STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION, BENEFITS ADMINISTRATION

REQUEST FOR PROPOSALS #31786-00184 AMENDMENT #ONE FOR THIRD PARTY ADMINISTRATOR SERVICES FOR A VARIABLE COPAY BENEFIT PLAN DESIGN

DATE: November 15, 2024

RFP #31786-00178 IS AMENDED AS FOLLOWS:

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

EVENT	TIME (central time zone)	DATE
1. RFP Issued		October 16, 2024
2. Disability Accommodation Request Deadline	2:00 p.m.	October 22, 2024
3. Pre-response Conference	1:00 p.m.	October 23, 2024
4. Notice of Intent to Respond Deadline	2:00 p.m.	October 24, 2024
5. Written "Questions & Comments" Deadline ***NOTE: Submit written questions and comments on Appendix 7.21 the written questions and comments template.**	2:00 p.m.	October 31, 2024
6. State Response to Written "Questions & Comments"		November 15, 2024
7. Written "Questions & Comments" Deadline ROUND 2 ***NOTE: Respondents may submit no more than five (5) questions to the State in the 2nd round of Written Questions and Comments.**	2:00 p.m.	December 4, 2024
8. State Response to Written "Questions & Comments" ROUND 2	2:00 p.m.	December 20, 2024
9. Response Deadline	2:00 p.m.	January 10, 2025
10. State Completion of Technical Response Evaluations		February 4, 2025
11. State Schedules Respondent Oral Presentations		February 6-7, 2025
12. Respondent Oral Presentations	9 a.m. - 3:30 p.m.	February 18-20, 2025
13. State Opening & Scoring of Cost Proposals	2:00 p.m.	February 21, 2025
14. Negotiations		February 27-March 3, 2025

15. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	March 20, 2025
16. End of Protest Period		March 27, 2025
17. State sends contract to Contractor for signature		March 28, 2025
18. Contractor Signature Deadline	2:00 p.m.	April 4, 2025

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

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

RFP SECTION		QUESTION / COMMENT	
	1.	Does the state have any expectations as to the penetration level of the Co-pay plan?	No. The initial target group for this plan are members of the Local Government plan, which includes approximately 17,000 heads of contract and 9,000 dependents for a total of 26,000 members. However, members will have a choice of other plans (currently 3 PPOs and 1 CDHP) so it is unknown how many will choose this option. However, the success of the plan could possibly open it up to members of the Local Education and/or State plans in the future should the Insurance Committees approve that.
	2.	Can you confirm how many HRMIS systems we will need to link/coordinate with or will there be a centralized billing system coordinated by the state?	The state has one HR system, Edison, that will require a connection to our SFTP server for the Contractor to pick up the weekly Eligibility file. Billing is centralized with the State.
	3.	Because of the special arrangement with [REDACTED], the pharmacy benefits are integrated within the product. Are we able to continue package this product to deliver this unique member experience?	No. Pharmacy benefits will not be provided under this contract and will remain carved out to the State's contracted PBM.
RFP Section A.6	4.	As it pertains to the independent financial audit, does a full year independently audited financial statement suffice to meet this requirement.	No. Respondents must follow criteria outlined in RFP Section A.6. Instead of the independent audited financial statements, Respondents are permitted to provide a financial institution's letter of commitment for a general line of credit in the amount of one million dollars ($1,000,000).
RFP Section C.12	5.	Certain staffing is requested by the state. Can this staffing be contingent based on the level of participation within the healthcare plan?	No. None of the staffing roles are required to be dedicated to the account. The roles are required to ensure proper account and contract support, but the individuals can support multiple accounts or contracts.

RFP SECTION		QUESTION / COMMENT	
Pro Forma Contract A.14	6.	The expectations are to do 60 to 70 marketing events annually. Can this be contingent upon number of participants	No. The marketing events occur prior to and during annual enrollment and are the way to gain enrollment of participants. Without attendance at the 60-70 events, it is unlikely that the Contractor will recruit the full opportunity of participants.
Contract Attachment B, Performance Guarantees and LDs	7.	Could the performance guarantees outlined be adjusted based on a sliding scale for membership. Those stated are more appropriate for a complete take-over with an account exceeding 100,000 members. We do not anticipate this slice option generating this participation, especially year one.	The State agrees. See Amendment item #5.
Pro Forma Contract, A.11	8.	Please explain the state's expectations around the value-based initiatives (requirements) and how they want that contract coordinating with a Co-pay driven model, moving members to best cost and quality for that procedure for that specific region.	The State recognizes the importance of value-based programs like patient centered medical homes, in driving cost and quality outcomes at the provider practice level. These programs can coexist with a Variable Copay model as the incentives for the Copay model are patient focused while a PCMH is provider focused. A.11.d is a requirement for any covered transplant procedures regardless of member cost. A.11.e is also a requirement for any covered Bariatric procedures regardless of member cost. A.11.h. allows for point solutions such as virtual physical therapy that could be offered at a lower copay vs. in person if the cost and quality align. A.11.i. is a requirement to ensure access to care. A.11.j. is also a requirement to help aid in diabetes prevention. Ultimately, all value-based programs enhance the effectiveness of any benefit plan.
Pro Forma Contract, A.11.e.	9.	Does the state currently or have plans to carve out certain surgical bundles to a COE vendor solution on a voluntary or mandatory basis? If so, how does the state envision this impacting the variable copay solution?	Yes. The state is currently exploring a carve out COE vendor solution for certain surgical and treatment bundles. If implemented, the state may offer the COE bundles to members as a voluntary benefit option. However, the state may also require members to utilize certain COE bundles for coverage such as bariatric or joint replacements. The

RFP SECTION		QUESTION / COMMENT	
			state will expect the Contractor to work with the carve out COE vendor solution to implement any benefits approved and set forth by the Insurance Committees. See Amendment item #3.

3. Add *pro forma* contract Section A.11.f (any sentence or paragraph containing revised or new text is highlighted). Renumber any subsequent sections as necessary.

f. The Contractor agrees that the State, at the State's sole discretion, may utilize third party services for Centers of Excellence and bundled payment arrangements without objection, charge, or penalty if the State chooses to exercise this right. The Contractor will also, at no charge and as directed by the State, provide support needed by such third party or parties to perform its services including any benefit design changes such as requiring Members to utilize said third party COEs for certain services.

4. Delete *pro forma* contract Section B, Term of Contract in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**. Renumber any subsequent sections as necessary**

B. TERM OF CONTRACT:

This Contract shall be effective on May 1, 2025 ("Effective Date") and extend for a period of sixty-two (62) months after the Effective Date ("Term"). This provides for 8 months of implementation, thirty-six (36) months of service delivery to Members, and 18 months of runout. The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

5. Delete *pro forma* contract Attachment, B, Performance Guarantees in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**. Renumber any subsequent sections as necessary**

PERFORMANCE GUARANTEES	
1. Implementation	
Guarantee	The Contractor shall complete all tasks, deliverables, and milestones included in the project implementation plan, as required in Contract Section A.3.e. necessary to install the program by Go-Live.
Assessment	Five hundred dollars ($500) for each Business Day for each late deliverable and/or milestone leading up to and by Go-Live.
Justification	This is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
2. Operational Readiness	
Guarantee	The Contractor shall resolve all findings identified by the State during its operational readiness review, as required in Contract Section A.3.f., prior to Go-Live.
Assessment	Five thousand dollars ($5,000) per finding if the issue is not resolved prior to Go-Live.
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to Go-Live and operations.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
3. Edison System Interface	
Guarantee	Contractor's interface with the Edison System shall be fully operational by the date specified in Contract Section A.23.a.
Assessment	Five thousand dollars ($5,000) per Business Day beyond the deadline that the interface is not fully operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
4. Call Center Operational	
Guarantee	The Contractor's call center shall be fully operational no later than the date specified in Contract Section A.3.a.
Assessment	Five thousand dollars ($5,000) for every Business Day beyond the deadline that the call center or other system is not operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
5. Program Go-Live Date	
Guarantee	All medical claims administrative services for the Public Sector Plans shall take effect (*i.e.*, "go-live") and be fully operational on or before Go-Live.

Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond Go-Live that medical claims administrative services are not fully operational.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide medical benefits coverage to our Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months Go-Live.
6. Plan Design	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design and State approved covered benefits, see Contract section A.13.a. and A.13.c.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) plus the actual costs incurred of the incorrectly processed claim. This includes any administrative costs incurred by the Contractor or State to correctly reprocess claims or reimburse members and the plan for any overpayment.
Justification	Plan design information must be accurate as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
7. Website and Splash Page	
Guarantee	The Contractor's website and splash page for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information at least thirty (30) days prior to the first day of annual enrollment (generally October 1) as specified in Contract Section A.16.i.
Assessment	One thousand dollars ($1,000) per Business Day, per site until operational or updated.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live and annually thereafter.
8. Initial and Annual Welcome Packet and ID Card Distribution	
Guarantee	Ninety-five percent (95%) of welcome packets and ID cards shall be produced and mailed no later than fourteen (14) days prior to Go-Live and annually as required in Contract Section A.15.d and A.15.i.
Assessment	Five thousand dollars ($5,000) if the guarantee is not met.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three months after Go-Live.
9. Plan Changes	
Guarantee	Unless otherwise directed by the State, the Contractor shall correctly implement any plan design changes annually no later than January 1st of the benefit plan year or within sixty (60) days of written notification from the State for mid-year changes as required in Contract Section A.13.c.

Assessment	Fifteen thousand dollars ($15,000) per incorrect plan design setup such as, but not limited to, incorrect member cost share, incorrect covered services or excluded services.	
Justification	Plan changes must be timely and accurately implemented as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.	
10. Member Notice of Provider Termination		
Guarantee	The Contractor shall provide written notice to members regarding terminated hospitals and physician groups, as specified in Contract Section A.6.k.	
Assessment	Ten thousand dollars ($10,000) per occurrence (defined as each provider termination) if the guarantee is not met.	
Justification	Members must be notified timely of any provider terminations as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.	
11. Medical Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's medical provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.d. and A.6.e. Should there be a deficiency in the network due to the unavailability of licensed providers in a specific area, the Contractor shall provide sufficient documentation and a corrective action plan with their access analysis report to request reconsideration of the access standard for that provider type for the reporting period in question.	
Definition	**Provider Group – Urban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 5 miles
	Obstetricians/Gynecologists	2 physicians within 5 miles
	Pediatricians	2 physicians within 5 miles
	Cardiologists	1 physician within 5 miles
	Endocrinologists	1 physician within 10 miles
	Acute Care Hospitals	1 facility within 10 miles
	Provider Group – Suburban	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 10 miles
	Obstetricians/Gynecologists	2 physicians within 10 miles
	Pediatricians	2 physicians within 10 miles
	Cardiologists	1 physician within 10 miles
	Endocrinologists	1 physician within 15 miles
	Acute Care Hospitals	1 facility within 10 miles

	Provider Group – Rural	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 15 miles
	Obstetricians/Gynecologists	2 physicians within 25 miles
	Pediatricians	2 physicians within 25 miles
	Cardiologists	1 physician within 20 miles
	Endocrinologists	1 physician within 50 miles
	Acute Care Hospitals	1 facility within 20 miles
Assessment	Fifty thousand dollars ($50,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a Geographic Access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without medical services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled, and assessed quarterly.	
12. Behavioral Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's behavioral provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.d. and A.6.e. Should there be a deficiency in the network due to the unavailability of licensed providers in a specific area, the Contractor shall provide sufficient documentation and a corrective action plan with their access analysis report to request reconsideration of the access standard for that provider type for the reporting period in question.	
Definition	**Provider Group - Urban**	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 10 miles
	Psychologists	2 providers within 10 miles
	Child/Adolescent Providers	2 providers within 10 miles
	All other Master's Level Providers	2 providers within 10 miles
	Medication Assisted Treatment Providers	1 provider within 10 miles
	Inpatient Acute Care Facilities	1 facility within 20 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 20 miles
	Intensive Outpatient Facilities	1 facility within 20 miles
	Provider Group – Suburban	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 15 miles

	Psychologists	2 providers within 15 miles
	Child/Adolescent Providers	2 providers within 15 miles
	All other Master's Level Providers	2 providers within 15 miles
	Medication Assisted Treatment Providers	1 provider within 15 miles
	Inpatient Acute Care Facilities	1 facility within 30 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 30 miles
	Intensive Outpatient Facilities	1 facility within 30 miles
	Provider Group – Rural	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 30 miles
	Psychologists	2 providers within 30 miles
	Child/Adolescent Providers	2 providers within 30 miles
	All other Master's Level Providers	2 providers within 30 miles
	Medication Assisted Treatment Providers	1 provider within 30 miles
	Inpatient Acute Care Facilities	1 facility within 40 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 40 miles
	Intensive Outpatient Facilities	1 facility within 40 miles
Assessment	Fifty thousand dollars ($50,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a Geographic access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without behavioral services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled and assessed quarterly.	
13. Enrollment Set-Up		
Guarantee	As required in Contract Section A.25.d., enrollment information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to Go-Live.	
Assessment	Five thousand ($5,000) for each Business Day beyond the date specified in Contract Section A.23.d.	
Justification	Enrollment file set-up is a critical step in providing Members medical benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving medical services. This assessment and amount take into	

	account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
14. Claims Data Submission	
Guarantee	The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.23.l.1).
Assessment	One thousand dollars ($1,000) per Business Day up to the twentieth (20th) Business Day.
Justification	Timely submission of claims data ensures that the State and Members have accurate and timely information. The State relies on the claims data information for reporting and planning purposes. Members rely on this data for Plan information such as deducible and out of pocket maximum amounts. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed quarterly.
15. NCQA Accreditation	
Guarantee	The Contractor shall submit a copy of their NCQA Health Plan Report Card Accreditation at a level of 3.5 or more stars as specified in Contract Section A.20.l.
Assessment	Ten thousand dollars ($10,000) per guarantee that is not met.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive NCQA accreditation. This assessment and amount take into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Measured, reported, reconciled and assessed annually.
16. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per violation until resolved. The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. ***In the event Contractor is responsible for Federal Penalties related to a Privacy or HIPAA violation, the State may, at their discretion waive any Liquidated Damages due the State in association with the same violation.***
Justification	This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours;

	2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours; 3. Program Director associated with this contract time and work estimated at fifteen (15) hours; 4. Executive Director's time and work estimated at one (1) hour; 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
17. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally-required media release to media outlets across the State.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.

6. **Delete *pro forma* contract Attachment C, Reports #9, #10, and #11 in their entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**. Renumber any subsequent sections as necessary**

- **Value Based Initiatives and Payments Report,** as applicable in compliance with contract section A.11.h.(5).
- **Telehealth Utilization Report,** submitted quarterly in compliance with contract section A.11.j.
- **Diabetes Prevention Program Outcomes Report,** submitted quarterly in compliance with contract section A.11.k.

7. **Delete *pro forma* contract Attachment D, KPI #21 in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**. Renumber any subsequent sections as necessary**

21.	**Medical and Behavioral Health Claims Data Quality**	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.23.l.(4). Measures and Benchmarks: • Gender Data missing for </= (less than or equal to) 3% of claims • Date of birth Data missing for </= 3% of claims • Outpatient diagnosis coding Data invalid or missing for </= 5% of outpatient claims • Outpatient provider type ~~missing~~ ——Data missing for </= 1.5% of outpatient claims • Provider ID missing Data missing for </= 1.5% of claims	If the Contractor fails to meet any requirement.	$5,000 if any requirement is missed

8. **Delete RFP #31786-00184 in its entirety, and replace with RFP #31786-00184, Release #2.** Revisions of the original RFP document are emphasized within the new release. Any sentence or paragraph containing revised or new text is highlighted.

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