employee handbooks on the web sites identified in paragraph 1.2. NOTE: The Behavioral Health benefits are described within each applicable medical/surgical section of each plan’s employee handbook. These booklets describe the contract between the employee and the Department. To the fullest extent applicable, all the definitions, general rules, descriptions of services, exclusions, basic provisions, definitions, and eligibility rules apply to all contracts issued pursuant to this RFP. Please note that Behavioral Health services may be covered under both institutional and professional services, and there are no distinctive co-payments or benefit limitations.

The Contractor shall provide a full range of employee assistance services including assessment, referral, crisis management and counseling, including financial counseling as required by the circumstances of the employee and prevailing patterns of practice. Except for assessment, referral and counseling services provided directly by credentialed employees of the Contractor, the provisions shown in Description of Benefits, found in paragraph 1.6 of this RFP and as shown on the web site limit employee assistance services.

The Contractor must maintain a statewide or national network of sufficient numbers of providers, counselors and other trained professionals and have the ability to mobilize those providers and respond to a large-scale critical incident event such as the Virginia Tech tragedy of April 2007.

The plan must include an out-of-network option.

2.9.3.1 Behavioral Health Telephone Responses

- a. The Contractor must be able to meet the following standards for telephone services and access. These standards shall be measured and reported monthly.
- b. The Contractor must ensure that there will be no busy signals for the crisis telephone Line. Any deviation from the 100% standard is below standard.
- c. The Contractor must ensure that no caller to the crisis telephone line will ever be put on hold or fail to reach a live individual within 10 seconds, regardless of day or time.
- d. The Contractor must ensure that for claims administration, utilization review and other Contractor services (for example

basic non- crisis related functions), adequate toll-free telephone lines must be available for access by covered persons during normal business hours. The following standards must be met each month:

- (1) Fewer than 2% of calls are abandoned.
- (2) Average waiting time is 30 seconds or less.

2.9.3.2 Behavioral Health Processing Time

These processing standards shall be measured and reported monthly.

- a. The Contractor shall authorize/deny inpatient treatment within 24 hours of the request.
- b. The Contractor shall authorize/deny outpatient treatment within five working days of the request.
- c. Each month the Contractor will adjudicate (i.e., pay or deny) 90% of all submitted claims within 15 working days of receipt.
- d. All claims (100%) will be adjudicated (i.e., pay or deny) within 30 working days of receipt.

2.9.3.3 Proposals should state the Contractor's willingness to accept these standards, and to install the necessary telephone, telecommunications and other systems to ensure adherence to the standards without cost to the Commonwealth. The Contractor must be able to provide the Department with documentation of its performance.

2.9.3.4 In addition to those found in this section and section 3.9, the Offeror shall propose any additional plan specific standards of performance by which its performance shall be judged. Specific areas of interest are identified in the Attachment 2 questionnaire. Liquidated damages will be attached to these additional standards through the negotiation process, should the Offeror be selected as a finalist.

Brief Reference	Liquidated Damage Award
no busy signal on crisis line	\$5,000 per occurrence of busy signal
10 second answer on crisis line	\$5,000 per occurrence of longer than 10 second wait
2% abandoned calls	\$1,000 per each percent or fraction thereof above standard

30 second average wait time	\$1,000 for each second above Standard
24 hour inpatient authorization	\$1,000 per occurrence
5 day outpatient authorization	\$1,000 per occurrence
90% of claims adjudicated	\$2,500 for each working day after the 15 th necessary to achieve 90%
100% of Claims adjudicated	\$1,000 for each working day after the 30 th necessary to achieve 100%

2.9.4 DENTAL PLAN

2.9.4.1 In addition to those found in section 3.9, the Offeror shall propose any additional plan specific standards of performance by which its performance shall be judged. Specific areas of interest are identified in the Attachment 2 questionnaire. Liquidated damages will be attached to these additional standards through the negotiation process should the Offeror be selected as a finalist.

2.9.5 FLEXIBLE BENEFITS PLAN—The Contractor shall:

2.9.5.1 Construct appropriate master files from enrollment information. All enrollment records will be retrieved by the Contractor from the Department's File Transfer Protocol (FTP) file.

2.9.5.2 After enrollment, provide participants notice of the reimbursement accounts and, if requested by the Department, provide their agencies with a verification of participation and the amount(s) elected.

2.9.5.3 Record and update changes in the master files as contribution information is received from the Department of Accounts (DOA) and the decentralized payroll systems. Payrolls are processed and updates are expected semi-monthly. If a scheduled contribution is not received for an individual account, suspend that account's activity, as appropriate, and request clarification from their agency. Release the suspended account only after the correct contribution or related election change has been received.

2.9.5.4 Develop, print, and distribute to appropriate agencies any and all forms required for all tasks.

2.9.5.5 Receive and track requests for payment (claims) from participants.

2.9.5.6 Verify documentation and determine conformance of the claim to IRS regulations, DHRM regulations and instructions and the DHRM's plan documents.

- 2.9.5.7 Determine that the claim is valid with respect to the object of expense and the date of incurrence and the eligibility of the claimant. All complete paper claims shall be processed and paid within 5 to 7 business days of receipt. All documentation for debit card transactions should be validated within 5 to 7 business days of receipt.
- 2.9.5.8 Maintain a claim payment accuracy that exceeds 99% for financial accuracy and 95% for non-financial processing accuracy of all claims processed in each measured period of the contract.
- 2.9.5.9 Screen claims prior to payment to uncover potentially duplicate claims. Checking for duplicate claims must be an automated feature of the payment system. Investigate and resolve potential duplicates. Record and code claims in sufficient detail to permit required reporting and to avoid duplicate payments.
- 2.9.5.10 Produce payment checks and remittance statements for individuals that clearly explain the nature of the payment being made, plan year to date activity and account balances. If a claim is being denied partially or in its entirety, the statement should clearly explain the basis of the denial and advise the claimant of how the claim may be perfected or to whom the denial may be appealed.
- 2.9.5.11 Provide each participant a statement disclosing the status of his/her account as of the end of the quarter, within thirty days of the close of each calendar quarter.
- 2.9.5.12 Provide participants on or about 60 days prior to the end of each plan year a statement of balances alerting participants of possible forfeitures. Mailing of the year end notice should be no earlier than 70 days and no later than 50 days prior to the end of the plan year.
- 2.9.5.13 Process claims for at least ninety (90) days after the close of the plan year. Except during the first and the last year of the contract, process claims simultaneously for more than one plan year (that is, claims for the current plan year and claims for the ninety day "run out" period of the previous plan year). Control and report claim payments by plan year, regardless of plan year status. During this ninety day period, mail to participants whose accounts have balances, a statement of the account as soon as practical after the close of the first month of the run out period, but no later than 15 days.
- 2.9.5.14 Provide educational materials and standard election and revision forms for each Open Enrollment during the life of the contract if

required by the Department. Provide or arrange for the provision of educational materials, as required herein or agreed to by the Department, at sites throughout the State. This task includes all design, typeset, printing, overprinting and distribution costs. No additional costs shall be billed outside of this contract.

- 2.9.5.15 Prepare an administrative plan manual with provisions for updates, for the use of your processors, which is Commonwealth of Virginia plan specific, including as a minimum the reporting requirements, standards, processing procedures and policies. Provide a draft of this manual to DHRM for approval at least 30 days prior to start of contract.
- 2.9.5.16 Provide staffing to ensure that no more than 5% of telephone calls may be abandoned in any week and the average time that callers are left on hold shall be less than 30 seconds. The Contractor shall deliver a monthly report detailing the number of calls received, abandoned, hold time and wait time for the previous month.
- 2.9.5.17 Ensure that correspondence from beneficiaries shall be date stamped on the day it is received, and shall be answered within 10 business days.
- 2.9.5.18 Provide a website with a direct link to the Department's web page. Provide all FRA participants with on-line access to account balance, claim status and the ability to submit claims electronically.
- 2.9.5.19 Provide all FRA participants the ability to request direct deposit for all claim payments and a debit card via a web application, customer service center or form. Provide FRA participants that elect the debit card with a monthly statement of activity.
- 2.9.5.20 Enroll in the Commonwealth's Electronic Data Interchange (EDI) program as all payments shall be made through EDI. Additional information is available from the Department of Account's website: http://www.doa.virginia.gov/General_Accounting/EDI/EDI_Main.cfm
- 2.9.5.21 Acknowledge that no later than one week prior to the start of the plan year for the new contract, the Commonwealth will provide a mutually acceptable amount as an initial deposit or pre-fund. The purpose of this deposit is to cover claims paid out by the Contractor until the claims may be invoiced and reimbursed to the Contractor by the Commonwealth.
- 2.9.5.22 Invoice the Commonwealth for claims processed during the previous payment cycle as agreed upon by the Contractor and Commonwealth. Invoices shall provide totals by account type and plan year, regardless of the status of the plan year. Documentation providing details by employee, account type and plan year for claims

reimbursed per the invoice must also be provided. Adjustments and/or claims paid for prior plan years must be identified separately and include employee, account type and plan year details.

- 2.9.5.23 Safeguard check stock and control signature authority according to best GAAP equivalent business practices. Account for all wasted, voided and manual checks.
- 2.9.5.24 Provide the Commonwealth with a monthly accounting of all disbursements by account type and plan year.
- 2.9.5.25 Provide forfeiture balances and listing of all stale-dated checks (identified by account type and plan year) within 45 days of the end of the run out period at the end of each plan year.
- 2.9.5.26 Acknowledge that Contractor is responsible for completion of escheatment process according to policies and procedures established by the Treasurer of Virginia for all stale-dated checks and shall provide a report to the Department listing amounts sent to Treasury, identified by employee, account type and plan year. Additional information regarding Commonwealth's escheatment process may be found on Department of Treasury's website: <http://www.trs.virginia.gov/UCP/Holder/default.aspx>
- 2.9.5.27 Process payments accurately and timely. Advise the Department's contract representative (paragraph 8.7) within two working days whenever there are problems in the system which may create public inquiries, such as system breakdowns, missed payment cycles, or egregious errors. Produce demand letters for collecting any amounts due from participants and process refunds for participants as required.
- 2.9.5.28 Provide a toll free number for the use of participants to obtain general information regarding the respective programs and specific information about account balances and transactions. This number shall be activated no later than sixty days prior to the effective date of the first plan year. Operate a call tracking system which allows for the measurement of the number of calls abandoned, wait time, etc. Answer inquiries, whether by phone or by mail, accurately, politely and timely.
- 2.9.5.29 Have performed by an outside auditor, within 180 days of the end of each plan year, an audit of the plan year's activity and provide the Department with the results.
- 2.9.5.30 Demonstrate the ability to administer a section 132 qualified Transportation Fringe Benefit Program to include mass transit and parking for the Commonwealth if requested.

- 2.9.5.31 Administer future salary reduction plans (such as 125 or 132) if requested by the Department.
- 2.9.5.32 Have the ability to accept a claim file(s) for out of pocket expenses associated with the health plan and auto process these claims upon the participant's request.
- 2.9.5.33 Have the ability to integrate and/or coordinate claim reimbursement with a Health Reimbursement Arrangement medical plan design.
- 2.9.5.34 Provide the report contents as agreed to and adhere strictly to the agreed upon reporting time frames.
- 2.9.5.35 Adhere strictly to the agreed upon implementation schedule.
- 2.9.5.36 Comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, including, but not limited to 45 CFR Section 160.103.
- 2.9.5.37 Update the Master files within 3 business days upon the date of receipt of a processable eligibility file from the Commonwealth. Contractor must post contributions to customer accounts within 3 business days upon the date of receipt of processable payroll files from the Commonwealth.
- 2.9.5.38 Deliver a monthly report within 30 days of the end of each calendar quarter providing the status of each individual account including contributions, payments, annual elections and account balances. This information should also be summarized for each plan.
- 2.9.5.39 Deliver separate comprehensive reports by January 15 of each year for the previous plan year's operations for each account. In addition to statistical information, these reports shall include an evaluation of the program with recommendations for improvement.
- 2.9.5.40 In addition to those found in section 3.9, the Offeror shall propose any additional plan specific standards of performance by which its performance shall be judged. Specific areas of interest are identified in the Attachment 2 questionnaire. Liquidated damages will be attached to these additional standards through the negotiation process, should the Offeror be selected as a finalist.

3.0 STANDARDS OF PERFORMANCE

3.1 GENERAL

The Contractor shall be solely responsible to the Department and liable for any delay or non-performance of any portion of the contract which results from this RFP, and for

erroneous payments. The Contractor shall not be responsible for delay or non-performance if the non-performance is caused by the failure of the Commonwealth, covered persons, or non-network providers to provide information necessary for the Contractor to meet its contractual obligations.

Certain performance obligations are of such importance that a Contractor's failure to achieve the requirements found herein jeopardizes the value which the Department expected of the contract. In acknowledgment of this, and in consideration of the extra expenses and other damages incurred by the Department, should the Contractor fail to fulfill specified contractual obligations, both parties agree that the Contractor shall pay to the Department the amount contained in the appropriate schedule of liquidated damages (see Section 2.9 and paragraph 3.9) when the Contractor's performance fails to meet the specified standards of performance.

It is expressly agreed that, unless otherwise specified, the determination of liquidated damages, if any, shall be determined annually by comparing the system generated reports in Attachment 2 and 3 to the related Schedules submitted by the Contractor.

3.2 CLAIMS MUST BE PAID CORRECTLY

The goal is 100% accuracy.

Below Standard:

Total payment error rate in excess of 1% of benefit payments, where total payment error rate is the dollar amount of erroneous payments, including payments to an incorrect payee (any reason) or paid in an incorrect amount (any overpayment plus any underpayment) or any other payment error (including both incorrect payee and incorrect amount), divided by the total dollar amount of claims paid during the audit period, **OR**

Total error rate in excess of 5% of claims processed, where total error rate is the number of claims with any kind of error (including payment errors) divided by the total number of claims processed during the audit period.

Compliance with this standard shall be determined by internal audit, verified by external audit. Should the internal and external audits arrive at different results regarding the amount of liquidated damages, the Contractor and the Department shall negotiate the actual amount of the damages. If these parties cannot reach an agreement through negotiation, they shall jointly pay for an independent audit whose determination shall be binding on both parties.

3.3 COORDINATION OF BENEFITS SAVINGS

Produce savings from coordination of benefits of at least 2% of non-Medicare paid claims per calendar year for the active employee-early retiree group.

Compliance with this standard shall be determined by audit as described in 3.2.

Contractor(s) must respond to requests from other vendors who are monitoring Medicare primacy of active employees on behalf of the Department for purposes of recovering primary payments made in error and will maintain accurate coordination of benefits based on Medicare secondary payer guidelines and/or designation of Medicare primacy through eligibility file designations. Medicare Secondary Payer Demands and Primary Payment Notices will be forwarded to the Department for processing. This paragraph does not apply to the Flexible Benefits Contractor.

3.4 ACCESS OF ELIGIBILITY FILES UPDATES

The Department will maintain current eligibility files for the state employee group. The Medical/Surgical Contractor will be responsible for maintaining current eligibility files for the TLC program. The Department provides the Contractor with eligibility information in the HIPAA 834 Transaction File format as described on the DHRM Website (<http://web1.dhrm.virginia.gov/itech/itdocs.htm>). Two types of files are regularly provided: The Daily Change File provided Tuesday through Saturday, and the Monthly Audit File provided on the third of each month. The Contractor must connect to the Department's secure FTP server for file transfers by one of the following protocols: SFTP using SSH2 on port 22; or HTTPS for manual retrieval. Additionally, until the Department takes over maintenance of the TLC eligibility files, the Medical/Surgical Contractor will be responsible for updating and moving changes to a file for pickup by other Contractors. The Medical/Surgical Contractor will assign a non-Social Security Number identifier for TLC enrollees and provide to other Contractors as a common TLC enrollee ID. It is expected that each Contractor will comply with the Department's eligibility file processing as scheduled.

3.5 REPORTING

Reports containing the requested information shall be submitted timely and accurately. The submission of a materially inaccurate report does not constitute timely submission for the purposes of this section. NOTE: Timely reporting also includes the submission of accurate and readable weekly claims files, paid claims invoices, and monthly administration invoices.

The Department shall determine compliance with this standard by the date of receipt of reports.

3.6 INVOICE PROCESSING

The Medical/Surgical Contractor is responsible for processing TLC premium invoices from member groups. The Contractor must process 90% of TLC premium invoices within 3 business days of receipt of payment and 100% of premium invoices within 5 business days of receipt.

Compliance with this standard shall be determined by audit as described in 3.2.

3.7 PREMIUM PROJECTIONS

The total discount representing the Net Payment after Application of Your Reimbursement Method reported (in Attachment 2), upon finalist negotiations, will be compared with subsequent results on a fiscal year basis. If is less than 95% of the total discount representing the Net Payment after Your Application of Reimbursement Method projected on the Projected Savings Schedule for the same fiscal year such that the amount paid for claims is higher than projected, then 1% of the Contractor's administrative fee shall be owed and due to the Department as liquidated damages for each 0.1% by which the actual discount received is lower than 95% of the projected discount.

3.8 MEMBER SATISFACTION

At least 90% of the covered persons responding to the Contractor's annual surveys (Paragraph 4.1.8) must rate their overall experience with the program as "satisfactory" or better.

3.9 SCHEDULE OF LIQUIDATED DAMAGES – GENERAL

This schedule of liquidated damages is mutually agreed in view of the difficulty and the cost of measuring the actual damages incurred from complaints, lost productive time, intrusion into other business, etc., as a result of under-performance in the areas noted.

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
99% of benefit \$ paid correctly	3% of administrative costs for each 1% or fraction below standard
95% of claims paid without error	1% of administrative costs for each 1% or fraction below standard
Eligibility Files not picked up as scheduled	\$1,000 first occurrence, \$10,000 per occurrence thereafter
COB savings of 2%	1% of administrative costs for each 1% or fraction below standard
Late/Missing/Inaccurate Reports	\$1,000 per day, days 1-5; \$10,000 per day thereafter
Invoice Processing	\$2,000 per invoice not meeting standard
Inaccurate projections	1% of contracted administrative fee for each 0.1% of unrealized provider discount after 5%.
Patient Satisfaction	\$5,000 for each 1% or fraction thereof below standard

Exclusive Website must be developed timely	\$50,000 per month or prorated for a partial month
Real-Time Information to customer service and other internal/external Contractor partners. real-time means instantaneous electronic transfer of information.	\$100,000 per month or prorated for a partial month
False representations during RFP process resulting in awarding of contract, as determined by the Department	\$1,000,000 (subject to binding arbitration)

Additional performance standards specific to the Prescription Drug and Behavioral Health products may be found at Section 2.9. above.

4.0 REPORTS AND DELIVERABLES

Generally, separate report sets are required for each separate group, including but not necessarily limited to (1) TLC local governments, (2) TLC school jurisdictions, (3) TLC in total, (4) the state employee active employee group, (5) the state employee early retiree group, (6) state program Extended Coverage/COBRA participants, and (7) the state employee group in total. Attachments 2 and 3 also contain formats of some system-generated reports that will be used to assess Contractor performance and to determine the amount of liquidated damages due, if any. Report formats are generally contained in Attachments 2 and 3. Offerors are invited to suggest improvements or additional reports.

4.1 REPORTS

4.1.1 Rate and Administrative Expense Buildup Schedule

This form, which may be found in Attachment 2, must be submitted.

4.1.2 Weekly Claims Report

The Weekly Claims Report is to be prepared in MS Excel format and E-mailed on the third business day after the close of the week. The format is contained in Attachment 3.

4.1.3 Weekly claims file

The format for the file will be provided to the finalist.

4.1.4 Administrative Fee Report

This report is used by all ASO plans to invoice administrative costs on a monthly basis. The format is contained in Attachment 3.

4.1.5 Monthly Service Report

This report discloses Contractor's results in meeting customer service and claims processing goals. The format can be found in Attachment 3.

4.1.6 TLC Monthly Income Report

The Monthly Income Report shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format (see Attachment 3) and E-mailed on the 20th day after the close of the month.

4.1.7 Monthly Utilization Management Report

This report discloses the Contractor's assessment of its utilization management activities, including admission review, concurrent review and case management. The specifications for this electronic file are found in Attachment 3.

4.1.8 Annual HEDIS

The Contractor shall submit the latest appropriate version of the HEDIS (or Department-approved equivalent), including the standard Member Satisfaction Survey for the most recent calendar year, by August 15th or with the Contractor's renewal, as appropriate.

4.1.9 Annual Accounting and Renewal

On or before September 15, or such date as determined by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit specified IBNR lag triangle data in the required form to the Department Actuary.

On or before September 15, or such date as determined by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit a complete accounting of its operations for the fiscal year ended the last June 30th, and shall propose a rate, for the fiscal year beginning the next July 1. The accounting and rate analysis should treat separately each major class of benefits, Medical/Surgical, Behavioral Health, Prescription Drug, and Dental.

In addition, the Annual Report shall contain:

- 4.1.9.1 costs by employee, spouse and dependents (separately for active employees, retirees, and extended coverage enrollees),
- 4.1.9.2 a list of the fifty highest cost cases (enrollees) with relevant detail on admissions, diagnoses, etc.,
- 4.1.9.3 amounts paid to hospitals (including inpatient surgical per diem, inpatient acute medical per diem, inpatient acute obstetrical case rate,

inpatient outlier minimum charge per case and inpatient outlier rate, and outpatient case rates for those procedures which comprise 50% of outpatient hospital reimbursement, or for the 25 procedures which have the highest total dollar impact together with an indication of the percentage of total outpatient reimbursement these 25 procedures represent),

- 4.1.9.4 show the fifty professional providers of services receiving the largest payments, and
- 4.1.9.5 claims in excess of \$100,000 for Medical/Surgical, if not previously reported. The Department will work with Contractor(s) providing services for other products (Prescription Drug, Behavioral Health, and Dental) to determine appropriate dollar amount thresholds for this report.

Finally, the Annual Report shall provide a frequency distribution of contracts, claims and dollars paid in total and by type of benefit.

- 4.1.10 Each Contractor must provide an annual mandated benefit report as required by § 2.2-2818(R)
- 4.1.11 Monthly Behavioral Health Services Report

This report discloses requests for services, pre-authorized amounts, and the impact of appeals. The format can be found in Attachment 3.

- 4.1.12 Such other reports as may be necessary to document the performance of the Contractor and its adherence to the contracted standards.

4.2 ALL CONTRACTORS: UTILIZATION OF SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES.

UTILIZATION OF SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES

- 4.2.1 Periodic Progress Reports/Invoices. Within sixty days of each six months' operation under this contract, disclose the actual dollars contracted to be spent to-date with such businesses, and the total dollars planned to be contracted with such businesses on this contract. This information shall be provided separately for small businesses, women-owned businesses and minority-owned businesses.

4.2.2 Final Actual Involvement Report: The Contractor will submit, prior to completion of the contract and prior to final payment, a report on the actual dollars spent with small businesses, women-owned and minority-owned businesses during the performance of this contract. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., comparison of the total actual dollars spent on this contract with the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value. Final payment may be withheld pending receipt of this report. A suggested format is as follows:

Business Class: Small, Women-Owned or Minority-Owned

<u>FIRM NAME, ADDRESS AND PHONE NUMBER</u>	<u>TYPE GOODS/ SERVICES</u>	<u>ACTUAL DOLLARS</u>	<u>PLANNED DOLLARS</u>	<u>%OF TOTAL CONTRACT</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTALS FOR BUSINESS CLASS		_____	_____	_____

4.3 OTHER DELIVERABLES

4.3.1 The Contractor agrees to furnish and warrants that the administrative charge quoted includes all enrollment materials, benefits booklets, and brochures describing plan benefits, applications, notices, claims forms, checks, remittance advices, two articles for employee publications, administrative manuals, provider networks, directories, forecasts, invoices, identification cards, criteria sets and such services and materials stated or implied anywhere in this RFP or the Contractor's response thereto, including any correspondence associated with new programs as a result of provisions of this RFP.

4.3.2 The statewide medical surgical ASO Contractor shall assist the Department with the ongoing operations of the TLC program by providing direct support with, but not limited to, the marketing; communications; underwriting; renewal and proposal preparation and delivery; group billing and collections; collecting, validating, and distributing eligibility and enrollment data; and distributing ASO membership to other ASO carve-out products' Contractors.

5.0 PROCUREMENT PROCEDURES

5.1 METHOD OF AWARD

5.1.1 The Department shall select two or more Offerors per product deemed to be fully qualified and best suited among those Offerors submitting proposals, unless the Department has made a determination in writing that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration. The selection of Offerors will be based on the evaluation factors included in this RFP. Negotiations shall be conducted with the selected Offeror(s). Price shall be considered when selecting finalists for negotiation, but shall not be the sole determining factor.

5.1.2 After negotiations have been conducted with each selected Offeror, the Department shall select the Offeror, which, in its opinion, has made the best proposal. The Department shall award the contract to that Offeror. The Department may cancel this RFP, or reject proposals at any time prior to an award. The Department is not required to furnish a statement of the reason why

a particular Offeror was not deemed to have made the best proposal (Section 2.2-4359, Code of Virginia).

- 5.1.3 Should the Department determine in writing, and in its sole discretion, that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror.
- 5.1.4 The contract will incorporate by reference all the requirements, terms and conditions of this RFP and the Contractor's proposal, except as either or both may be amended through negotiation. All statements and representations, written or verbal, relating to the award of this and renewal contracts must be construed to be consistent with the following submission instructions.

5.2 SUBMISSION OF WRITTEN PROPOSALS

- 5.2.1 All proposals must be in the form requested (See paragraph 6.0 and Attachment 2). The data required on the schedules submitted in response to this RFP are subject to verification. Material errors shall be a basis for rejecting such a proposal. An **Original**, an Electronic **Redacted** and twenty-five (25) electronic copies of the original, on separate CDs, shall be delivered in a sealed container, and labeled as a proposal, with the words "**Do Not Open**" and **the type of benefit plan enclosed** prominently displayed on the outside. Proposals must be received no later than 2:00 p.m. on October 26, 2012, by:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219

The original proposal should be bound in a **loose-leaf notebook**. All documentation submitted with the proposal should be contained in that single volume. (If necessary, additional notebooks may be submitted in clearly marked and referenced sequence.) *Offerors are required to submit a CD containing their response in MS Excel and Word format, as directed by the Attachment 2 schedules, along with each copy of the proposal.*

- 5.2.2 Ownership of all data, materials and documentation originated and prepared for the Department pursuant to the RFP shall belong exclusively to the Department and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of Section 2.2-4342 of the Code of Virginia, in writing, at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified as required and must indicate only the specific words, figures, or paragraphs that constitute trade secrets or

proprietary information. The Department, in its sole discretion, may not consider proposals with unduly broad requests for protection against disclosure.

5.3 MODIFICATION OF PROPOSALS

Any changes, amendments or modifications of an Offeror's proposal prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposals. All modifications must be labeled conspicuously as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals, except when the Department requests modifications.

5.4 ORAL PRESENTATION

Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the Department. This provides an opportunity for the Offeror to clarify or elaborate on the proposal. This is a fact finding and explanation session only and does not include negotiation. The Department will schedule the time and location of these presentations. Oral presentations are an option of the Department and may or may not be conducted.

5.5 INQUIRIES CONCERNING THE RFP

Any communication concerning this RFP or any resulting contracts must be addressed in writing including the RFP # in the subject line to:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219
E-mail: dan.hinderliter@dhrm.virginia.gov

5.6 PUBLIC INSPECTION OF PROCUREMENT RECORDS

Proposals will be subject to public inspection only in accordance with Section 2.2-4342 of the Code of Virginia.

5.7 CLARIFICATION OF PROPOSAL INFORMATION

The Department reserves the right to request verification, validation or clarification of any information contained in any of the proposals. This clarification may include checking references and securing other data from outside sources, as well as from the Offeror.

5.8 REFERENCE TO OTHER MATERIALS

The Offeror cannot compel the Department to consider any information except that which is contained in its proposal, or which is offered in response to a request from the Department. The Offeror should rely solely on its proposal. The Department, however,

reserves the right, in its sole discretion, to take into consideration its prior experience with Offerors and information gained from other sources.

5.9 MANDATORY PRE-PROPOSAL CONFERENCE

A **mandatory** pre-proposal conference will be held at 9:00 a.m. October 1, 2012, in the James Monroe Building, Conference Rooms C, D and E, 1st Floor, 101 North 14th Street, Richmond, Virginia. The purpose of this conference is to allow potential Offerors an opportunity to present questions and to obtain clarification relative to any facet of this procurement.

Attendance at this conference is a prerequisite to submitting a proposal. Offerors who intend to submit a proposal are **required** to attend. Any changes resulting from this conference will be issued in a written addendum to the RFP. Attendance at the conference will be documented by the representative's signature on the attendance roster. Offerors should bring a copy of this RFP to the conference

It is requested that any known questions regarding the RFP be sent by e-mail to Dan Hinderliter prior to date of conference to facilitate the conference. Include the RFP # in the subject line of all correspondence. See E-mail address in paragraph 5.5.

5.10 TIMETABLE

RFP Published	September 21, 2012
Mandatory Pre-Proposal Conference	October 1, 2012
Proposals Due, 2:00 P.M.	October 26, 2012
Notice of Intent to Award	December 15, 2012

6.0 FORM OF RESPONSE AND CRITERIA

6.1 GENERAL

The Department encourages bundled offerings and, at its discretion, may choose one Offeror to administer all or any combination of products. "Bundled offering" means that all products (Medical/Surgical, Prescription Drug, Behavioral Health, Dental, and Flexible Benefits) must be included in the single proposal. Combinations of vendors may choose to partner to propose a single bundled offering.

Offerors may choose to submit both a bundled submission and submissions for single products as noted above. Bundled submissions will not be reviewed on a per product basis. In other words, a bundled submission will only be evaluated in its entirety. Bundled submissions will be given preference, all other criteria being equal. Should the Department select multiple Offerors, the selections will be based on unbundled submissions. If an Offeror is submitting an unbundled proposal, then a separate proposal is required for each product (Medical/Surgical, Prescription Drug, Behavioral Health, Dental, Flexible Benefits).

Fully insured and less than statewide proposals for each area for which the Offeror is proposing must be bundled.

A proposal for the statewide ASO Medical/Surgical plan must include provisions for vision and hearing services.

Similarly, a proposal for the statewide Behavioral Health plan must include provisions for EAP services. The provisions for an EAP plan must be such that they are considered an excepted benefit plan under HIPAA.

Offerors must clearly identify the plan type and products for which they are bidding. Additionally, if they are bidding for a fully insured and less than statewide proposal, they must clearly identify the area for which they are bidding.

Attachment 2 contains the schedules required to complete a proposal. Please review Attachment 2 carefully and complete those section(s) that apply to the plan being offered.

Proposal shall be in the form of a loose-leaf binder tabbed to point to each section below. Before the first tab:

- Place the executed RFP Cover Sheet followed by a statement defining those sections of your proposal which may not be released because they are proprietary.
- Following the executed Cover Sheet and statement of confidentiality, place a properly completed Proposal Checklist, which is found in Appendix 9.

An original proposal, an electronic redacted version, and twenty-five (25) electronic copies are required. The original shall contain a Cover Sheet bearing an original signature signed in BLUE ink and be labeled on the cover as "Original".

6.2 REDLINE RFP NOTING DEMURRALS (TAB 1)

Include a copy of the RFP. Using the *Track Changes* and *Highlight Changes* MS Word tools, annotate in redline **any and all** demurrals or deviations to the requirements of the RFP. Demurrals are statements that reflect and describe any disagreement the Offeror has with any term of the RFP. Please note that demurrals are a rating criterion for this RFP. As such, Offerors who include demurrals should expressly describe the reasons for each demurral. You may enter any substantive comments on the RFP provisions, but please restrict such to issues that are necessary to clearly understand your proposal. Information required in the tabs below need **NOT** be repeated in this tab. Also, affirmations or confirmations of compliance to RFP requirements are unnecessary in this tab and are **NOT** to be included.

6.3 LEGALLY CORRECT DESCRIPTION OF BENEFITS (TAB 2)

6.3.1 For the statewide employees program, itemize any benefit changes to current plans.

6.3.2 For the TLC program, itemize any benefit changes to current plans (1) utilizing Co-Pays and hospital deductibles and (2) utilizing the coinsurance benefits. If you intend to duplicate the current program in its entirety, you may simply so note.

6.4 BENEFITS BROCHURE (TAB 3)

The Offeror shall submit a model brochure containing supplemental information for employees to help them understand how the plan works.

6.4.1 The brochure shall consist of the information required by the monthly service report (see paragraph 4.1), and all of the following available or applicable to the type plan offered.

6.4.1.1 the plan's NCQA certification status,

6.4.1.2 selected HEDIS (or Department approved substitute) information on

a. plan membership

b. effectiveness of care

c. PCP availability

d. physician turnover

e. disenrollment

f. rate trends

6.4.1.3 highlights from the HEDIS (or Department approved substitute) Member Satisfaction Survey, including

a. overall satisfaction

b. overall quality of care and services

c. access

d. recommendation to family and friends

6.4.1.4 a brief summary of the report, which describes the plan's adherence to the access standards, found in paragraph 2.3, subparagraph 1.

6.4.1.5 a brief discussion of the criteria used to admit institutional and professional providers into the network and the bases on which the plan pays the providers.

6.4.1.6 optionally, the plan may include practice guidelines covering those outpatient procedures representing about one-half of outpatient professional costs.

6.5 TECHNICAL QUESTIONNAIRE

Attachment 2 contains the Technical Questionnaire, which constitutes the technical proposal. Attachment 2 will include a separate section for each product. Offerors should only complete any specific product section if they are submitting a proposal for that product. Attachment 2 must be completed in accordance with the instructions contained in the Questionnaire. In addition to the hard copy contained in this tab, the electronic file must be provided with your response as requested in the Questionnaire.

6.6 COST PROPOSAL (TAB 5)

Attachment 2 contains the schedules which, along with the Offeror’s latest certified audit report, constitute the cost proposal. Include in this tab, a copy of the audited report for the most recently completed fiscal year and a hard copy of the schedules. Also, the schedules must be submitted as directed in Attachment 2 instructions.

The attachment also contains administrative cost schedules that provide the following cost proposal detail:

- 6.6.1 A firm, fixed price per contract month for the first contract year.
- 6.6.2 A firm, fixed price per contract month for the second contract year. This price may not be indexed to the price of the first contract year.
- 6.6.3 A firm, fixed price per contract month for the third contract year. This price may not be indexed to the price of either the first or the second contract year.
- 6.6.4 A guaranteed interest rate for funds in the operating account or an index which will constitute a minimum guarantee. (Offerors of fully insured plans are exempt from this sub-paragraph)
- 6.6.5 A cost summary page

Please note: The administrative cost schedule requires component cost information. The level of detail requested must be provided.

6.7 PARTICIPATION OF SMALL, WOMEN, AND MINORITY OWNED BUSINESSES (TAB 6)

Complete the information required on Exhibit TWO.

6.8 CRITERIA

Proposals for each product will be evaluated on multiple criteria as listed below, in no particular order:

Prescription Drug	Points
Offeror’s organization and financial stability	10
Qualifications of staff	5

Provider network	10
Demurrals	10
Administrative capability, flexibility, and innovation	15
Benefit cost management and administrative cost	20
Participation of small, women and minority owned businesses	20
Comprehensiveness and quality of integrated bundled offering	10
Dental	Points
Offeror's organization and financial stability	10
Qualifications of staff	5
Provider network	10
Demurrals	10
Administrative capability, flexibility and innovation	15
Benefit cost management and administrative cost	20
Participation of small, women and minority owned businesses	20
Comprehensiveness and quality of integrated bundled offering	10
Medical/Surgical	Points
Offeror's organization and financial stability	10
Qualifications of staff	5
Provider network	10
Demurrals	10
Plan benefit administration capability, flexibility and innovation	15
Benefit cost management and administrative cost	20
Participation of small, women and minority owned businesses	20
Comprehensiveness and quality of integrated bundled offering	10
Behavioral Health	Points
Offeror's organization and financial stability	10
Qualifications of staff	10
Provider network	10
Demurrals	10
Administrative capability, flexibility and innovation	15
Benefit cost management and administrative cost	15
Participation of small, women and minority owned businesses	20
Comprehensiveness and quality of integrated bundled offering	10
Flexible Benefits	Points
Offeror's organization and financial stability	10
Qualifications of Staff	5
Administrative capability, flexibility and innovation	25
Demurrals	10
Administrative cost	20
Participation of small, women and minority owned businesses	20
Integration with health plan payers	10

7.0 GENERAL TERMS AND CONDITIONS

7.1 VENDOR'S MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia Vendor's Manual and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is normally available for review at the Department's office on the 13th floor of the James Monroe Building. In addition, a copy can be obtained from the Department of General Services' Division of Purchases and Supply by calling (804) 786-3842.

7.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia, and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Contractor shall comply with all applicable federal, state, and local laws, rules, and regulations.

7.3 ANTI-DISCRIMINATION

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians with Disabilities Act, the Americans with Disabilities Act, and Section 2.2-4311 of the Virginia Public Procurement Act.

In every contract over \$10,000 the provisions in 1 and 2 below apply:

7.3.1 During the performance of this contract, the Contractor agrees as follows:

7.3.1 The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex or national origin, or disabilities, except where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

7.3.2 The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.

7.3.3 Notices, advertisements, and solicitations placed in accordance with federal law, rule, or regulation shall be deemed sufficient for the purpose of meeting these requirements.

7.3.2 The Contractor will include the provisions of 1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each sub contractor or vendor.

7.4 ETHICS IN PUBLIC CONTRACTING

By submitting their proposals, Offerors certify (1) that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer, or sub contractor in connection with their proposal, and (2) that they have not conferred on or promised, any public employee having official responsibility for this procurement transaction, any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, unless consideration of substantially equal or greater value was exchanged.

7.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By submitting their proposals, Offerors certify that they do not and will not, during the performance of this contract, employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

7.6 DEBARMENT STATUS

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia from submitting proposals for the type of goods or services covered by this solicitation, nor are they an agent of any person or entity that is currently so debarred.

7.7 ANTITRUST

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title, and interest in and to all causes of the action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

7.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS

Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

7.9 CLARIFICATION OF TERMS

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Dan Hinderliter in writing no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the Department.

7.10 PAYMENT

7.10.1 To Prime Contractor:

- 7.10.1.1 Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payments address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- 7.10.1.2 Any payment terms requiring payments in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- 7.10.1.3 All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
- 7.10.1.4 The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.

7.10.2 To Subcontractors:

- 7.10.2.1 A Contractor awarded a contact under this solicitation is hereby obligated:
 - a. To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
 - b. To notify the agency and the subcontractor(s) in writing, of the Contractor's intention to withhold payment and the reason.
- 7.10.2.2 The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) day following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U.S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be

construed to be an obligation of the Commonwealth.

7.11 PRECEDENCE OF TERMS

Paragraphs 7.1 - 7.10 of these General Terms and Conditions shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

7.12 QUALIFICATIONS OF OFFERORS

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

7.13 TESTING AND INSPECTION

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure supplies and services conform to the specification.

7.14 ASSIGNMENT OF CONTRACT

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth.

7.15 CHANGES TO THE CONTRACT

Changes can be made to the Contract in any one of the following ways:

7.15.1 The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

7.15.2 The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to such things as services to be performed, the method of packing or shipment and the place of delivery or installation. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

- 7.15.2.1 By mutual agreement between the parties in writing; or
- 7.15.2.2 By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
- 7.15.2.3 By ordering the Contractor to proceed with the work and to keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall resolve in accordance with the procedures for resolving disputes provided by the Disputes Clause (paragraph 8.12) of this contract and in accordance with the disputes provisions of the Commonwealth of Virginia's Vendor's Manual. Neither the existence of claim or a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

7.16 DEFAULT

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have.

7.17 INSURANCE

By signing and submitting a bid or proposal under this solicitation, the bidder or offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded. The bidder or offeror further certifies that the contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

INSURANCE COVERAGES AND LIMITS REQUIRED:

7.17.1 Worker's Compensation - Statutory requirements and benefits.

7.17.2 Employee Liability - \$100,000

7.17.3 Commercial General Liability - \$500,000 combined single limit. Commercial General Liability is to include Premises/Operations Liability, Products and Completed Operations Coverage, and Independent Contractor's Liability or Owner's and Contractor's Protective Liability. The Commonwealth of Virginia must be named as an additional insured when requiring a Contractor to obtain Commercial General Liability coverage.

7.18 ANNOUNCEMENT OF AWARD

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the Agency's web site, <http://www.dhrm.virginia.gov/rfps/rfpmain.html> , for a minimum of 10 days.

7.19 DRUG-FREE WORKPLACE

During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of controlled substance or marijuana is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

7.20 NONDISCRIMINATION OF CONTRACTORS

A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is made to a faith-based organization and an individual, who applies for or received goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

7.21 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION

The eVA Internet electronic procurement solution, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service, and complete the Ariba Commerce Services Network registration.

7.21.1 eVA Basic Vendor Registration Service: \$25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, online registration, and electronic bidding, as they become available.

7.21.2 eVA Premium Vendor Registration Service: \$200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research historical procurement data, as they become available.

7.21.3 Ariba Commerce Services Network Registration. The Ariba Commerce Services Network (ACSN) registration is required and provides the tool used to transmit information electronically between state agencies and vendors. There is no additional fee for this service.

Note: Vendors are strongly encouraged to register your company prior to submitting a bid or offer. Failure to register will result in your bid or offer being found non-responsive and rejected. All vendors must register in both the eVA and the Ariba Commerce Services Network Vendor Registration Systems.

8.0 SPECIAL TERMS AND CONDITIONS

8.1 COST LIMITS

The Contractor is responsible for all the costs of implementing and administering the program. The Department is responsible for ensuring that the Contractor receives payment of all fees that are established pursuant to the contract which results from this RFP. Any cost incurred by the Contractor to address the tasks and responsibilities identified in this RFP which exceeds the contractually established fees is the risk of the Contractor.

8.2 RENEWAL OF CONTRACT

The term of this contract is three years with three one-year renewal options. For the one-year renewal options, the contract may renew annually subject to the following.

- 8.2.1 The Contractor shall advise the Department in writing no later than 2:00 PM on the last business day before September 16 that the insurer is willing to renew the contract on the same terms and conditions as currently in force or as modified pursuant to a request from the Department. This advice shall be in the form of a proposal which meets the requirements of Section 6, except that the submission of tabs 1 and 2 are necessary only to the extent that there are changes from the original proposal. Selected tab 5 detail is required with each renewal.
- 8.2.2 All Contractors require a finding by the Department that the Contractor's performance has been satisfactory. Such findings are within the sole discretion of the Department but will be based on materially important issues such as the plan's accreditation status (if applicable), employee satisfaction, and the amount of liquidated damages due the Department because of failure of the Contractor to meet standards.
- 8.2.3 If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price for the additional one year shall not exceed the contract price of the original increased/decreased by more than the percentage increase/decrease of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.
- 8.2.4 If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price for the subsequent renewal period shall not exceed the contract price of the previous renewal period increased/decreased by more than the percentage increased/decreased of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of labor Statistics for the latest twelve months for which statistics are available.

8.3 TERMINATION, SUSPENSION AND CANCELLATION OF CONTRACT

Either party may terminate this contract for its sole convenience effective July 1 of any year by delivery of written notice at least nine months prior to the effective date of cancellation, that is, by the previous September 1. Some school groups in the TLC program have plan years ending on September 30th. Therefore, it is agreed that for any Contractor having enrollment in one or more of these school groups, the termination of this contract as applied to the particular school group will be effective September 30 following the July 1 termination date of the contract.

If the Department determines, in its sole discretion, that limiting additional enrollment would enhance the administration of this contract, the Department may limit enrollment or suspend entirely new enrollments by a written order to the Contractor.

Furthermore, in the event of emergency requirements or significant changes in the Contractor's financial or organizational status which could not have reasonably been foreseen, the Department reserves the right to cancel and terminate this contract, in part or in whole without penalty, upon 60 days written notice to the Contractor.

Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

8.4 PAYMENTS AND INTEREST

8.4.1 State Employee Program - The Department will send or make available (through the internet) to each Contractor an electronic file of changes in eligible enrollees and eligible dependents in a form to be mutually agreed upon on a daily or other basis as may be mutually agreeable. Contractor agrees that BES shall be the only official source for any eligibility file maintained by the Contractor for any claims payment made by the Contractor, unless the Department agrees to changes in writing.

If the plan is an insured plan, the Department will provide a premium payment sufficient to pay for the coverage of persons determined to be eligible by the Department. This payment will be made to the Contractor no later than the tenth business day of the month for which coverage is effective. The premium payment will reflect appropriate retroactive adjustments. The Contractor will pay claims or provide services only for persons determined to be eligible by the Department.

8.4.2 The Local Choice Program - Bills for premiums shall be submitted by the Medical/Surgical Contractor to each local employer which has one or more enrollees in the plan by the twentieth day of the month prior to the month for which coverage is billed. The Medical/Surgical Contractor agrees to submit bills in a form acceptable to the Department. Employers will reconcile bills and attach thereto applications effecting changes in coverage. The Medical/Surgical Contractor will receive reconciled bills, applications and payments. Payments shall be made generally by the tenth of the month for which coverage is billed. The Medical/Surgical Contractor agrees to reconcile bills timely, and update membership files and issue membership cards promptly. The plan will pay claims or provide services only for persons whose premiums are paid when due.

Note: The Medical/Surgical Contractor will provide the ability for large (as determined by the Department) TLC groups to pay their monthly premiums utilizing wire transfers or other electronic transfers of funds.

8.4.3 Each Contractor will bill the Department for claims payments on a weekly basis and for administrative costs on a monthly basis. The Department will pay, subject to verification, the Contractor for services rendered. The form of the bills and the schedule of payments shall be acceptable to both parties. The plan will pay claims or provide services only for persons determined to be eligible by the Department.

8.4.4 The standard form of payment utilized by the Commonwealth is by EDI (See Appendix 9 for description). Unless a different method is agreed upon through negotiations, each Contractor must complete the EDI agreements required by the Department of Accounts.

8.4.5 Retroactive Adjustments

Where the Department discovers an error in enrollment for which the Contractor has no responsibility, Contractor agrees to correct such an error retroactively up to a period of eighteen months from the date on which the error is discovered.

8.4.6 COBRA Eligibles and Direct Bill Retirees

For all state employee groups, the Medical/Surgical Contractor agrees to bill Extended Coverage (COBRA) enrollees and certain retiree group participants designated by the Department for premiums. Plans shall submit a listing of anyone who has failed to pay their monthly premium within 15 days of the end of the month for which premium has not been paid, identified by alternate ID number. Billing format will comply with Department policy and/or governing law. The ASO Medical/Surgical plan shall report those collections on the Monthly Income Report.

The above paragraph does not currently apply to TLC enrollees. Each TLC member group is responsible for administering COBRA eligibility for their group and the collection of premiums for all of their enrollees, including COBRA and retirees.

8.4.7 Settlement and Payment of Liquidated Damages

There shall be an annual settlement between the Contractor and the Department on or before November 30th, unless both parties agree to an extension. The settlement agreement shall provide for the final settlement of contract expenses, including liquidated damages. It is mutually agreed that liquidated damages, if any, shall be determined by reference to claims incurred for the fiscal year in settlement and paid through the 30th of September following the close of that year. Amounts owed to either party shall be paid within 30 days of settlement. Late payments by either party are subject to interest at 1% per month on the unpaid balance, such that interest is due and payable on the 31st day following the date of settlement for the 30 days the balance would have remained unpaid. The settlement agreement shall specify the last business day on which timely payment may be made.

8.4.8 Interest

A Contractor shall pay the Department interest on all funds held by the Contractor for the Department, including check float. The Department will bargain in good faith with respect to the total structure of the financial arrangements such that the Contractor and the Department are both protected

against the untimely payment of amounts due, including weekly claims reimbursements.

- 8.4.9 The Contractor shall deliver only those services actually ordered by the Department. The Department will accept and pay only for those services which have been fully rendered. The Contractor shall invoice the Department each month for services provided during the prior month. Payment will be made by the Department within 30 days of receipt of an approved invoice by the Commonwealth's EDI payment method.

8.5 PREMIUMS

The Offerors shall propose premiums using the Premium Buildup form referenced in paragraphs 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the Contractor's proposal, the costs of the Department in the administration of the employee health benefits program, and in the costs of activities which benefit the members of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

- 8.5.1 Insured plans shall establish premiums in accordance with their own procedures. Notice of any change in premiums shall be accomplished using the Premium Buildup form referenced in sub-paragraph 1 of paragraph 4.1.
- 8.5.2 ASO plans shall propose premiums using the Premium Buildup form referenced in sub-paragraph 1 of paragraph 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the Contractor's proposal, the age, gender, the administrative costs of the Department, the relative efficiency of the plan's provider networks, the prices the plan pays for services, the plan's administrative costs, and such other factors as may be relevant.

8.5.3 Surcharges

All plans shall participate in the costs of the Department in the administration of the employee health benefits program and the TLC programs, and in the costs of activities which benefit the insureds of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

For the state employee group plans, all insured plans will be paid 98% of the agreed upon premium.

For the TLC program, all insured plans will be required to reimburse the Department at 2% of the total monthly premium paid by each group having enrollees under the insured plan. This 2% calculation should be included in any rate buildup.

8.6 AUDITS

Some standards of performance under this contract shall be measured by audits. Results of claims audits shall be extrapolated to the universe of claims being audited, and the Contractor's performance with respect to the universe of claims shall be deemed to be the same as the Contractor's performance on the sample of claims, provided that the audit sample was randomly drawn and statistically valid (+/-3% error rate at 95% confidence level).

The Contractor shall assist the Department and the Department's auditors, who may be employees of the Department, employees of other Contractors, or agents of the Department, in the conduct of audits. This assistance shall include the provision of secure, quiet office space, including furnishings and telephones needed by the auditors.

The Contractor agrees to retain all books, records, and other documents relative to the contract which results from this RFP for five (5) years after final payment, or until the conclusion of any audit by the Commonwealth, whichever is sooner. The Department, its authorized agents, and State Auditors, shall have full access to, and the right to examine, any of the Contractor's materials relevant to the contract which results from this RFP.

8.7 CONTRACT REPRESENTATIVES

Both the Department and the Contractor shall appoint a contract representative who shall ensure that the provisions of this contract are adhered to.

The Contractor shall provide the full name and address of their contract representative including telephone and fax number. In the event of a change in contract representatives, an official written notice shall be provided within 15 days of the change.

The Department reserves the right, after adequate notice, to require the Contractor to replace any members of the State or TLC health plan's dedicated account team.

8.8 CERTIFIED CORPORATE ANNUAL REPORTS

Within 120 days of the close of its fiscal year, the Contractor shall furnish to the Department an annual report of its consolidated operations. This report shall be certified by an independent auditor. In the event that a bundled submission is selected, reports from all partners of the Contractor are required.

8.9 CONFIDENTIALITY OF INFORMATION

The Contractor shall treat all information utilized in its performance of the contract as confidential, personal information. The Contractor shall handle all confidential information in accordance with the Virginia Privacy Protection Act, Virginia Code Section 2.1-377 et seq and with the privacy and security provisions of the Health Insurance Portability and Accountability ACT (HIPAA). All files, computer data bases and other records developed or maintained pursuant to the execution of the contract are the property of the Department, and shall be delivered to the Department upon demand. The Contractor merely serves as the custodian of the files, and acts as agent for the Department in the

payment for services and the performance of other assigned tasks, including assisting the Department with requests under the Virginia Freedom of Information Act.

8.10 COMMISSIONS AND BROKERAGE FEES

The Contractor agrees that, in the performance of this contract, no payments shall be made to brokers or sales persons who are not employees of the Contractor.

8.11 SEVERABILITY

In the event any portion of the contract shall be determined by a court of competent jurisdiction to be invalid or unenforceable, such provision shall be deemed void and the remainder of the contract shall continue in full force and effect.

8.12 ELIGIBILITY

The Department shall determine who is eligible for the employee Health Benefits program.

8.13 EMPLOYER CONTRIBUTIONS TOWARDS PREMIUMS

The Department shall set the employer contribution for all plans. Generally, the employer shall contribute the same percentage of the total premium which the employer contributes to the state wide PPO plan or the actual dollar amount, whichever is less, further adjusted to account for the age and sex of employees actually enrolled in other plans and the Department's cost of administering all plans.

8.14 FORCE MAJEURE

Neither party shall be deemed to be in default of any of its obligations hereunder, if, and so long as, it is prevented from performing such obligations by an act of war, hostile foreign action, nuclear explosion, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

8.15 INTERNET SITE

Contractor agrees to maintain dedicated Internet sites devoted to enrollees covered under the employee health benefits program and TLC. As a minimum, the sites shall contain the following.

8.15.1 if applicable, a link to the Contractor's current provider directory with a capability to locate providers by geographic locations and type of practice

8.15.2 the data specified in paragraph 6.3.

8.15.3 an outline of coverage

8.15.4 other information about the plan

8.15.5 secure access to claims information by participants

8.15.6 access to comparison cost and quality information for participating providers.

8.16 SUBCONTRACTING

The Contractor is fully responsible for all work performed under the contract. The Contractor may not assign, transfer, or subcontract any interest in the contract, without prior written approval of the Department. The Contractor shall require all subcontractors to comply with all provisions of this RFP. The Contractor will be held liable for contract compliance for all duties and functions whether performed by the Contractor or any subcontractor.

8.17 DISPUTES

In accordance with section 2.2-4363 of the Code of Virginia, disputes arising out of the contract, whether for money or other relief, may be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Director of the Department of Human Resource Management at the James Monroe Building, 12th Floor, 101 North 14th Street, Richmond, Virginia 23219. Disputes will not be considered if submitted later than sixty (60) days after the final payment is made by the Department under the contract. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at the time of the occurrence or at the beginning of the work upon which the dispute is based. The Department shall render a final written decision regarding the dispute not more than ninety (90) days after the dispute is submitted, unless the parties agree to an extension of time. If the Department does not render its decision within 90 days, the Contractor's sole remedy will be to institute legal action, pursuant to section 2.2-436411-70 of the Code of Virginia. The Contractor shall not be granted relief as a result of any delay in the Department's decision. During the time that the parties are attempting to resolve any dispute, each party shall proceed diligently to perform its duties.

8.18 CONTRACTOR AFFILIATION

If an affiliate (as defined below in this paragraph) of the Contractor takes any action which, if taken by the Contractor, would constitute a breach of the contract, the action taken by the affiliate shall be deemed a breach by the Contractor. "Affiliate" shall mean a "parent," subsidiary or other company controlling, controlled by, or in common control with the Contractor, sub Contractor or agents of the Contractor.

8.19 TRANSFER OF FILES

If for any reason the Department decides to no longer contract with the Contractor, the Contractor agrees to transfer to the party designated by the Department, at no cost, all data, records, computer files, other files, and materials of any sort that were maintained for the Commonwealth. The Contractor agrees to assist the Department in understanding, using, and transferring all files and records, including those maintained in computer language.

8.20 ADVERTISING

In the event a contract is awarded as a result of this RFP, the Contractor shall not advertise that the Commonwealth of Virginia, or any agency or institution of the Commonwealth, has purchased, or uses its products or services.

8.21 INDEMNIFICATION

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages, and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the Department.

8.22 ANNUAL ENROLLMENT

The Department will provide employees an annual opportunity to change health benefits plans or types of membership. Contractor agrees to follow all instructions of the Department with respect to the conduct of the annual enrollment, including and especially the form and content of information supplied to eligible persons. The Contractor agrees to supply to agencies and TLC employers sufficient quantities of benefits booklets and brochures, both written and electronically, for the orderly conduct of annual enrollment activities. Annual enrollment expenses are the responsibility of the Contractor and are to be absorbed in its administrative costs. There will be no special recognition of annual enrollment expenses without the prior agreement of the Department.

Enrollment and changes in the state group are currently accomplished by paper form or online by participants through the Department's Web based system, EmployeeDirect also referred to as E-Direct. Changes through EmployeeDirect are automatically updated real time in the Department's Benefits Eligibility System (BES) which serves as the central, sole source of all eligibility and enrollment information to Contractors, including those enrollees whose premium is direct billed. See Appendix 5 for more detail. The Department has implemented a personal identification number for participants, which is not a Social Security number.

The local employers currently conduct enrollment in the TLC program each April and May prior to the new fiscal year (July 1) or August and September for certain school groups prior to October 1. The plans offered by each employer are group specific to that employer with the completed forms returned to the medical/surgical carriers by early June to allow for delivery of ID cards by the July 1 effective date or early September for October 1 effective date. The TLC current procedures are discussed in greater detail in Appendix 6.

8.23 HIPAA PRIVACY BUSINESS ASSOCIATES AGREEMENT

The Contractor agrees to be bound by the HIPAA Privacy Business Associates Agreement. This agreement must be executed prior to any contract award. See Exhibit ONE.

8.24 CHANGES IN PARTICIPATING PROVIDERS

The Plan shall require, among other things, that the provider will abide by the provisions of the agreement with the Plan for a full contract year with respect to State and TLC employees, except for such changes as retirement, abandonment of practice, etc. This provision does not apply to staff/group type HMOs. Note well that the end of the contract year for many, but not most, TLC groups is September 30, not June 30.

8.25 MAILINGS AND NOTICES

The Medical/Surgical Contractor agrees to notify retiree group participants and extended coverage enrollees annually in a form acceptable to the Department of changes, regardless of under which product they fall, in premiums and benefits or other contract amendments in a form acceptable to the Department. All notices shall be mailed first class. Each Contractor agrees to supply group administrators with all necessary forms and supplies.

Contractor will strictly limit the content and form of mailings and notices, other than claims related transactions, to the benefits booklet and brochure cited in paragraphs 6.2 and 6.3 and an approved cover letter, unless otherwise approved by the Department. Benefits booklets and brochures shall be printed in black ink on plain white paper, grade number 3, 50 pound offset, without any illustrations except graphs to illustrate HEDIS data. Under no circumstances will any communication of the Contractor, written or verbal, compare its cost, benefits, or performance with that of another plan in the employee health benefits program without express permission from the Department. The logo of the Department and the title of the document shall be the most prominent features on the first page of each document.

Contractor will never generate mass correspondence without review and approval of the Department.

8.26 IDENTITY THEFT:

The Contractor assures that any and all personal information and data obtained as a result of performing contractual duties associated with this contract shall be held in strict confidence. Such information shall not be divulged without written permission from the individual and this Agency.

8.26.1 All personal information whether electronic or hard copy shall be stored in a manner that will prevent intrusion by unauthorized persons.

8.26.2 All intrusions or suspicion of intrusion into secured files containing personal information shall be reported to the Agency within 24 hours of detection.

8.26.3 All remedies suggested by the Contractor shall be approved by the Agency prior to being implemented.

Office of State Health Benefits Programs
of the
Department of Human Resource
Management

H I PAA Privacy
Business Associate
Agreement
With
(Insert Company Name)

Effective Date:
(Insert Date)

Group Health Plan Business Associate Agreement

This agreement (“Agreement”) is effective as of (insert date) and is made among (insert vendor name) (“Claims Administrator”), and the Commonwealth of Virginia Group Health Plan, administered by the Office of Health Benefits Programs (“Plan”) for the Department of Human Resource Management.

WITNESSETH AS FOLLOWS:

WHEREAS, the Commonwealth of Virginia has established and maintains the Plan as a program that provides health care coverage for employees pursuant to § 2.2-2818 of the Code of Virginia. The Plan meets the definition of a “health plan” under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64);

WHEREAS, the Plan has retained Claims Administrator to provide certain administrative services with respect to the Plan which are described and set forth in a separate Administrative Services Agreement among those parties procured under RFP numbered OHB06-1 (“ASO Agreement”) which is in effect on the effective date of this Agreement, as amended or replaced from time to time;

WHEREAS, the parties to this Agreement desire to establish the terms under which Claims Administrator may use or disclose Protected Health Information (as defined herein) such that the Plan may comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64) (“HIPAA Privacy Regulations”);

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan, and Claims Administrator hereby agree as follows:

PART 1—CLAIMS ADMINISTRATOR’S RESPONSIBILITIES

I. PRIVACY OF PROTECTED HEALTH INFORMATION

A. Confidentiality of Protected Health Information

Except as permitted or required by this Agreement, Claims Administrator will not use or disclose Protected Health Information without the authorization of the Covered Person who is the subject of such information or as required by law.

B. Prohibition on Non-Permitted Use or Disclosure

Claims Administrator will neither use nor disclose Covered Persons’ Protected Health Information except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by the Plan, (3) as authorized by Covered Persons, or (4) as required by law.

C. Permitted Uses and Disclosures

Claims Administrator is permitted to use or disclose Covered Persons’ Protected Health Information as follows:

1. Functions and Activities on Health Plan’s Behalf

Claims Administrator will be permitted to use and disclose Covered Persons’ Protected Health Information

- a. for the management, operation and administration of the Plan,
- b. for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 Code of Federal Regulations § 164.501, and
- c. as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties provided such use or disclosure would not violate the HIPAA Privacy Regulations if done by the Plan.

2. Claims Administrator's Own Management and Administration

a. Protected Health Information Use

Claims Administrator may use Covered Persons' Protected Health Information as necessary for Claims Administrator's proper management and administration or to carry out Claims Administrator's legal responsibilities.

b. Protected Health Information Disclosure

Claims Administrator may disclose Covered Persons' Protected Health Information as necessary for Claims Administrator's proper management and administration or to carry out Claims Administrator's legal responsibilities only (i) if the disclosure is required by law, or (ii) if before the disclosure, Claims Administrator obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will (x) hold Covered Persons' Protected Health Information in confidence, (y) use or further disclose Covered Persons' Protected Health Information only for the purposes for which Claims Administrator disclosed it to the entity or as required by law; and (z) notify Claims Administrator of any instance of which the entity becomes aware in which the confidentiality of any Covered Persons' Protected Health Information was breached.

3. Miscellaneous Functions and Activities

a. Protected Health Information Use

Claims Administrator may use Covered Persons' Protected Health Information as necessary for Claims Administrator to perform Data Aggregation services, and to create Deidentified Information, Summary Health Information and/or Limited Data Sets.

b. Protected Health Information Disclosure

Claims Administrator may disclose, in conformance with the HIPAA Privacy Regulations, Covered Persons' Protected Health Information to make disclosures of Deidentified Information, Limited Data Set Information, and Summary Health Information, and to make Incidental Disclosures.

4. Minimum Necessary

Claims Administrator will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Covered Persons' Protected Health Information to accomplish the intended purpose.

D. Disclosure to Plan and the Commonwealth (and their Subcontractors)

Other than disclosures permitted by Section I.C above, Claims Administrator will not disclose Covered Persons' Protected Health Information to the Plan, the Commonwealth, or any business associate or subcontractor of such parties except as set forth in Section VIII.

E. Disclosure to Claims Administrator's Subcontractors and Agents

Claims Administrator will require each subcontractor and agent to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Covered Persons' Protected Health Information as this Agreement applies to Claims Administrator.

F. Reporting Non-Permitted Use or Disclosure

Claims Administrator will report to the Plan within 5 business days any use or disclosure of Covered Persons' Protected Health Information (whether by itself or by its subcontractors) not permitted by this Agreement or in writing by the Plan of which Claims Administrator becomes aware.

G. Termination for Breach of Privacy Obligations

Without limiting the rights of the parties set forth in the ASO Agreement, the Plan will have the right to terminate the ASO Agreement if Claims Administrator has engaged in a pattern of activity or practice that constitutes a material breach or violation of Claims Administrator's obligations regarding Protected Health Information under this Agreement and, on notice of such material breach or violation from the Plan, fails to take reasonable steps to cure the breach or end the violation. The Plan will follow the notice of termination procedures as set forth in the ASO Agreement.

H. Disposition of Protected Health Information

1. Return or Destruction Upon ASO Agreement End

The parties agree that upon cancellation, termination, expiration or other conclusion of the ASO Agreement, destruction or return of all Protected Health Information, in whatever form or medium (including in any electronic medium under Claims Administrator's custody or control) is not feasible given the regulatory requirements to maintain and produce such information for extended periods of time after such termination. In addition, Claims Administrator is required to maintain such records to support its contractual obligations with its vendors and network providers. Claims Administrator shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those consistent with applicable law for so long as Claims Administrator, or its subcontractors, maintains such Protected Health Information. Claims Administrator may destroy such records in accordance with its record retention policy that it applies to similar records, except to the extent a longer period of time is specified by the ASO Agreement or the law.

2. Exception When Claims Administrator Becomes Plan's Health Insurance Issuer

If upon cancellation, termination, expiration or other conclusion of the ASO Agreement, Claims Administrator (or an affiliate of Claim Administrator) becomes the Plan's health insurance underwriter, then Claims Administrator shall transfer any Protected Health Information that Claims Administrator created or received for or from the Plan to that part of Claims Administrator (or affiliate of Claims Administrator) responsible for health insurance functions.

3. Survival of Termination

The provisions of this Section I.H. shall survive cancellation, termination, expiration, or other conclusion of the ASO Agreement.

II. ACCESS, AMENDMENT AND DISCLOSURE ACCOUNTING FOR PROTECTED HEALTH INFORMATION

A. Access

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests for access to their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Claims Administrator will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Covered Person (or the Covered Person's personal representative), any Protected Health Information about the Covered Person created or received for or from the Plan in Claims Administrator's custody or control, so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

B. Amendment

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests to amend their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

Upon receipt of written notice (includes faxed and e-mailed notice) from the Plan, Claims Administrator will amend any portion of the Protected Health Information created or received for or from the Plan in Claims Administrator's custody or control, so that the Plan may meet its amendment obligations under 45 Code of Federal Regulations § 164.526.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

C. Disclosure Accounting

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests for an accounting of disclosures of their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

So the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528, Claims Administrator will do the following:

a. Disclosure Tracking

Claims Administrator will record each disclosure that Claims Administrator makes of Covered Persons' Protected Health Information, which is not excepted from disclosure accounting under Section II.C.2.b.

The information about each disclosure that Claims Administrator must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Claims Administrator made the disclosure, (c) a brief description of the Protected Health Information disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512.

For repetitive disclosures of Covered Persons' Protected Health Information that Claims Administrator makes for a single purpose to the same person or entity, Claims Administrator may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

b. Exceptions from Disclosure Tracking

Claims Administrator will not be required to record Disclosure Information or otherwise account for disclosures of Covered Persons' Protected Health Information (a) for Treatment, Payment or Health Care Operations, (b) to the Covered Person who is the subject of the Protected Health Information, to that Covered Person's personal representative, or to another person or entity authorized by the Covered Person (c) to persons involved in that Covered Person's health care or payment for health care as provided by 45 Code of Federal Regulations § 164.510, (d) for notification for disaster relief purposes as provided by 45 Code of Federal Regulations § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are incidental to a use or disclosure that is permitted by this Agreement or the ASO Agreement, (h) as part of a limited data set in accordance with 45 Code of Federal Regulations § 164.514(e), or (i) that occurred prior to the Plan's compliance date.

c. Disclosure Tracking Time Periods

Claims Administrator will have available for the Plan the Disclosure Information required by Section II.C.2.a above for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information (except Claims Administrator will not be required to have Disclosure Information for disclosures occurring before April 14, 3003.

d. Provision of Disclosure Accounting

Upon receipt of written notice (includes faxed and e-mailed notice) from the Plan, Claims Administrator will make available to the Plan, or at the Plan's direction to the Covered Person (or the Covered Person's personal representative), the Disclosure Information regarding the Covered Person, so the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests for an accounting of disclosures. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely accounting to the Covered Person.

D. Confidential Communications

Claims Administrator will promptly, upon receipt of notice from the Plan, begin to send all communications of Protected Health Information directed to the Covered Person to the identified alternate address.

Claims Administrator will respond directly to Covered Persons' requests for a confidential communication. If a Covered Person's request, made to Claims Administrator, extends beyond information held by Claims

Administrator or Claims Administrator's affiliates or agents, Claims Administrator will inform the Covered Person to direct the request to the Plan, so that the Plan may coordinate the request. Claims Administrator assumes no obligation to coordinate any request for a confidential communication of Protected Health Information maintained by other business associates of Plan.

E. Restrictions

The Plan understands that Claims Administrator administers a variety of different complex health benefit arrangements, both insured and self-insured, and that Claims Administrator has limited capacity to agree to special privacy restrictions requested by Covered Persons. Accordingly, the Plan and the agrees that it will not commit Claims Administrator to any restriction on the use or disclosure of Covered Persons' Protected Health Information for Treatment, Payment or Health Care Operations without Claims Administrator's prior written approval.

Claims Administrator will promptly, upon receipt of notice from the Plan, restrict the use or disclosure of Covered Persons' Protected Health Information, provided the Claims Administrator has agreed to such a restriction.

Claims Administrator will not respond directly to Covered Persons' requests to restrict the use or disclosure of Protected Health Information for Treatment, Payment or Health Care Operations. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

III. PLAN'S NOTICE OF PRIVACY PRACTICES

The Plan will be solely responsible for the content of any Notice of Privacy Practices that is created, including that its content accurately reflects the Plan's privacy policies, procedures and practices and complies with all the requirements of 45 Code of Federal Regulations § 164.520. The Plan shall not create any Notice of Privacy Practices that imposes privacy obligations on the Claims Administrator that have not been accepted in writing in advance by the Claims Administrator.

IV. SAFEGUARD OF PROTECTED HEALTH INFORMATION

Claims Administrator will develop and maintain reasonable and appropriate administrative, technical and physical safeguards, as required by Social Security Act § 1173(d) and 45 Code of Federal Regulation § 164.530(c), to ensure and to protect against reasonably anticipated threats or hazards to the security or integrity of health information, to protect against reasonably anticipated unauthorized use or disclosure of health information, and to reasonably safeguard Protected Health Information from any intentional or unintentional use or disclosure in violation of this Agreement.

Claims Administrator will also develop and use appropriate administrative, physical and technical safeguards to preserve the availability of electronic Protected Health Information, in addition to preserving the integrity and confidentiality of such Protected Health Information. "Availability" means the electronic protected health information is accessible and useable upon demand by an authorized person. The "appropriate safeguards" Claims Administrator uses in furtherance of 45 Code of Federal Regulation § 164.530(c), will also meet the requirements contemplated by 45 Code of Federal Regulation Parts 160, 162 and 164, as amended from time to time.

In addition to reporting to the Plan any use or disclosure of Protected Health Information not permitted by the Agreement, Claims Administrator will also report any security incidents of which Claims Administrator becomes aware. A security incident is an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, and involves only electronic Protected Health Information that is created, received maintained or transmitted by or on behalf of Claims Administrator, that is in electronic form

V. NOTICE OF BREACH - OBLIGATIONS AND ACTIVITIES OF CLAIMS ADMINISTRATOR

In the event of any "breach" of "unsecured PHI" in Claims Administrator's control, as both terms are defined in Sec. 13402 of the American Reinvestment and Recovery Act of 2009 ("ARRA") and as clarified pursuant to any regulations adopted pursuant thereto, Claims Administrator shall, in accordance with such section and any applicable regulations

thereunder: (a) notify the Plan of such breach; (b) notify each affected individual of such breach; and (c) provide any other notice, on behalf of the Plan, that is required under ARRA Sec.13402. This notice obligation shall take effect as of the effective date of the notice provisions of ARRA Sec. 13402.

VI. COMPLIANCE WITH STANDARD TRANSACTIONS

On and after October 16, 2003, Claims Administrator will comply with each applicable requirement for Standard Transactions established in 45 Code of Federal Regulations Part 162 when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with the Plan.

VII. INSPECTION OF BOOKS AND RECORDS

Claims Administrator will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information created or received for or from the Plan available to the U.S. Department of Health and Human Services to determine Plan's compliance with 45 Code of Federal Regulations Parts 160-64 or this Agreement.

VIII. MITIGATION FOR NON-PERMITTED USE OR DISCLOSURE

Claims Administrator agrees to mitigate, to the extent practicable, any harmful effect that is known to Claims Administrator of a use or disclosure of Protected Health Information by Claims Administrator or its subcontractors in violation of the requirements of the Agreement.

PART 2—DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN, AND OTHER BUSINESS ASSOCIATES

IX. DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following provisions apply to disclosures of Protected Health Information to the Plan, the Office of Health Benefits Programs for the Department of Human Resource Management in its role as plan sponsor and plan administrator, and other business associates of the Plan on behalf of the Plan. Ownership of Protected Health Information is governed by the ASO Agreement and applicable law.

A. Disclosure to Health Plan

Unless otherwise provided by this Section VII, all communications of Protected Health Information by the Claims Administrator shall be directed to the Office of Health Benefits Programs in its role as plan administrator.

B. Disclosure to the Commonwealth in its Role of Plan Sponsor

Claims Administrator may provide Protected Health Information regarding the Covered Persons in the Plan to the Commonwealth upon the Commonwealth's written request for the purpose either (a) to obtain premium bids for providing health insurance coverage for the Plan, or (b) to modify, amend or terminate the Plan. Claims Administrator may provide information to the Commonwealth in its role of plan sponsor on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any insurance coverage offered by the Plan

C. Disclosure to Other Business Associates and Subcontractors

Claims Administrator may disclose Covered Persons' Protected Health Information to other entities or business associates of the Plan if the Plan authorizes Claims Administrator in writing to disclose Covered Persons' Protected Health Information to such entity or business associate. The Plan shall be solely responsible for ensuring that any contractual relationships with these entities or business associates and subcontractors comply with the requirements of 45 Code of Federal Regulations § 164.504(e) and § 164.504(f).

PART 3—MISCELLANEOUS

X. AGREEMENT TERM

This Agreement will continue in full force and effect for as long as the ASO Agreement remains in full force and effect. This Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the ASO Agreement.

XI. AUTOMATIC AMENDMENT TO CONFORM TO APPLICABLE LAW

Upon the effective date of any final regulation or amendment to final regulations with respect to Protected Health Information, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement or to the ASO Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan, and Claims Administrator remain in compliance with such regulations, unless Claims Administrator elects to terminate the ASO Agreement by providing the Plan notice of termination in accordance with the ASO Agreement at least thirty (30) days before the effective date of such final regulation or amendment to final regulations.

XII. CONFLICTS

The provisions of this Agreement will override and control any conflicting provision of the ASO Agreement or other agreement. All other provisions of the ASO Agreement or other agreement remain unchanged by this Agreement and in full force and effect.

XIII. INTENT

The parties agree that there are no intended third party beneficiaries under this Agreement.

XIV. INTERPRETATION

Any ambiguity in this Agreement or the ASO Agreement or in operation of the Plan shall be resolved to maintain compliance with the rules enacted pursuant to HIPAA Administrative Simplification.

XV. DEFINITIONS

The following terms when used in this Agreement have the following meanings:

- A. “Covered Employee” means the person to whom coverage under the Plan has been extended by the Health Plan and to whom Claims Administrator has directly or indirectly issued an identification card bearing the Plan group number.
- B. “Covered Person” means the Covered Employee and the Covered Employee’s legal spouse and/or unmarried dependent children as specified in the plan document.
- C. “Data Aggregation” means the combining of Protected Health Information that Claims Administrator creates or receives for or from the Plan and for or from other health plans or health care providers for which Claims Administrator is acting as a business associate or a covered entity to permit data analyses that relate to the Health Care Operations of the Plan and those other health plans or providers. (*See* 45 Code of Federal Regulations § 164.501.)
- D. “De-Identified Information” has the same meaning as that term is defined in the HIPAA Privacy Regulations (*See* 45 Code of Federal Regulations § 164.514(b).)

E. “Health Care Operations” mean any of the following activities of a health plan, such as the Plan, as relate to the functions that make it a health plan (*see* 45 Code of Federal Regulations § 164.501):

1. Quality Improvement and Control

- a. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines (except research or other studies or activities that have as their primary purpose obtaining generalized knowledge);
- b. Conducting population-based activities relating to improving health or reducing health care costs;
- c. Conducting protocol development, case management or care coordination;
- d. Contacting health care providers and enrollees (such as Covered Persons) with information about treatment alternatives; and
- e. Conducting other related functions that do not include treatment.

2. Credentialing and Training

- a. Reviewing the competence or qualifications of health care professionals;
- b. Evaluating health care provider performance;
- c. Evaluating health plan performance;
- d. Conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers;
- e. Conducting training of non-health care professionals; and
- f. Conducting accreditation, certification, licensing or credentialing activities.

3. Insuring Functions

- a. Engaging in underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; and
- b. Ceding, securing, or placing a contract of reinsurance of risk relating to claims for health care (including stop-loss insurance), subject to any applicable limitations of 45 Code of Federal Regulations § 164.514(g).

4. Audit and Legal Activities

- a. Conducting or arranging for medical review;
- b. Conducting or arranging for legal services;
- c. Conducting or arranging for audit functions; and
- d. Conducting activities involving fraud and abuse detection or compliance programs.

5. Business Strategy

- a. Engaging in business planning and development;
- b. Conducting cost-management and planning-related analyses related to managing and operating the health plan;
- c. Developing and administering a formulary; and
- d. Developing or improving methods of payment or policies of coverage.

6. Business Management and Administration

- a. Engaging in business management and general administrative activities of the health plan;
- b. Managing activities relating to implementation of and compliance with the requirements for the information privacy, security, transaction standards and other provisions of 45 Code of Federal Regulation Subtitle A, Subchapter C;
- c. Managing customer service, including provision of data analyses for policy holders, plan sponsors, or other customers (provided that no Protected Health Information is disclosed to the policy holders, plan sponsors, or other customers, except as otherwise provided for herein);
- d. Resolving internal grievances;

- e. Creating de-identified health information (consistent with the requirements of 45 Code of Federal Regulations §§ 164.514(a)-(c));
- f. Creating limited data set health information (consistent with the requirements of 45 Code of Federal Regulations § 164.514(e); and
- g. Conducting activities in connection with the sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity.

7. Wellness and Other Health-Related Communication

Provided that these activities are not performed under conditions that would cause the activity to constitute “marketing” as defined in 45 Code of Federal Regulations § 164.501:

- a. Communicating with health plan enrollees about health-related products or services (or payment for such products or services) that are provided by or included in the health plan or that are available only to a health plan enrollee that add value to, but are not part of, a health plan;
- b. Communicating with health plan enrollees about health care providers in the health plan’s networks;
- c. Communicating with health plan enrollees about the health plan’s coverage or benefits, or the replacement of, or enhancements to a health plan;
- d. Communicating with health plan enrollees concerning products or services of nominal value;
- e. Communicating with health plan enrollees face-to-face about any products or services;
- f. Communicating with health plan enrollees by newsletter or similar type of general communication device distributed to a broad cross-section of enrollees or other broad group of individuals; and
- g. Communicating with health plan enrollees for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

F. “Incidental Use or Disclosure” means a secondary use or disclosure that can not reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure under the HIPAA Privacy Regulations. Such a secondary use or disclosure shall only be considered an incidental use or disclosure if reasonable safeguards have been put in place to prevent such use or disclosure.

G. “Individually Identifiable Health Information” means information, including demographic information collected from an individual, that (1) is created or received by a health plan, health care provider, employer, or health care clearinghouse, (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (3) either identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. (*See* 45 Code of Federal Regulations § 164.103.)

H. “Limited Data Set” means Protected Health Information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

1. Names;
2. Postal address information, other than town or city, State, and zip code;
3. Telephone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers, including license plate numbers;
12. Device identifiers and serial numbers;
13. Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers;
14. Biometric identifiers, including finger and voice prints; and

15. Full face photographic images and any comparable images (*See* 45 Code of Federal Regulations § 164.514(e).)
- I. “Payment” means any of the following activities of a health plan, such as the Plan (*see* 45 Code of Federal Regulations § 164.501):
1. Obtaining premium payments or reimbursement for the provision of health care;
 2. Determining or fulfilling responsibility for coverage and provision of benefits under the health plan;
 3. Determining an enrollee’s eligibility or coverage;
 4. Coordinating benefits, determining cost sharing amounts, adjudicating or subrogating health benefit claims;
 5. Adjusting risk amounts due based on enrollee health status or demographic characteristics;
 6. Engaging in billing, claims management, issuance of explanations of benefits, collection activities, and related health care data processing;
 7. Obtaining payment under a contract of reinsurance (including stop-loss insurance and excess loss insurance);
 8. Reviewing health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 9. Conducting utilization review, precertification and preauthorization of services, and concurrent and retrospective review of services; and
 10. Disclosure to consumer reporting agencies not more than the demographic data permitted by 45 Code of Federal Regulations § 164.501 (“Payment” ¶ 2(vi)).
- J. “Plan Administration Functions” means administrative functions performed by a plan sponsor on behalf of a group health plan and excludes functions performed by the plan sponsor in connection with (1) obtaining premium bids for providing health insurance coverage for the group health plan or for modifying, amending or terminating the group health plan, or (2) functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.
- K. “Protected Health Information” means Individually Identifiable Health Information that is transmitted or maintained electronically, on paper, orally or in any other form or medium. Education records covered by the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g); records described in Section 1232g(a)(4)(B)(iv) of Title 20 of the United State Code; and employment records held by a covered entity in its role as an employer are excluded from Protected Health Information. (*See* 45 Code of Federal Regulations § 164.501.)
- L. “Summary Health Information” means information, which may be Individually Identifiable Health Information, (1) that summarizes the claims history, claims expenses, or types of claims experienced by enrollees for whom a plan sponsor has provided health care benefits under a group health plan, and (2) from which the identifiers specified in 45 Code of Federal Regulations § 164.514(b)(2)(i) have been deleted (except that the zip code information described in 45 Code of Federal Regulations § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five (5) digit zip code). (*See* 45 Code of Federal Regulations § 164.504(a).)
- M. “Standard Transactions” mean health care financial or administrative transactions conducted electronically for which standard data elements, code sets and formats have been adopted in 45 Code of Federal Regulations Part 162.
- N. “Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. (*see* 45 Code of Federal Regulations § 164.501)

XVI. REFERENCES

References herein to statutes and regulations shall be deemed to be references to those statutes and regulations as amended or recodified.

SIGNATURES

PLAN: COMMONWEALTH OF VIRGINIA EMPLOYEE GROUP HEALTH PLAN

By: _____
Title: _____
Date: _____

CLAIMS ADMINISTRATOR:

By: _____
Title: _____
Date: _____

Small Business Subcontracting Plan

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of \$10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbe.virginia.gov (Customer Service).

Offeror Name: _____

Preparer Name: _____ **Date:** _____

Instructions

- A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.
- B. If you are not a DMBE-certified small business, complete Section B of this form. For the offeror to receive credit for the small business subcontracting plan evaluation criteria, the offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified small business in this section. Points will be assigned based on each offeror's

proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the offeror's total price.

Section A

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a **(check only one below)**:

- Small Business
- Small and Women-owned Business
- Small and Minority-owned Business

Certification number: _____ Certification Date: _____

Section B

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

A. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement

Small Business Name & Address DMBE Certificate #	Status if Small Business is also: Women (W), Minority (M)	Contact Person, Telephone & Email	Type of Goods and/or Services	Planned Involvement During Initial Period of the Contract	Planned Contract Dollars During Initial Period of the Contract

Totals \$					

List of Appendices

- Appendix 1 Current Standard Contract
- Appendix 2 Selected Enrollment, Costs, Workload, Demographics and Utilization for State Employees
- Appendix 3 Website Links for Benefit Program Descriptions and Current Forms
- Appendix 4 Enrollment for TLC
- Appendix 5 State Employee Eligibility, Enrollment and Billing
- Appendix 6 TLC Program Administration
- Appendix 7 EDI Website Link
- Appendix 8 Flexible Benefits Program Description
- Appendix 9 Proposal Checklist

Appendix 1

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

STANDARD CONTRACT

This contract is entered into _____, 2008, by _____, hereinafter called "Contractor" and the Commonwealth of Virginia, Department of Human Resource Management, hereinafter called "Purchasing Agency."

WITNESSETH that the Contractor and the Purchasing Agency, inconsideration of the mutual covenants, promises and agreements herein contained, agree as follows:

SCOPE OF SERVICES: The Contractor shall provide the services to the Purchasing Agency as set forth in the Contract Documents.

PERIOD OF CONTRACT:

COMPENSATION AND METHOD OF PAYMENT: The Contractor shall be paid monthly according to the terms of its accepted proposal.

CONTRACT DOCUMENTS: The Contract Documents shall consist of this signed Contract; the Request for Proposals; proposal submitted by the contractor dated _____, _____; the general conditions, special conditions, specifications, and other data contained in the Request for Proposals.

Any contractual claims shall be submitted in accordance with the contractual dispute procedures set forth in the Request for Proposals.

In witness whereof, the parties have caused this Contract to be duly executed intending to be bound thereby.

CONTRACTOR:

PURCHASING AGENCY:

BY: _____

By: _____

Print Name

Print Name

Title: _____

Title: _____

Date: _____

Date: _____

Appendix 2

Selected Enrollment, Cost, Workload, Demographic and Utilization for State Employees

Files containing claims, enrollment data and the Attachment 2 schedules you will need to prepare and submit a proposal are available in electronic form. To obtain these files, please send email to Jim Rogers (james.rogers@aonhewitt.com) and Leah Snider (leah.snider@aonhewitt.com) with copy to Dan Hinderliter (dan.hinderliter@dhrm.virginia.gov) requesting credentials and instructions necessary to download the files from a secure site.

Please note, these files are proprietary and available only to vendors of the services requested by this RFP

Summary Description of All Plans Offered to COVA and TLC Groups

Please access the web addresses shown for summary benefit descriptions of plans

1. COVACare:

www.dhrm.virginia.gov/hbenefits/cova/covacare.html

2. COVA Connect

www.dhrm.virginia.gov/hbenefits/cova/covaconnect.html

3. The Local Choice

- a. Key Advantage Expanded
- b. Key Advantage 250
- c. Key Advantage 500
- d. Key Advantage 1000

www.thelocalchoice.virginia.gov

Appendix 4

The Local Choice Enrollment July 1, 2010 - June 30, 2011

	<u>Key Advantage Expanded</u>	<u>Key Advantage 250</u>	<u>Key Advantage 500</u>	<u>Key Advantage 1000</u>	<u>HDHP</u>
Average Monthly Enrollment	14,022	7,150	5,036	1,419	195

State Employee Eligibility, Enrollment and Billing

A. Benefits Eligibility System

The Department collects, validates, and distributes data from a central, sole source eligibility and enrollment database known as the Benefits Eligibility System (BES). BES is updated in a real-time environment and contains the official records for State participants and their covered dependents. Participants include all employees, retirees, long-term disability participants, and survivors eligible for coverage. Participants and their dependents are identified by a personal identification number which is not the participant's social security number. Contractors are required to use the personal identification number assigned by the Department on their databases.

Enrollment and changes in enrollment are currently accomplished by paper form or online by participants through the Department's Web-based system, EmployeeDirect, also referred to as E-Direct. Changes through EmployeeDirect are automatically updated real time in BES. Agency benefits administrators can also update BES.

The Department uses data in BES to provide the Contractor with eligibility information in the HIPAA 834 Transaction File format as described on the DHRM Website (<http://web1.dhrm.virginia.gov/itech/itdocs.htm>). Two types of files are provided:

The Daily Change File which includes maintenance transactions that add or terminate coverage. Change transactions are provided as term/add pairs. Daily Change Files are provided Tuesday through Saturday and are to be processed by the Contractor within one business day.

The Monthly Audit File is provided on the 3rd of each month and contains the State's full, active membership as of the 1st day of that month. It is used only for comparison of information between the Department's database and the Contractor's database. The Contractor is expected to report discrepancies found in the comparison to the Department no later than the 20th of that month.

The Contractor must connect to the Department's secure FTP server for file transfers by one of the following protocols: SFTP using SSH2 on port 22; or HTTPS for manual retrieval. It is expected that Contractors update their databases on a regular basis to provide for accurate claims processing.

B. Billing for Self Funded Plans

The services billed under the self-funded plans fall into two categories. These are billing for claims payments and billing for administrative fees (Section 4.0) as records accumulated, and invoiced in total to the Department on a weekly basis. The Department's staff reviews the invoice when it is received and processed for

payment. The Contractor(s) will be reimbursed for payment within three business days through an electronic transfer of funds. The Contractor(s) is responsible to set up their payment and bank information through the Department of Accounts Electronic Data Interchange (EDI) web site.
http://www.doa.virginia.gov/General_Accounting/EDI/EDI_Main.cfm

The billing documentation will at a minimum consist of: a cover invoice which provides the net claim dollars to be paid broken between the state employee and the TLC program, and support documentation for each program that provides the claims dollars paid for each benefit category during the period covered by the invoice and year to date. This procedure will be finalized with each Contractor as part of the negotiation process and the cycle may be varied based upon compelling reasons, such as claim volume and dollars.

The administrative expenses are invoiced monthly to the Department by each Contractor by the 15th of the following month. In this process, the Department will review the invoice and authorize reimbursement through the EDI process. Again the billing documentation will consist of a cover invoice providing the administrative dollars in total for each program with a summary for all programs, and documentation which supports the summary invoice. This support will at minimum consist of a breakdown by each program of billing units by price per unit, shown for the current period and year to date. The number of billing units for each employer under the TLC program will also be required. The monthly administrative invoice may also be used as the financial transfer document for miscellaneous non-claim items that are either due from or to the Department when supported by clear documentation. This procedure will also be finalized during final negotiations.

C. Billing for Fully Insured Plans

The Department makes monthly premium payments to all fully insured carriers by a self-billing procedure based on the BES records as of the first day of each month of coverage. The self-billing process is run on the fifth working day of each month of coverage based on all first day eligibles and takes into consideration any retroactive changes. The self-billing file includes all eligibles for a Contractor shown by agency and premiums due. The file is transferred electronically to the carrier and at the same time generates the request for payment. An EDI transfer around the 10th working day of each month makes payments. (See Appendix 7 for a description of the Commonwealth's EDI payment system and forms required to be completed)

THE LOCAL CHOICE (TLC) PROGRAM ADMINISTRATION

A. Adoption by Local Governmental Employer Groups

The TLC was established by the General Assembly of Virginia to provide an optional source of health insurance benefits to local government entities within Virginia. The program operates under regulations established by the Commonwealth of Virginia and enrolled its first member groups on July 1, 1990. The regulations require that a prospective group complete a formal application, and the Department's underwriters provide the applicant with monthly premiums for each of the plans which are available to the group based on area of the state. A group may join the program at the beginning of any month, but all groups renew with a July 1 effective date (except for a few school groups who may choose an October 1 renewal date). A prospective group joins the program by completing a legal adoption agreement and submitting a document containing the plan choices that they will offer to their employees. The choice of the plans is an employer decision and their employees may only choose from the plans selected. At this time all selected Contractors are notified and the Contractor's representatives meet with the group and provide them with the material needed to conduct an open enrollment.

B. Enrollment by employees of TLC Member Groups

Each member group conducts an open enrollment process prior to the start of each plan year. For the renewing groups, this Municipal plan open enrollment is normally held during the months of April and May. Schools frequently hold open enrollment in August and September. Open enrollments will vary in length and formality depending upon the group's size and other influencing factors. Standard enrollment/waiver forms are provided to the groups by the program, along with summary information on plans offered. Each Contractor is required to provide a toll free customer service line to provide information about their plan and to receive orders for plan specific materials from either individuals or to ship in bulk supply to the group's benefit administrator.

Each member group defines their eligible employees within the policies of the TLC program's eligibility rules. A group is required to complete the enrollment process and provide each selected plan with completed enrollment/waiver forms or electronic files by June 1 or early in September for certain School groups. This allows each plan at least 30 days in which to set up the enrollees on their membership system, issue identification cards, and provide the current July or October billing to the groups.

C. Membership Files and Group Billing

Each Contractor is responsible for collecting, validating, and distributing eligibility data for enrollees of any TLC group that selects their plan as one of the group offerings. It is the intent of the program to develop a consolidated eligibility and

enrollment database and claims history database as is used with the state employee program, but this may not be in place at the effective date of this contract. Therefore, the Medical/Surgical Contractor may be required to maintain eligibility records and distribute the TLC eligibility to all Contractors or each Contractor with a plan offered to a TLC group may be required to handle the membership functions as if the group was one of their direct contracted groups.

The monthly premium billing to TLC groups plans is due to the group by the 20th of the month preceding the month of coverage. Payments are due back to the plan by the first day of the coverage month with normally a 10-day grace period for late payments to be received. This monthly billing and reconciliation should be handled by the plans like it is done with groups, which are contracted with directly. The billing of the self-funded plans to the Department for claims payments was described previously in Appendix 7.

For self-funded plans, the premiums collected during any month are transferred to the Department by the 5th working day of the following month. The premiums submitted should be shown by group and coverage period with total dollars by plan. For fully insured plans, the carrier retains the premiums.

D. Renewal Process

Each year, TLC member groups go through a formal renewal process in which they are provided the full menu of plans available in their area with the premiums for the upcoming plan year. The renewal process starts on September 15th prior to the upcoming July 1 or October 1 effective date when each carrier is required to provide firm premiums for the next year. The communications development for the upcoming year begins immediately with the involvement of all Contractors. The paid claims data for the self-funded plans is pulled through December 31st for each member group and is entered into the tabular rating system along with current demographics and the costs of the pooled products (Medical/Surgical, Dental, Behavioral Health, and Prescription Drugs). The program underwriters proceed to develop rates by group for each self-funded plan and print a complete proposal including any fully insured plans available in the TLC group's area. Proposals are assembled and delivered to member groups by February 28th. The groups then have until April 1st, or July 1st for certain school groups, to either renew or withdraw from the program. Renewing groups conduct open enrollment during April and May or August and September for certain school groups and are responsible for getting enrollment changes to the appropriate carrier by June 1st or early September for certain school groups.

Electronic Data Exchange (EDI)

All payments to Contractors will be made by EDI. The Financial Handbook and forms to be completed are found at the Web location below:

http://www.doa.virginia.gov/General_Accounting/EDI/tradingpartnerguide.pdf

Flexible Benefit Plan

The Department established a flexible benefits plan for the Commonwealth of Virginia employees with the first plan year effective July 1, 1990. Effective January 1, 1996, the plan year was changed to a calendar year basis. On July 1, 2004, the plan year was returned to a fiscal year and all foreseeable future plan years will continue on that basis. The current contract with Fringe Benefits Management Company, a division of WageWorks, Inc. is scheduled to run through June 30, 2013.

The Commonwealth's Flexible Benefits Plan consists of three parts: (1) Premium Conversion, (2) Dependent Care Reimbursement Accounts and (3) Medical Reimbursement Accounts. The services procured under this RFP pertain only to the two reimbursement account plans. There are approximately 95,000 eligible employees in the Commonwealth. The current enrollment in the medical reimbursement account is 11,300 with an average annual election of \$2,900.00 and 1,475 in the dependent care account with an average annual election of \$3,800.00.

Currently, employees of over 200 state agencies, located across the state are eligible to participate in the Commonwealth's Flexible Reimbursement Accounts Program. **Included in the state agencies are seven institutions of higher education and four authorities that have decentralized their payroll activities from the central payroll system. As a result, an Offeror submitting a proposal must have the capability of processing enrollee contribution information from multiple sources.**

Proposal Checklist

Complete the form below in full, sign in blue ink the completion certification at the bottom of the form, and enclose it following the Cover Sheet as directed in RFP Section 6.

Offeror:

1.a. Indicate the plan design you have proposed by checking the appropriate blocks:

Plan Scope	Benefits*				
	Medical w/ Vision and Hearing	Behavioral Health w/ EAP	Rx.	Dental	Flexible Spending Account
1 Statewide Plan					
3 Less than Statewide PPO, POS/PPO					
4 Health Maintenance Organization HMO					

*Note: Mark any benefit plans quoted on a fully insured basis with an asterisk.

1.b. If you have proposed an HMO or PPO with less than statewide coverage, check the block below to affirm that you have attached a copy of your HMO license showing the cities/counties comprising your service area.

- (1) HMO license showing service area enclosed with Tab 1.
- (2) Quoting under exception provision as briefly described below.

2. If you have proposed any network-based plans (i.e., plan designs (2) (3) & (4) in 1.a. above), affirm by checking the appropriate blocks below, that you meet the Mandatory Minimum Qualifications stated in RFP. Your affirmation will also declare your intent to submit appropriate documentation as may be required to demonstrate these qualifications are met throughout the contract period.

<i>Mandatory Qualifications for Contractors</i>	Meet Standard (3)
a. Meet GeoAccess standard as specified in Section 2, or	
b. Will apply for Certificate as specified in Section 2.4.1	
c. Will submit HEDIS report annually	
d. Will submit specified member satisfaction results annually	
e. Comply with NCQA requirement	
f. Comply with Section 2.4.4. area coverage requirement (or claim test file	

<i>Mandatory Qualifications for Contractors</i>	Meet Standard (3)
requirement)	
g. Comply with toll-free service requirement	

3. Affirm below that you are in agreement with the Standards of Performance specified in RFP Section 3, including the Schedule of Liquidated damages, and will provide the requested documentation and claims tapes substantiating your performance and will meet the claims file test requirements if you are a finalist.

<i>Statement</i>	Agreement (3)

4. Affirm, by checking the appropriate block below, that you have completed and submitted all of the following required proposal components as required in RFP Section 6.

<i>Proposal Component</i>	Completed and Submitted (3)
a. Cover Sheet, original signed in blue ink	
b. This Proposal Checklist and Questionnaire, original signed in blue ink	
c. Redacted version of submission excluding Confidential/Proprietary information	
d. Redlined version of the RFP showing all demurrals	
e. Benefits exceptions description	
f. Benefits brochure	
g. All questionnaires and exhibits as required in formats specified in Attachment 2	
i. Small, Women, and Minority-Owned Business detail (Exhibit Two)	

5. **Virginia State Corporation Commission (SCC) registration information. The offeror:**

is a corporation or other business entity with the following SCC identification number: _____ -

-OR-

is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from offeror's out-of-state location) **-OR-**

is an out-of-state business entity that is including with this proposal an opinion of legal counsel which accurately and completely discloses the undersigned offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

****NOTE**** >> Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver):

LIST OF ATTACHMENTS

1. Benefit/Program Description
2. Technical/Cost Questionnaire/Schedules/Claim & Eligibility Data
3. Report Formats

Attachment One

Benefit/Program Description

<http://www.dhrm.virginia.gov/hbenefits/employeestoc.html>

Attachment Two

Technical/Cost Questionnaire/Schedules/Claim & Eligibility Data

Files containing claims, enrollment data and the Attachment 2 schedules that you will need to prepare and submit a proposal are available in electronic form. To obtain these files, please send email to Jim Rogers (james.rogers@aonhewitt.com) and Leah Snider (leah.snider@aonhewitt.com) with copy to Dan Hinderliter (dan.hinderliter@dhrm.virginia.gov) requesting credentials and instructions necessary to download the files from a secure site.

Please note that these files are proprietary and available only to vendors of the services requested by this RFP.

Report Formats

Report Formats

The general form and contents of each contractor submitted report are outlined below. It is not the intent of the Department to require special designed reports if the Contractor has a standard report format that will satisfy the Department's needs for oversight of the various programs. However, the Department reserves the right to require a special report design if the standard reports are not satisfactory, in the Department's opinion. Offeror shall submit a sample report with the final format and details to be determined during the negotiation process. The primary reports are addressed below, however the Offeror should submit a sample of any requested report, whether identified below or not.

1. Weekly Claims Report

A. Cover Letter – Each report provides Cover Charges broken by the following categories:

- (a) State Employees, and Early Retirees
- (b) TLC Government,
- (c) TLC Schools, and
- (d) Total column. Each column will reflect any applicable discounts on a separate line and show net charges by category. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

B. An Excel spread sheet for each category will provide a detail of covered charges broken by type of charge. Examples can be: Inpatient, Hospital, Vision, EAP, Mail order, etc. The spreadsheet shall provide a Plan Year-To-Date column followed by month-to-date column and a separate column for each week of the current month.

2. Administrative Fee Report – Monthly Invoice

A. Cover Letter – Each report provides Monthly Administrative Fees broken by the following categories:

- (a) State Employees, and Early Retirees,
- (b) TLC Government,
- (c) TLC Schools, and
- (d) Total column. Any pre-approved charges or credits will be shown under each category and added to or subtracted from the categories fees. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

B. Support Documentation

- (a) Enrollment summary – For each category in A, the enrollment by plan within that category will be provided along with the applicable fee singularly and in total for all units within the plan. A Y-T-D column shall also be provided for each enrollment line. The total for all units within a category shall be the amount invoiced in A above.

NOTE: THE DEPARTMENT WILL AUDIT EACH MONTH'S REPORTED ENROLLMENT BY THE CONTRACTOR. A VARIANCE IN EXCESS OF 0.5% (1/2 OF A PERCENT) FROM THE ENROLLMENT SHOWN ON BES MAY RESULT IN A DELAY IN PAYMENT OF THE INVOICE UNTIL THE DISCREPENCY IS RESOLVED. SEE LIQUIDATED DAMAGES SCHEDULE AS PERTAINS TO ELIGIBILITY FILES NOT PICKED UP TIMELY.

- (b) Pre Approved Charges or Credits – A schedule of any charges or credits will be included by category as provided in A above. Support documentation for such charges/credits must be provided.

3. TLC Monthly Income Report

This report pertains to the ASO contractor for medical/surgical benefits only (See paragraph 4.1.6 in RFP OHB03-2). The report shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format and E-mailed on the 8th day after the close of the month.

4. Monthly Service Report

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month. The report shall be contained one page, if possible, and address all Standards of Performance, Section 3.0, except for the annual premium projections due by September 15th. The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. Examples of headings, if applicable, would be: network, participants, customer service call statistics, claims activities, cycle time, inventory, accuracy rates, COB savings, claims dollars paid (by plan and by enrollee), EAP services, and pharmacy scripts by tier. Additional columns should show standards, if applicable, YTD statistics, and most recent two quarters of activity broken by month.

5. Monthly/Quarterly Utilization Management Report

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month/quarter. The report shall be contained one page, if possible. The purpose of this report is to disclose the Contractor's assessment of its utilization management activities, including admission review, concurrent review and case management. The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. The additional columns should show the activity YTD, the current month, average of the past 3 months, and average of past 12 months. In addition to the utilization report described above, the Contractor shall submit support reports that allow the Department to monitor utilization by the specific product covered.

Examples of, but not limited to, such reports are:

- (a) Medical and MISA - Large inpatient claims expected to exceed \$100,000 with amount paid to date and expected total
- (b) Pharmacy – Top 10 drugs processed by quantity and dollar volume.
- (c) EAP – Services requested and provided by type.
- (d) Interventions provided – Type and quantity for disease and pharmacy management.