ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

200 E. 18TH STREET, AUSTIN, TEXAS 78701 | P. O. BOX 13207, AUSTIN, TEXAS 78711-3207 | (512) 867-7711 | (877) 275-4377 TOLL-FREE | WWW.ERS.STATE.TX.US

December 15, 2011

Health Maintenance Organization Carrier

RE: Request for Application ("RFA") for Health Maintenance Organization ("HMO") Services

To Whom It May Concern:

The Employees Retirement System of Texas ("ERS") will be issuing a RFA to provide HMO services for the Texas Employees Group Benefits Program ("GBP") Participants for all Texas counties for Fiscal Year 2013, beginning September 1, 2012. ERS reserves the right to contract with one or more HMO Carriers.

ERS is the administrator of the GBP under the authority of Chapter 1551 of the Texas Insurance Code and will accept HMO Applications that offer "gated" or "open access" features. However the RFA responses shall be specific to a fully insured offering; responses offering an Exclusive Provider Organization (EPO) or self-insured plans will not be considered. All HMO programs will be subject to a Theoretical Cost Index ("TCI") test, which is based on the HealthSelect[sm] of Texas ("HealthSelect") Point-of-Service "gated" product. While the TCI compares cost between HealthSelect and HMO offerings based on various demographic data, no additional adjustment will be made for open access provisions. Successful Applications shall produce a savings to the GBP of at least 5% percent when compared to the TCI. Please note, that the condition of the COB method has been changed from previous years. The HMO shall be responsible for paying the applicable/appropriate copayment. ERS will no longer accept an HMO who does not pay any applicable or appropriate copayments.

A Texas Register Notice has been published at: http://www.sos.state.tx.us/texreg/index.shtml and by an Electronic State Business Daily ("ESBD") Notice at: http://esbd.cpa.state.tx.us with additional RFA information. Your firm has been identified as offering the services listed above, and ERS encourages you to review the posting and request access to the secured bid materials when they become available on the ERS website.

ERS anticipates receiving high quality Applications for the services listed above and we encourage your organization to give full consideration to the development of an Application.

If you have any questions regarding this process, please submit your inquiry directly to the iVendor Mailbox at: ivendorquestions@ers.state.tx.us.

Thank you for your interest in doing business with the GBP.

Sincerely,

Robert P. Kukla

ROBERT P. KUKLA
Director of Benefit Contracts

Request for Application

To Provide Health Maintenance Organization Services for Fiscal Year 2013

ERS
Employees Retirement System of Texas

December 15, 2011

Table of Contents

HMO RFA 2013 Deliverables Check List

Order of Return: The HMO is required to submit a total of six (6) sets of the HMO's Application in the following formats: One (1) printed "Original" (which shall be labeled as such) and three (3) additional printed copies shall be submitted and include fully executed documents as appropriate, signed in ***blue ink*** and without amendment or revision. The remaining two (2) complete copies shall be submitted via CD-ROMs in Excel or Word format and labeled *HMO RFA Application Duplicate FY 2013*. **No PDF documents may be reflected on the CD-ROMs with the exception of sample GBP-specific marketing, GeoNetworks® Analysis , financial statements, and audited financial materials.**

All binders must contain:

PAPER FORMAT	RFA REFERENCE
RFA FEEDBACK FORM	Page vii
TAB I Instructions	**I.**
☐ Executed RFA Signature Pages signed in ***blue ink*** (Appendix A)	I.B.8
☐ Executed Business Associate Agreement signed in ***blue ink*** (Appendix L)	I.B.15
☐ Confidential and Proprietary schedule	I.B.24.
☐ HUB Designation Acknowledgement (if applicable)	I.B.25.
TAB II Application Evaluation Criteria	**II.**
☐ Minimum Requirements *(evidence of HMO's satisfaction of Requirements)*	II.B.
TAB III Financial Requirements and Rate Proposal	**III.**
☐ Payment Methodology	III.A.
☐ Rating Methodology Used and Actuarial Certification of the Proposed Rate	III.D.4 – III.D.8.j.
☐ Rate Proposal for Application (either Open, Gated or both types of Access)	III.F. – III.F.2.
☐ Rate Proposal for Application FY 2013 with Federal Health Care Reform	III.F.
☐ Completed HMO Provider Reimbursement Arrangements	III.G.
TAB IV Communication Requirements	**IV.**
☐ Provide draft copies of all proposed marketing materials to include, but not be limited to: power point presentations, scripts for presentations, newspaper/press releases, billboard, television, and radio advertisements for GBP Annual Enrollment or for any other GBP-specific purpose	IV.A. and IV.B.4.
☐ Proposed PY 2013 Evidence of Coverage (with tracked-change modifications) submit for initial ERS review	IV.C.5. – IV.C.5.iii.
☐ Fact Sheet – Submit as part of Response	IV.C.7.
☐ ID Card – Provide electronic mock-up of GBP-specific ID **on CD-ROM**	IV.C.8. – IV.C.8.b.
☐ Provide a format of HMO's proposed website to include ALL screen shots on CD-ROM in the GBP website format and an ACTIVE URL address	IV.C.13.a.
☐ URL address to access proposed GBP-specific FY 2013 TEST website	IV.C.13.a.
☐ Proposed FY 2013 screen shots of ALL web materials in the required GBP website format (*draft copies)*.	IV.C.13.a.
☐ Provide a report evidencing the HMO Carrier's organization's Section 508, Level 1, compliance	IV.E.1.b

TAB V Operational Specifications	**V.**
☐ Implementation Plan (if applicable)	V.A.2.
☐ Data Exchange and Services Supplement Form provided by the HMO (Exhibit P)	V.F.
TAB VII Summary of HMO Benefits	**VI.**
☐ In-Vitro Fertilization Rider Rejection Form provided by the HMO (Exhibit I)	VI.A.
TAB VIII Service Area Requirements	**VII.**
☐ Provide a copy of TDI's date stamped approved service area	VIII.B.1.
☐ Service Area Map(s) of proposed service area(s) must be complete county areas	VIII.B.2.
☐ Service area CD-ROM in ERS format, listing the counties for each proposed service area	VIII.B.3.
TAB IX Provider Network Requirements	**IX.**
☐ Documentation of the TDI approved provider network as of February 1, 2011 in the prescribed ERS format	IX.A.1.
☐ Provide a copy of GeoNetworks® Provider Network Accessibility Analysis	IX.A.1.
☐ A provider network for each service area, containing separate files for each of the following four (4) proposed provider networks:	IX.C.
❑ Hospitals	IX.C.2.
❑ Primary Care Physicians	IX.C.3.
❑ Specialty Care Physicians (including Ancillary Providers)	IX.C.4.
❑ Pharmacies	IX.C.5
TAB X Organizational Information	**X.**
☐ Organizational Information Responses	X.A.1 – X.D.11.
☐ Provide a copy of the HMO's 2011 NAIC annual statement including HMO Supplement as reported to TDI related to GBP-specific data.	X.D.4.
TAB XI Deviations	**XI.**
☐ Deviation Responses	XI.A.1. - XI.A.16.
TAB XII Interrogatories	**XII.**
☐ Interrogatory Responses and Requested Materials	XII.A.1. – XII.K.1.
CD Format	REFERENCE
☐ All materials described above shall be received in CD-ROM Format. The two (2) separate Application CD-ROMs shall be in either Word or Excel format.	I.B.4.b.
☐ Two (2) complete sets of CD-ROMs – Set One (Confidential and Proprietary Information) and Set Two (Public Information).	I.B.23. - I.B.23.b.

NOTE: Keep this Check List for your records. Do not return with your submission.

Request for Feedback

Employees Retirement System of Texas

The Employees Retirement System of Texas, Benefit Contracts Division, periodically publishes requests for proposals, applications or information and is interested in your organization's feedback regarding our request. To assist the Benefit Contracts Division in creating future requests, we would be interested in knowing what could be done to improve our solicitation process or how we could make our request more user-friendly. Please take a moment to answer the following questions and return it at your earliest convenience.

1. Did your organization submit a bid?
   - ☐ Yes
   - ☐ No
2. If No, why did your organization elect not to bid? (Check all that apply)
   - ☐ Timing, not enough time to complete bid
   - ☐ Contract Provisions/Parts of the Contract
   - ☐ Complexity of RFP
   - ☐ Other: _____
3. Please elaborate on question #2 or provide other reasons for not submitting a bid.

   _____
4. Please provide any suggestions that might improve the bid process.

   _____

Additional Comments

_____

_____

_____

About Your Organization

Name _____ Contact E-mail _____

Address _____ Phone _____

City, State, ZIP Code _____

An ERS representative may, if necessary, contact you by email or telephone for further clarification of your responses.

Thank you for your consideration and participation!

I. Instructions

A. Request for Application ("RFA") Summary

A.1. **Introduction.** The Board of Trustees ("Board") of the Employees Retirement System of Texas ("ERS") is soliciting Applications from qualified Health Maintenance Organizations ("HMO") to provide a health care option to members and their dependents eligible for HMO services under the Texas Employees Group Benefits Program ("GBP"), for FY 2013 beginning September 1, 2012 through August 31, 2013.

A.1.a. An HMO responding to this request shall submit an Application assuming that applicable federal health care reforms, if any, take effect on September 1, 2012.

A.2. An HMO wishing to respond to this request shall meet the following minimum requirements reflected herein and as referenced in Article II. In order to be considered, an HMO shall have appropriate licensing through the Texas Department of Insurance ("TDI") and been providing HMO services in Texas since at least March 1, 2011. An HMO meeting these prerequisites may submit an Application to serve one or multiple service areas subject to the requirement to serve full counties only. ERS may approve none, one, or more than one HMO to provide HMO coverage to GBP Participants in each area. ERS may limit the number of HMOs to only the number (none, if applicable) it deems necessary to provide an efficient and choice of health care providers to GBP Participants.

ERS will accept Applications from HMOs offering both gatekeeper delivery models and open access models and the RFA responses shall be specific to a fully insured offering; responses offering an Exclusive Provider Organization ("EPO") or self insured plans will not be considered. However, all programs will be required to meet the Theoretical Cost Index ("TCI") without any additional adjustment.

FAILURE TO PROVIDE APPLICATIONS IN THE FORMAT REQUESTED MAY RESULT IN THE HMO BEING ELIMINATED FROM FURTHER CONSIDERATION. ALL APPLICATIONS SHALL BE VALID THROUGHOUT THE ENTIRE RFA PROCESS AND RESULTING CONTRACT TERM.

A.3. **Schedule of RFA Process.** The RFA process and Contract awards shall be conducted in accordance with the following schedule, unless notified otherwise by ERS:

On or after December 15, 2011		RFA is available on ERS' website. To access the RFA, the HMO shall email a request to ivendorquestions@ers.state.tx.us **A USERID and Password will be provided only to those HMOs requesting access to the secured sections of the RFA. All HMOs are prohibited from contacting agency employees, officials, and ERS'consulting actuaries regarding any aspects of the RFA by telephone or in person throughout the bid process other than as directed by ERS.**
January 5, 2012	4:00 p.m. (CT)	Submission deadline for All RFA questions. RFA questions should be submitted to ivendorquestions@ers.state.tx.us
January 19, 2012	12:00 Noon (CT)	The HMO is required to submit all bid materials in the formats reflected below in one (1) sealed container: • One (1) fully executed and labeled "Original"; • Three (3) identical printed, hard copies; and • Two (2) identical copies provided on CD-ROMs. Two (2) complete sets of CD-ROMs – Set One *(Confidential and Proprietary Information)* and Set Two *(Public Information).* **No PDF documents may be reflected on the CD-ROMs with the exception of sample GBP-specific marketing, GeoAnalysis, financial statemens, and audited financial materials.** **Submit bid materials to:** **Robert P. Kukla, Director of Benefit Contracts** **Employees Retirement System of Texas** **200 E. 18th Street** **Austin, Texas 78701** **RE: HMO RFA Application** Note: ERS may request that the HMO be interviewed via phone conference and/or site visit prior to the Board meeting.
May 2012		ERS' Board selects HMO(s)
July 2012		AE Period
September 1, 2012		Fiscal Year ("FY") 2013 begins

ERS RESERVES THE RIGHT TO EXTEND ANY AND ALL DEADLINES ABOVE, TO REJECT ANY AND ALL APPLICATIONS, TO CONTRACT WITH ONE OR MORE HMOs, OR TO ISSUE A NEW RFA AT ANY TIME, IN ITS SOLE DISCRETION. ERS WILL NOT NOTIFY RESPONDENTS UNLESS THEY ARE SELECTED FOR INTERVIEWS OR ENGAGEMENT.

A.4. The HMO is responsible for reviewing and responding to the RFA materials available on the ERS website at: http://www.ers.state.tx.us/community_group.aspx?groupid=2view=contracts. ERS' website provides interested HMOs with background information and an electronic version of the RFA. The information contained in this offering provides instructions for the HMO to submit an Application to ERS' RFA and specifies a deadline for the submission of questions as reflected in the table provided in Section I.A.3. above. and Sections I.B.3.- I.B.3.a. below.

B. General Information

B.1. **Agent of Record.** ERS shall not designate an Agent of Record or any other such company employee or commissioned representative to act on behalf of either ERS or the HMO. Any requests for ERS to provide such designation shall be rejected.

B.2. **News Release.** Prior written approval by ERS shall be required for any news releases regarding a Contract awarded to an HMO. Additional requirements regarding the management of News Releases are further outlined in Sections IV.A.8. – IV.A.8.d.

B.3. **Inquiries.** Questions regarding ERS and/or the RFA shall be submitted via email, no later than 4:00 p.m. CT on January 5, 2012.

B.3.a. In its sole discretion, ERS shall post the question and response that it deems appropriate on ERS' website in a timely manner. Such inquiries should be directed to:

Robert P. Kukla, Director of Benefit Contracts
Email: ivendorquestions@ers.state.tx.us

B.4. **Application Submission.** All bid materials shall be packaged collectively in one (1) sealed container and submitted to ERS as noted below. ERS may not consider an Application unless one (1) "Original" and five (5) copies are received by ERS at the appropriate address no later than 12:00 Noon CT on January 19, 2012. The mailing label for the Application shall be clearly marked as: *HMO RFA Application*.

B.4.a. The one (1) printed "Original" (which shall be labeled as such) and three (3) additional printed copies shall be submitted with all requested supporting documentation, including, but not limited to, the Data Security and Breach Notification (see Sections I.B.14. and I.B.14.a. below), and Signature Pages, (see Section I.B.8 below) fully executed in ***blue ink***.

B.4.b. The remaining two (2) copies of the entire response, shall be submitted via CD-ROMs in Excel and/or Word format and labeled *HMO RFA Application Duplicate FY 2013*. **No PDF documents may be reflected on the CD-ROMs with the exception of sample GBP-specific marketing, GeoAnalysis, financial statements, and audited financial materials.**

B.4.c. For instructions relating to the submission of Confidential and/or Proprietary Information in response to the RFA, please refer to Sections I.B.23. – I.B.23.a. below.

B.4.d. ERS is not responsible for receipt of any Application that is not labeled, packaged or delivered properly. All bid materials shall include complete, properly executed, and detailed supporting documentation as required.

The HMO shall mail or deliver its sealed Application to ERS at the following address:

Robert P. Kukla, Director of Benefit Contracts
Employees Retirement System of Texas
200 E. 18th Street
Austin, Texas 78701
RE: HMO RFA Application

B.5. **Retention of Application.** All Applications submitted become the sole property of ERS.

B.6. **Notification of Withdrawal of Application.** An Application may be withdrawn prior to the date and time specified for Application submission with a formal written notice by an authorized representative of the HMO and accepted by the Executive Director of ERS.

B.7. **Order of Application Materials.** The HMO shall submit its Signature Pages, as well as all Application materials, in the order prescribed in the *RFA Deliverables Check List* located behind the *Table of Contents* contained in this RFA.

B.7.a. All proposed HMO marketing materials, including proposed GBP-specific test website screen shots, shall be submitted in final draft form for ERS' review with the HMO's Application submission or the materials may NOT be approved for use during AE in any given plan year.

B.8. **Signature Requirements.** The Chief Executive Officer or other authorized officer who is at a Vice President or higher level of the HMO shall execute, in ***blue ink***, the Signature Pages referenced as Appendix A, which is a part of this RFA. The signature of the HMO's authorized representative on the Application's signature page and all other related documents submitted by the HMO reflects the HMO's agreement with the truth and accuracy of all statements, warranties and representations contained in the Application and other documents submitted by the HMO. The signature further reflects the HMO's authorization for ERS to rely on same for all purposes in connection with the RFA/Application process.

B.9. **Supplements to RFA.** In the event that it becomes necessary, at ERS' discretion*,to revise any part of this RFA, or if ERS determines that any additional information is needed to clarify the provisions of this RFA, supplemental information shall be provided to the HMO that has indicated interest in this RFA. However, ERS shall not be bound by any deviations from or to this RFA unless ERS specifically agrees in writing to the specific deviation.

B.10. **Reserved Rights.**

B.10.a. Sections 1551.213, and 1551.214, Texas Insurance Code ("TIC"), specifies that ERS retains the right to approve the Applications of those HMO(s) which shall be in the best interest of the employees, retirees and their dependents covered under the Texas Employees Group Benefits Act ("the Act"), Chapter 1551, TIC, and further that ERS is not required to select the lowest proposed rate, but shall take into consideration other relevant criteria, including the HMO's ability to service contracts, past experience, quality and accessibility of the provider network, financial stability and other factors as ERS may require. Evaluation criteria are described in Article II, *Application Evaluation Criteria*, of the RFA. ERS staff and Board may determine that other factors may be considered important based on their review of the HMO's response to the RFA and the Interrogatories. ERS and the HMO shall enter into a Contractual Agreement acceptable to ERS and in which shall include, but not be limited to, the Contractual Agreement identified in Appendix B.

B.10.b. ERS reserves the right to reject any and all Applications submitted that do not fully comply with the RFA's instructions and criteria, including minimum requirements for the HMOs as reflected in Sections II.B.1 – II.B.3, and call for new Applications if deemed by ERS to be in the best interest of ERS, the GBP, its Participants and the state of Texas. ERS is under no legal requirement to execute a Contract on the basis of this RFA.

B.10.c. The HMO understands and agrees that ERS reserves the right to accept or reject the submitted rates for the *Summary of HMO Benefits*, Article VII, and to request from the HMO a revised premium rate application with a **Substitute Benefits Package** ("SBP"). ERS reserves the right to accept or reject the rates proposed for the SBP or to revise the SBP in a manner deemed appropriate by ERS. Therefore, the HMO agrees to cooperate with ERS and its representatives and to negotiate in good faith in connection with any changes that may be made to the benefit plan.

B.10.d. ERS specifically reserves the right to revise any or all RFA or Contract provisions set forth at any time prior to ERS' execution of a Contract where ERS deems it to be in the best interest of ERS, the GBP, its Participants and the state of Texas.

B.10.e. ERS reserves the right to modify the performance requirements and benefit plans during this RFA process or contract term.

* All references in this RFA to matters within ERS' discretion mean ERS' sole discretion.

B.11. **Costs incurred for Application preparation.** ERS shall not pay any costs incurred prior to execution of a Contract. Issuance of this RFA in no way obligates ERS to award a Contract or to pay any costs incurred by the HMO in the preparation of an offer or Application.

ERS specifically reserves the right to vary all provisions set forth at any time prior to execution of a Contract where ERS deems it to be in the best interest of ERS, the GBP, its Participants and the state of Texas. Furthermore, the HMO agrees to act in good faith and to cooperate with ERS in the execution of any document necessary to effect a change to the RFA or Contract, following execution of the Contract by ERS, if ERS deems it to be in the best interest of ERS, the GBP, its Participants and the state of Texas.

B.12. **Prohibited Interest.** Except as a Participant in the GBP, a member, Board member or employee of ERS may not have a direct interest in the gains or profits of any Contract executed by ERS pursuant to this RFA, and may not receive any payment or emolument for any service performed for the HMO.

B.12.a. In the case where a member, Board member or employee of ERS receives any payment from the HMO for any services performed for the HMO or for any gains or profits from any Contract executed by ERS pursuant to this RFA, ERS may terminate its relationship with the HMO immediately, and ERS reserves the right to seek any legal, equitable or contractual relief to which it may be entitled. Under such circumstances, the HMO shall complete any outstanding transactions with ERS as soon as possible. In its discretion, ERS may choose not to consider any future Applications from the HMO.

B.12.b. By submitting its Application, the HMO warrants and represents that it does not have, nor shall it permit, any conflicts of interest that would impair its ability to perform the services required by the Contract in the best interests of ERS, the GBP, the HMO Participants, and the state of Texas. The Contract shall have additional requirements in this regard.

B.13. **HIPAA.** As a business associate of ERS, the HMO shall comply with the privacy protections as provided in Tex. Health & Safety Code Ann. Chapter 181 (Vernon 2010) and in the "Privacy Rule" adopted pursuant to the federal Health Insurance Portability Accountability Act of 1996 [Pub. L. No. 104-191], amended by the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and the implementing regulations issued and amended by the U.S. Department of Health and Human Services Secretary (45 C.F.R. parts 160 and 164) (hereinafter referred to as "*HIPAA*").

B.14. **Information and Data Security.** The HMO shall comply with the Privacy Act of 1974, Computer Matching and Privacy Protection Act of 1988, Texas Business and Commerce Code ("TBCC") and information security standards as outlined in Title 1, Texas Administrative Code § 202. Further, the HMO shall comply with the requirements for the handling and use of personal information as more fully outlined in Appendix L, *Data Security and Breach Notification*. The execution of the Data Security and Breach Notification will be required prior to final execution of a Contract.

However, if the HMO Carrier in good faith determines that it does not agree with any of the provisions of the Data Security and Breach Notification in the form attached as Appendix K, the HMO may elect not to return an executed Data Security and Breach Notification with its Application, but must instead submit deviations to the Data Security and Breach Notification terms, which must be provided in accordance with Section XI.A.15. of this RFA. Any such deviations will be considered by ERS; however, ERS will not be obligated to accept or agree to any such deviations, and ERS may determine in its sole discretion not to proceed with further negotiations with the HMO based upon such deviations. To prevent any misunderstanding, while the HMO's Application may be evaluated if returned with deviations, such deviations may themselves form a basis for ERS to conclude that the HMO's Application will not be considered further beyond its initial evaluation. Any HMO submitting a signed Data Security and Breach Notification with its Application shall have the Data Security and Breach Notification executed, in ***blue ink,*** by the duly authorized officer of the HMO as reflected in Sections I.B.8 and X.A.14.

B.14.a. The HMO shall utilize proven methods of ensuring the control and security of Participant and Program information.

B.15. **Business Associate Agreement.** The HMO is hereby notified that the execution of the Business Associate Agreement ("BAA") attached as Appendix L is a preferred submission requirement of this RFA. It includes additional duties and obligations the HMO is required to provide or perform. ERS prefers that the BAA be signed and returned without amendments or revisions with the Application submission. However, if the HMO in good faith determines that it does not agree with any of the provisions of the BAA in the form attached as Appendix L, the HMO may elect not to return an executed BAA with its Application, must submit deviations to the BAA's terms, which must be provided in accordance with Section XI.A.16. of this RFA. Any such deviations will be considered by ERS; however, ERS will not be obligated to accept or agree to any such deviations, and ERS may determine in its sole discretion not to proceed with further negotiations with the HMO based upon such deviations. To prevent any misunderstanding, while the HMO's Application may be evaluated if returned with deviations, such deviations may themselves form a basis for ERS to conclude that the HMO's Application will not be considered further beyond its initial evaluation. Any HMO submitting a signed BAA with its Application shall have the BAA executed, in *blue ink,* by the duly authorized officer of the HMO as reflected in Sections I.B.8 and X.A.12.

B.15.a. ERS reserves the right to reject any Application if the BAA is revised or returned unsigned, and ERS further retains the right to modify the BAA terms and to add additional terms at its discretion. Upon approval of the Application, notification to the HMO of its selection by the Board and any clarifications to be required in the Application, and upon execution of the BAA by ERS, it is ERS' intent that the written BAA shall be in force.

B.16. **Contractual Agreement.** The HMO is hereby notified that the execution of the Contractual Agreement ("Contract"), attached as Appendix B, is a preferred submission requirement of this RFA. ERS prefers that the Contract be signed and returned without amendments or revisions with the Application submission. However, if the HMO in good faith determines that it does not agree with any of the provisions of the Contract in the form attached as Appendix B, the HMO may elect not to return an executed Contract with its Application, but must instead submit deviations to the Contract's terms, which must be provided in accordance with Section XI.A.13.a. of this RFA. Any such deviations will be considered by ERS; however, ERS will not be obligated to accept or agree to any such deviations, and ERS may determine in its sole discretion not to proceed with further negotiations with the HMO based upon such deviations. To prevent any misunderstanding, while the HMO's Application may be evaluated if returned with deviations, such deviations may themselves form a basis for ERS to conclude that the HMO's Application will not be considered further beyond its initial evaluation. Any HMO submitting a signed Contract with its Application shall have the Contract executed, in ***blue ink,*** by the duly authorized officer of the HMO as reflected in Sections I.B.8 and X.A.12.

B.16.a. ERS reserves the right to reject any Proposal if the Contractual Agreement is revised or returned unsigned, and ERS further retains the right to modify the Contractual Agreement terms and to add additional terms at its discretion. Upon approval of the Application, notification to the HMO of its selection by the Board and any clarifications to be required in the Application, and upon execution of the Contractual Agreement by ERS, it is ERS' intent that the written Contract shall be in force.

B.17. **Contract Term and Chronology of Responsibility.** The Contract and all its aspects shall be for a term beginning after the Board has accepted the HMO's Application and has notified the HMO of its selection and immediately upon the execution of the Contract by ERS, and extending through the 31st day of August 2013, unless terminated or extended as provided herein or in the Contract. If a currently participating HMO is not selected for renewal or does not submit an Application for FY 2013, the HMO shall continue to perform in good faith all obligations it has under its existing Contract with ERS. This shall include, but not be limited to, providing COBRA or state continuation coverage, appropriate approval/certification of covered medical treatment and permitting the filling of all eligible pharmacy prescriptions as presented to or sought from the HMO and/or its participating health care providers and pharmacies through midnight, August 31, 2012, and thereafter where applicable in accordance with the existing Contract.

B.17.a. The HMO products and services to be provided under the Contract shall occur between September 1, 2012 and August 31, 2013. ERS and the HMO also agree and acknowledge that there are duties and obligations specified by the Contractual Agreement to be performed prior to September 1, 2012 and following August 31, 2013, and the parties each agree to perform all such duties and obligations, and all damage provisions including performance

assessments included herein and in the Contractual Agreement shall thereby be in effect. Such prerequisites, duties and obligations include, but are not limited to, the following:

- Selection by the Board of Trustees is anticipated for the May 2012 meeting.
- Execution of the Contractual Agreement by ERS' Executive Director after all clarifications have been agreed to and accepted or rejected by ERS.
- The Contract includes the RFA, the Contractual Agreement including all exhibits, and any other information, duties or obligations the HMO may be required to provide or perform thereto as accepted by ERS and that does not conflict with terms of the Contractual Agreement executed by the parties, and the HMO's Application. The Contract includes important requirements that may not be expressly referenced in this RFA.
- Any and all activities required by the HMO to effectively implement the requirements of this Contract.
- The HMO shall coordinate and work cooperatively with other GBP Vendors as applicable.

B.18. **Contract Renewals.** ERS and the HMO acknowledge and agree that the Rate agreed upon by ERS and the HMO will be the agreed-upon rate for FY 2013, and that they are effective for a period to begin on the Effective Date through August 31, 2013. Thereafter, the Rates for each subsequent calendar year will be adjusted annually no later than the last business day of April of each preceding year by mutual written agreement of the Parties.

B.19. **Termination of Contract.** In the event that the HMO fails or refuses to perform or it appears that the HMO is not capable of performing of its duties or obligations as provided by the Contract, (which includes this RFA, the HMO's Application accepted by ERS and the signed Contractual Agreement), ERS, without limiting any other rights or remedies it may have by law, equity or under Contract, shall have the right to terminate the Contract immediately. The HMO understands and acknowledges that, notwithstanding any termination of the Contract, certain obligations of the HMO shall survive the termination of the Contract. The Contract expands upon this provision.

B.20. **Liquidated Damages.** The HMO acknowledges that it is impossible or impractical to estimate certain damages with any degree of certainty. Therefore, the HMO understands and acknowledges that the Contract includes a liquidated damages provision that is in addition to any other remedies that ERS may have in the event the HMO fails or refuses to perform, or is negligent in performing, any obligation it may have in connection with the Contract to the satisfaction of ERS. The Contract has additional requirements in this regard.

B.21. **Contract Implementation.** To ensure the successful implementation and delivery of the HMO benefits, coverages and services to the GBP Program and its Participants, the HMO shall abide by the *Performance Assessments* standards set forth in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

B.21.a. **Implementation Period.** Following selection of an HMO by the Board and upon ERS' execution of the Contract, the HMO shall immediately staff an implementation team and name an implementation project manager. The names, positions and qualifications of the implementation team shall be immediately communicated to ERS and no less than fifteen (15) business days from the award of the Contract. The period of time beginning with the selection of the HMO by the Board and upon ERS' execution of this Contract to the point at which the HMO assumes full responsibility for the duties specified hereunder, such date being no later than September 1, 2012, shall be known as the "Implementation Period."

During the Implementation Period, the HMO warrants and represents the following:

- It shall maintain appropriate, sufficient and qualified staff, technical capabilities and resources that are fully devoted to the GBP Implementation. ERS reserves the right to require the HMO to add additional staff or to remove staff from the Implementation Team.
- It shall not permit any current or prospective business, projects or other matters to interfere in any manner with the smooth and timely implementation of the GBP.
- The HMO understands and agrees that time is of the essence in the performance of this Contract and in the implementation for the GBP.
- All communication materials dealing with the implementation, including Participant communication materials, call center staff training materials, Interactive Voice System ("IVR") and website design are subject to ERS' review and approval before Implementation.

B.21.b. The implementation project manager shall serve as ERS' primary contact throughout the Implementation Period, and shall have the legal authority to make binding decisions for the HMO, and be accessible during the Implementation Period. The Implementation Plan shall be attached to the Contract as an exhibit in the form most up-to-date at the time of Contract execution and may be modified thereafter by agreement of the parties.

B.21.c. The HMO acknowledges that it is impossible or impractical to estimate with any degree of certainty, the impact or damage that the failure of particular Implementation activities may have on the GBP and/or its Participants. Therefore, the HMO agrees that Implementation failures, judged by ERS to have adversely harmed the GBP and/or its Participants may immediately subject the HMO to the Liquidated Damages and *Performance Assessments* provisions as reflected in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

B.22. **Public Information Act.** As reflected in greater detail in Sections I.B.22. – I.B.22.b. below, ERS is required to provide access to certain records in accordance with the provisions of Chapter 552, Tex. Gov't Code, and the Texas Public Information Act ("PIA"), formerly known as the Open Records Act.

B.22.a. During the evaluation process, ERS shall make reasonable efforts as allowed by law to maintain Applications in confidence, and shall release Applications only to personnel involved with the evaluation of the Applications and implementation of the Contract unless otherwise required by law.

B.22.b. However, ERS cannot prevent the disclosure of public documents and may be required by law to release documents that the HMO considers to be confidential and proprietary. By execution of the Signature Pages as further referenced in Section I.B.8. above, the HMO warrants and represents that all information that the HMO in good faith considers to be properly excepted from disclosure under the PIA will be clearly labeled as confidential by the HMO upon submission to ERS. The HMO's signature further reflects that all documents submitted by the HMO that are not marked "confidential" shall be considered to be public information. All public information in response to this RFA may be fully disclosed by ERS without liability and without prior notice to or consent of the HMO or any of the HMO's subcontractors or agents.

B.23. **Disclosure of Information.** In order to protect and prevent inadvertent access to confidential information submitted in support of its Application in accordance with the PIA as referenced in Sections I.B.22. - I.B.22.b. above, the HMO is required to supply in good faith and with legally sufficient justification, a separate schedule of all pages considered by the HMO to contain any confidential and/or proprietary information. The HMO shall supply its confidential and proprietary information to ERS each time it submits information to ERS, whether in its initial Application or in any supplemental information submitted to ERS. The HMO shall submit its confidential and proprietary information in accordance with the instructions given in Sections I.B.24. - I.B.24.b . herein.

B.23.a. By submitting an Application, the HMO acknowledges and agrees that ERS shall have no liability to the HMO or to any other person or entity for disclosing information in accordance with the PIA. Furthermore, ERS shall have no obligation or duty to advocate the confidentiality of the HMO's material to the Texas Attorney General, to a court, or to any other person or entity.

B.23.b. The HMO further understands and agrees that, upon ERS' receipt of a PIA request for the HMO's information, the only information that ERS shall treat as the HMO's confidential and proprietary information in accordance with the PIA shall be the documents the HMO identifies as required above.

B.23.c. It is the HMO's sole obligation to advocate in good faith and with legally sufficient justification the confidential or proprietary nature of any information it provides to ERS. The HMO acknowledges and understands that the Texas Attorney General may nonetheless determine that all or part of the claimed confidential or proprietary information shall be publicly disclosed.

B.23.d. In addition, the HMO specifically agrees that ERS may release the HMO's information, including alleged confidential or proprietary information, upon request from individual members, agencies or committees of the Texas Legislature where needed for legislative purposes, as provided for in the PIA, or to any other person or entity as otherwise required by law.

B.24. **Confidential and/or Proprietary Schedule – Public Information Submission.** In order to protect and prevent inadvertent access to confidential information submitted in support of its Application, the HMO submitting an Application to this RFA is required to supply two (2) sets of CD-ROMs containing full and complete copies of all information that the HMO in good faith, and with sufficient legal justification, considers to: (Set One) contain any confidential and/or proprietary information; and (Set Two) contain all public material, a total of four (4) CD-ROMs to be received upon initial submission. The HMO shall supply information in this manner to ERS each time it submits information to ERS, whether in its initial Application or in any supplemental information submitted to ERS. Otherwise, ERS will presume that all information submitted by the HMO that does not comply with this directive is public information subject to disclosure. The documents reflected on the CD-ROMs shall correlate in order and by title to those reflected on the separate scheduled required in Section I.B.22. above.

B.24.a. The HMO shall provide to ERS no later than the fifth (5th) business day following the scheduled Board of Trustees meeting scheduled in May of each year, two (2) sets of CD-ROMs containing full and complete copies of any and all additional documents developed subsequent to the submission of the HMO's Application to ERS which the HMO considers to be (Set One) confidential and/or proprietary and (Set Two) public.

B.24.b. Upon ERS' receipt of a PIA request, ERS will provide the requestor the information provided on the HMO's public CD-ROM(s) (Set Two) under the applicable provisions above. If the HMO fails to submit its confidential and/or proprietary information as outlined herein, ERS shall consider the HMO's information to be public, and it will, therefore, be released without notification to the HMO upon receipt of a PIA request.

B.25. **Historically Underutilized Businesses ("HUB").** ERS makes a good faith effort to assist HUBs in receiving agency contract awards. As appropriate, the HMO shall provide the following information in the submitted Application materials:

a. If Respondent is certified as a Texas HUB, please provide the TBPC VID/Certification Number.
b. If an engagement is awarded and Respondent plans to engage a subcontractor for all or any of the contract services, the Respondent shall identify all proposed HUB subcontractors. The required forms with video instructions can be found at the following website:

http://www.window.state.tx.us/procurement/prog/hub/hub-forms/

B.26. **Subcontractors.** Any planned or proposed use of subcontractors by the HMO related to the management of or access to GBP Participant data shall be clearly disclosed and documented in the HMO's Application and shall not be accepted until agreed to in writing prior to bid award by ERS. The HMO shall be completely responsible for all services performed and fulfillment of its obligations under the Contract, even if such services are delegated to a subcontractor. The HMO shall be responsible for ensuring that its subcontractors are licensed by all necessary federal and Texas entities.

The HMO agrees that any and all subcontractors used by the HMO are the responsibility of the HMO. ERS will hold the HMO responsible for assuring that subcontractors meet all of the requirements of the Contract and all amendments thereto. The HMO shall provide complete information regarding each subcontractor used by the HMO to meet the requirements of the Contract.

B.26.a. The HMO shall agree to accept the following administrative requirements:
- The HMO will be required to sign an ERS Contract;
- The HMO shall be solely responsible for all subcontracted activities in support of the benefits and services outlined in any executed agreement with ERS;

- Any subcontractor utilized to provide the benefits and/or services including, but not limited to: call center, billing, eligibility, claims processing and programming, etc. in support of any subsequent Contract, shall be located within the United States for the duration of the contracted term; and
- If the HMO subcontracts any part of the outlined benefits and services, the subcontractor(s) are subject to review and acceptance by ERS throughout any contracted term.

B.27. **Board Rules.** The Board has sole rulemaking authority in connection with the GBP pursuant to Chapter 1551, TIC. In the event of a conflict of laws or regulations, then ERS' interpretation of the applicability and controlling status of the law or rules shall control. The Board Rules are located at Title 34, Part4, Tex. Admin. Code. The Board Rules, including any amendments, are a part of any Contract executed in accordance with this RFA process for all purposes as if they were contained verbatim therein. The HMO agrees to comply with all such Board Rules, and all applicable federal and Texas laws and regulations.

B.27.a. The determination of the amount of benefits to which any Participant is entitled shall initially rest with the HMO. However, the final determination of the extent of the benefit to which any Participant is entitled shall be made solely and exclusively by the Board in accordance with Article 1551.357, TIC, as amended.

B.28. **No Solicitation.** An approved HMO shall not use, or otherwise disseminate, copy, or make available to any person or entity, lists of GBP Participants or employees, or any other Participant data to solicit any other insurance coverage, annuity products, marketing, or any other services or products, unless specifically approved in writing by ERS' authorized representatives. This requirement shall survive the termination of the Contract. The Contract has additional requirements in this regard.

C. General Specifications

C.1. Changes Required by Statute, Regulation, Court Orders, or Program Funding: ERS acknowledges that certain factors may change conditions with regard to the HMO benefits. Some factors that may affect the HMOs include, but are not limited to:

- Changes in federal and state statutes, regulations, and new court decisions and administrative rulings;
- Changes in anticipated funding by the Texas Legislature; and
- Changes in HealthSelect.

The HMO agrees to make a good faith effort to comply with any additional responsibilities or changes to the GBP imposed as a result of the above factors, and other similar factors that may arise, requiring plan design changes and/or an increase or decrease of the HMO premiums, and to cooperate with ERS to effect any such changes and to execute any agreements that may be required as a result. However, should a mandated change materially affect the HMO's obligations under the Contract, ERS reserves the right to negotiate with the HMO regarding any premium rate increase (or decrease) that may be appropriate under the circumstances, as provided in the Contract.

C.2. **Alternative Benefit Design or Financial Arrangements**

C.2.a. ERS will evaluate Applications based on the current benefit design and financial arrangement. However, ERS reserves the right to revise the benefits and/or financial arrangements should that become necessary due to legislative, budgetary, or other factors. Alternative benefit design or financial arrangements, other than as requested herein, shall not be considered in selecting an HMO to provide services unless a SBP has been specifically requested by ERS. The purpose of this RFA and the subsequent review process is to select the HMO that ERS considers to be most qualified to provide the most effective, efficient and high-quality services, supplies and products to the GBP, its Participants, ERS and the state of Texas. ERS views the relationship with the HMO as a cooperative one, and nothing contained in this RFA, nor any action taken in the review and approval process, shall prevent ERS from continuing negotiations with the selected HMO after the selection is made.

C.2.b. The HMO agrees to act in good faith in connection with all such negotiations and in performing all of its services, duties, and provisions of coverage related to the GBP.

C.3. The HMO shall maintain fidelity and liability insurance coverage throughout the term of the Contract, and any extension, amendment, or renewal thereof. Evidence that such coverage (declaration page of policy) is being maintained throughout the term of the Contract shall be submitted to ERS no later than fifteen (15) business days following the effective date and each subsequent anniversary date of such policy. Failure by the HMO to comply with this requirement may subject the HMO to a monetary assessment as required in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.4. **Materials.** A copy of all materials to be used by the HMO in providing HMO coverage shall be provided as requested in Article IV, *Communication Requirements*. The HMO is required to submit proposed marketing and other informational materials in ERS' required format according to deadlines to be set by ERS, including, but not limited to, the Evidence of Coverage ("EOC") and marketing materials. This also includes, but is not limited to, all scripts to be used by the HMO customer service representatives. The cost for preparation of these materials for the term of the Contract should be included in the premium rate quoted by the HMO. ERS shall retain the right to review and approve all such documents before distribution.

C.5. **Service-Oriented Architecture.** ERS is moving toward a service-oriented architecture ("SOA"), which will combine a number of technologies to provide comprehensive and cost-effective technological solutions that will integrate our front-end information (website) and processes (login to the ERS website) with our back-end information systems. SOA deployment at ERS will be incremental and scaled as business processes, opportunities, and capabilities as required. An example of such technology would include ERS' ability to extract XML-tagged content from GBP Vendor website through the use of "data feeds". Throughout ERS' SOA evolutionary processes, the HMO shall provide complaint information in a timely manner and afford all necessary technological support as required by ERS' staff and consultants.

C.6. **Enrollment and Coverage.** ERS is responsible for determining the eligibility of its Participants in the GBP and for reporting coverage to the approved HMOs. ERS provides a 100% weekly enrollment file via **secure file transfer protocol ("SFTP")** within a site-to-site VPN tunnel and the file shall be encrypted with ERS' public key (PGP). ERS utilizes the login to the ERS website (www.ers.state.tx.us), which allows Participants to enroll in or change their coverage during the AE period (generally held in July each year) and throughout the plan year.

The HMO shall verify that it is capable of accepting enrollment via SFTP on a weekly basis. ERS is developing a new enrollment file to supplement information currently being reported in the 100% weekly file for deployment on or about February 1, 2011. This file fill reflect Participants effective on the 1st day of the month after their ninety (90) day wait. ***Note: ERS OnLine is the system of record for eligibility and enrollment.***

C.7. **Claims Payments.** The HMO pays all claims based on the enrollment data provided by ERS.

C.8. **Administrative Audit.** As plan administrator for the GBP, ERS may access, request, and audit the appropriate HMO documents and Participant records as required for purposes of administering the Plan.

C.9. **Employee Identification Number.** Current employee, retiree, and dependent (collectively referred to as Participants) enrollment reporting is based on the Participant's unique employee identification number ("ID"). Texas law mandates the removal of Social Security Numbers from ID cards.

The HMO's system shall have the capability to manage an eleven (11) digit number in its reporting system. The HMO shall be required to issue ID cards to Participants within fifteen (15) working days of the transfer of the final enrollment file at the end of AE or by September 1, 2012, whichever is sooner. The HMO shall be capable of identifying Participants based on the enrollment information submitted by ERS.

C.10. **Fiscal/Plan Year.** The fiscal/plan year ("FY/PY") begins each September 1st, and ends the following August 31st. This RFA applies to FY 2013, which begins September 1, 2012 and

ends August 31, 2013. ERS' fiscal year shall be determinative for all Contract reporting requirements.

C.11. **Definitions.** A list of definitions applicable to certain terms used in this RFA is referenced in Appendix J, *Glossary of Terms.*

D. GBP Enrollment Data

D.1. Refer to Enrollment, Demographic, and Premium Information located at the top of the ERS RFA web page, referenced in Appendix C.

D.2. Specific Eligibility Demographics (October 2011 Enrollment File) are referenced in Appendix D.

II. Application Evaluation Criteria

A. General Evaluation Information

A.1. **Introduction.** Applications submitted in response to this RFA shall be evaluated on the basis of the criteria listed below. The criteria are not listed in order of importance. While the criteria provides the basis for an objective evaluation of each Application, the experience and judgment of ERS' staff, Board and their advisors shall also be important in the selection process. The criteria include the HMO's response to all items reflected in its Application, and any clarifications. The criteria may include, but will not be limited to:

- Compliance with and adherence to the specifications of all terms contained in the RFA and Contractual Agreement;
- Meets the Theoretical Cost Index;
- Minimum requirements as reflected below;
- Experience serving public or governmental health benefit programs;
- Past experience;
- Administrative Capability/Network Management;
- Proposed Premium Rates;
- Financial Strength and Stability;
- Legal disclosure requirements;
- Technological capabilities;
- Operating requirements;
- References;
- Site Visits; and
- Other factors, as determined during the evaluation review process.

A.2. ERS reserves the right to reject any and/or all Applications and/or call for new Applications if ERS deems it to be in the best interest of ERS, the GBP, its Participants and the state of Texas.

A.2.a. The selected HMO shall adhere to these requirements upon Contract award and throughout the term of the Contract and any renewals or extensions thereof. ERS also reserves the right to reject any Application submitted that does not fully comply with the RFA's instructions and criteria. ERS is under no legal requirement to execute a Contract on the basis of this notice or upon issuance of the RFA or receipt of an Application.

A.2.b. Proposed deviations to the minimum requirements identified below shall not be considered, and submission of such may disqualify the HMO's Application package. Failure to satisfy the mandatory minimum requirements may result in elimination from the evaluation process.

B. Minimum Requirements

Those wishing to respond to the RFA shall demonstrate their competence to perform the services required by ERS, and shall evidence the ability to satisfy each of the following minimum requirements by specifically identifying supporting documentation contained in the HMO's response.

B.1. The HMO shall maintain its principal place of business and provide all products and/or services including, but not limited to: call center, billing, eligibility, claims processing and programming, etc. within the United States of America and shall have a valid Certificate of Authority or current license to do business in Texas as an HMO from TDI to serve in Texas as an insurance company, if applicable.

B.2. The HMO shall have been providing managed care services in the service area for which the Application is made at least since March 1, 2011.

B.3. The HMO shall demonstrate that it has a provider network in the proposed service area as of the due date of the Application response adequate to provide health care to GBP Participants.

III. Financial Requirements and Rate Proposal

This Article describes the requirements for the submission of premium rates for all proposed service areas. The HMO wishing to submit an Application shall comply with this Section. The HMO shall complete Sections III.F. and III.F.2., *Rate Proposal Application for FY 2013*, and return it with their Application.

A. Payment Methodology

A.1. The HMO shall accept monthly premium payments in accordance with ERS payment procedures. Monthly premium payments are based on information contained in ERS enrollment records. ERS submits payments to the HMO by the first business day following the fourteenth (14th) day of the month following the coverage period (i.e., payment for the month of September shall be made to the HMO by October 15th, if October 15th does not fall on a weekend or a legal holiday. In such case, the payment will be made on the next business day). The HMO is not permitted to submit billings to state agencies, institutions or GBP Participants.

A.1.a. Monthly payments are accompanied by a monthly Carrier Payment Detail file (100% of a month's enrollment) and a monthly Prior Period Termination file via SFTP, as well as premium reports mailed to the HMO. The HMO shall reconcile the payment with these enrollment files. Should any discrepancy occur, the HMO shall contact its ERS account liaison to assist in resolving the discrepancy. If payment continues to be unresolved, the HMO shall monitor the subsequent month's payment reports for up to ninety (90) days (or three (3) monthly payment reports) to reconcile the discrepancy. Occasionally, adjustments are made in subsequent month payment files.

A.1.b. If reconciliation cannot be made after ninety (90) days, the HMO account liaison should contact ERS Benefit Contracts via email for further assistance. Should the HMO not notify ERS in writing within ninety (90) days of identification of discrepancies between the billing file compared to the eligibility file, the HMO shall be required to bear all costs and all expenses to recover support data and forfeit any rights for appeal.

A.1.c. ERS shall withhold 5% of premium for each of the most recent three (3) months in order to prevent overpayment. Beginning with the payment for the fourth (4th) month, each month's payment shall include a return of the amount withheld for the third preceding month so long as the HMO is in compliance with the Contract. If the HMO does not continue GBP participation, ERS reserves the right to hold the final retention amount until all enrollment reconciliation is resolved.

B. Financial Requirements

B.1. Tex. Ins. Code, § 1551.012, exempts the GBP from any state tax, regulatory fee, or surcharge including premium or maintenance taxes or fees. The premium rate should not include any provision for such taxes or fees.

No sales, fees or commissions may be incorporated into any rating methodology utilized in response to this RFA.

B.2. All HMO programs, however, will be subject to a Theoretical Cost Index ("TCI") test, which is based on the HealthSelect℠ of Texas ("HealthSelect") Point-of-Service "gated" product. While the TCI compares cost between HealthSelect and the HMO offerings based on various demographic data, no additional adjustment will be made for open access provisions. Successful Applications shall produce a savings to the GBP of at least 5% percent when compared to the TCI.

B.3. **HMO Solvency.** The HMO shall maintain compliance with the Texas HMO Act, Chapter 843, TIC, as amended, rules promulgated and administered by TDI requiring a fiscally sound operation, and any other applicable laws and regulations. In the event the HMO fails to maintain such compliance, or if ERS reasonably believes that it is likely that the HMO shall be unable to maintain a fiscally sound operation, then ERS, without limiting any other rights or remedies it may have by law, equity or under the Contract, shall have the right to terminate

the Contract immediately. Although ERS reserves the right to terminate the Contract, ERS is not undertaking the duty to actively monitor the HMO's fiscal capability or financial solvency.

The HMO shall have a plan and take appropriate measures, as required by TDI, to ensure adequate provision against the risk of insolvency. Such provision shall be adequate to provide for the following in the event of insolvency: (a) continuation of benefits, until the time of discharge, to Participants who are confined on the date of insolvency in a hospital or other inpatient facility, (b) payments to unaffiliated Health Care Provider(s) and affiliated Health Care Provider(s) whose agreements do not contain Participant indemnification and "hold harmless" clauses acceptable to TDI, and (c) continuation of benefits for the duration of the Contract period for which payment has been made.

The establishment of adequate reserves, insurance and/or other guarantees shall make adequate provision against the risk of insolvency in full compliance with all financial requirements of TDI.

Should TDI determine or should ERS reasonably believe that there is an immediate risk of insolvency or that the HMO is unable to provide covered health care services to its Participants, then ERS, without limiting any other rights or remedies it may have by law or under the Contract, shall have the right to terminate the Contract immediately.

C. Composite and Rates

The HMO is required to provide composite rates. Rates shall be provided for seven (7) coverage categories:

- Member only;
- Member and spouse;
- Member and child(ren);
- Member and family;
- Spouse only;
- Spouse and child(ren); and
- Child(ren) only.

ERS requires that rates for the coverage categories satisfy the specified rating relationships described herein.

Potential budgetary constraints could require modifications to any Contract entered into as a result of this RFA. The HMO shall cooperate in good faith in the execution of any Contract amendment necessitated by budgetary constraints, and agree to comply with such requirements. In order to be considered for selection, the HMO shall cooperate with ERS if ERS exercises its option to request a SBP and shall act in good faith in preparing and determining any rates in connection with a SBP.

D. Rating Requirements

The following rating methods shall be employed and documentation provided as specified. Questions concerning the proper rating methodology for the HMO should be provided to ERS in a manner consistent with Sections I.B.3. and I.B.3.a.

D.1. **Actuarial/Financial Contact.** The HMO shall provide the name, mailing address, email address, telephone number, and fax number of the actuarial/financial personnel responsible for the preparation of the HMO's rates. The named personnel should be capable of responding to inquiries concerning the rates, and they shall cooperate with requests for information made by ERS or its consulting actuaries. ERS' Benefit Contracts division shall be copied on all written communications occurring between the HMO and ERS' Actuary.

D.2. The HMO shall submit a proposed set of rates for the Benefits as described in Article VII, *Summary of HMO Benefits*, for each proposed service area by completing Sections III.F.1. and III.F.2. herein.

D.3. **Separately Rated Service Areas.** At the option of the HMO, ERS shall consider proposed premium rates which vary by service area. Separately rated service areas should be established with a long-term perspective. The HMO should avoid annual revisions to the

rating areas. The final determination to approve separately rated service areas for an HMO shall rest solely with ERS.

D.4. **Rating Methodology.** The HMO shall demonstrate that its proposed premium rates do not exceed those derived by the methodology described in this Article. ERS shall not approve premium rates in excess of those derived by the methodology, less 5%, described in this Article and herein referred to as maximum premium rates.

D.4.a. In establishing its rates, the HMO shall employ the appropriate rating methodology as described in Sections III.D.6., III.D.7. and III.D.8., below according to the characteristics of the HMO's participation in the GBP. The HMO submitting separately rated service areas shall employ the appropriate methodology for each set of rates. As a result, the HMO may be required to utilize more than one (1) of the following methods. Full documentation, as specified below, is required for each of the HMO's rating areas.

D.5. **HealthSelect and PBM Experience by County.** Appendix H reflects HealthSelect FY 2011 paid claims experience by the member's county of residence which may be used by the HMO to evaluate its service area rates. The claim experience is combined with enrollment by county to provide a cost per employee comparison. The drug claims are those incurred and paid in FY 2011 with dates of service in the period September 1, 2010 through August 31, 2011 and paid through August 31, 2011 (no run-off).

D.6. **Method 1.** The HMO is required to use Method 1 to develop maximum premium rates for each separately rated service area in which the HMO does not currently provide services to GBP Participants. This methodology is applicable to new HMOs as well as currently participating HMOs applying to serve a new separately rated service area.

D.6.a. Under this methodology, the rates shall be based on the HMO's current community rating methodology for the service area. The HMO shall present the calculation of the applicable community rates and provide all documentation necessary to enable the ERS consulting actuary to reproduce the rates. The HMO's proposed rates shall be less than or equal to those calculated according to the above method.

D.6.b. The Application shall include certification by a member of the American Academy of Actuaries that the community rates are appropriate for FY 2013 and are neither excessive nor unfairly discriminatory.

D.7. **Method 2.** The HMO is required to use Method 2 to develop maximum premium rates for each separately rated service area in which it first enrolled GBP Participants on September 1, 2011.

D.7.a. Under this methodology, the rates shall be based on community rating by class ("CRC") methodology. CRC rates shall be based on the HMO's current community rates for the service area adjusted as appropriate for application to GBP Participants in the service area. Adjustment for GBP Participant demographics (age/sex/dependent mix) should be based on the most current enrollment information. The HMO shall present the calculation of the applicable CRC rates and provide all documentation necessary to enable the ERS consulting actuary to reproduce the rates. Documentation shall include the community rates and detailed actuarial analysis of any applicable adjustments. The HMO's proposed rates shall be less than or equal to those calculated according to the above method.

D.7.b. The Application shall include certification by a member of the American Academy of Actuaries that the community rates upon which the CRC rates are based are the rates appropriate for FY 2013 and are neither excessive nor unfairly discriminatory.

D.8. **Method 3.** Except as described above, the HMO is required to use Method 3 to develop maximum premium rates for each separately rated service area in which it enrolled GBP Participants on or before September 1, 2011. Under Method 3, the HMO is required to provide adjusted community rates ("ACR"), which are based on the HMO's anticipated revenue requirements for providing services specifically for GBP Participants in the service area during FY 2013. These GBP-specific rates should recognize historical as well as projected utilization of services by GBP Participants in the service area. The HMO should not provide community rates, even as an alternative to ACR, for any service area for which it is required to use this methodology.

D.8.a. The HMO shall provide a complete description of the methods and assumptions and full documentation of the data used in developing the GBP-specific rates. The documentation should include (a) actual GBP utilization data and the historical and projected cost associated with providing services to GBP Participants, (b) information regarding prices and/or capitation arrangements, and (c) any other information that would be required for an independent actuarial confirmation of the GBP-specific rates.

D.8.b. The HMO shall provide Utilization and Cost Data tables (Tables 1 through 5 included on the Vendor website at: https://www.ers.state.tx.us/Community/Vendors/UC_Data_Tables/ covering the experience period used in the rating formula. Cost and utilization data used in the rating formula documentation should reference the specific table from which the data is derived. It is required that the HMO use an experience period that ends no earlier than August 31, 2011. Note: Separate Utilization and Cost Data tables are required for each separately rated service area.

D.8.c. All components of the HMO's rates, including those that relate to services that are capitated or provided by plan facilities and/or providers, shall reflect GBP-specific utilization. An unadjusted community rate is unacceptable except in the case of minor, ancillary benefits such as hearing aids, over-age dependent coverage, etc.

D.8.d. The HMO shall document the manner in which the changing demographic characteristics (age/sex/dependent mix) of the HMO's GBP membership have been taken into consideration in establishing the ACR rates. The HMO shall demonstrate that an explicit adjustment has been made for the HMO's GBP-specific experience to reflect any change in expected costs between the experience period enrollment and that anticipated for FY 2013.

D.8.e. Any estimate of the HMO's liability for unpaid claims or change in liability for unpaid claims, used in the determination of ACR rates, should be fully documented.

D.8.f. The required description of the methods and assumptions and the documentation of the data should be presented in sufficient detail and with adequate clarity to allow the ERS consulting actuary to make an objective appraisal of the reasonableness and validity of the HMO's GBP-specific rates. An undocumented or unreasonable rate derivation is not acceptable. If the methodology depends on an adjustment to a community rate, the HMO shall provide complete documentation of the community rates and the applicable adjustment. Such documentation should be supported by a current actuarial analysis and a certification by a member of the American Academy of Actuaries that the community rates are appropriate for FY 2013 and are neither excessive nor unfairly discriminatory.

D.8.g. The HMO may find that certain circumstances, e.g., a significant increase or decrease in enrollment, invalidate previous GBP-specific experience for purposes of determination of ACR. In such a case, the HMO may use CRC in the determination of GBP FY 2013 rates. The HMO's justification for the abandonment of ACR shall be documented and shall be considered reasonable and appropriate by ERS, its Board and the ERS consulting actuary.

D.8.h. ERS recognizes that subjective considerations play an important role in the rating process. Therefore, the HMO may incorporate subjectivity into the ACR process. Nevertheless, the HMO's reasons for its judgmental modifications to ACR shall be documented. Subjective adjustments shall be reasonable and appropriate in the judgment of ERS, its Board and the ERS consulting actuary. The application review process shall attempt to identify subjectivity designed simply to avoid the provision of ACR.

D.8.i. For purposes of this rating section, the HMO shall present adequate documentation regarding the experience adjustments that are necessary to reflect any differences in the benefits required in this RFA as compared to those in effect for the experience period. This requirement is not limited to benefit changes, but also includes any other benefit or administrative revision, which will have significant impact on the Participant such as substantial changes to the HMO's network configuration or prescription drug formulary.

D.8.j. The HMO's proposed rates shall be less than or equal to those calculated according to the above method.

D.9. **Enrollment.** The HMO is required to reconcile its enrollment records with those of ERS. Experience period enrollment used in the rating process and any adjustments for changes in demographics shall be based on membership data that has been reconciled with ERS records.

D.10. **Trend.** The HMO shall provide documentation supporting the appropriateness of all trend assumptions, which have been used in the development of its rates. The trend assumptions may be based on provider negotiations, projections, etc., but the derivation of the assumptions shall be fully described. If the trend assumptions are derived on a component-by-component basis, list the components and allocate the trend to each component. The ERS consulting actuary will carefully scrutinize trend assumptions and will not recommend for approval rates that are based on excessive conservatism.

D.11. **Administrative Expenses/Profit.** The HMO shall provide an allocation of its administrative expense/profit charge by component, e.g., marketing, claims administration, network management, reinsurance, profit, etc.

In the evaluation of the HMO Applications, administrative expense/profit charges shall be carefully scrutinized by the ERS consulting actuary and a favorable recommendation concerning the proposed rates shall be in part dependent upon a determination that such charges are reasonable as compared to HealthSelect, the other HMOs and the HMO's general expense structure as indicated by its NAIC annual financial statement.

D.12. **Premium and Maintenance Tax Exemption.** The premium rate derivation shall include specific recognition of ERS' premium and maintenance tax/fee exemption.

D.13. **Investment Income.** Anticipated investment income shall be considered in the development of GBP rates. The HMO shall provide documentation of the manner in which investment income was considered, including an explicit indication of how administrative expenses have been reduced in recognition of the application of investment income. It is not satisfactory to simply state that administrative expenses have been implicitly adjusted to recognize investment income.

D.14. **Documentation Checklist.** The required documentation should be provided in a well-organized format that will allow the ERS consulting actuary to confirm the proposed rates. The rating documentation requirements are described below.

D.15. **The HMO using Method 1**: (from Section III.D.6. above) are required to provide the following documentation items (a) through (h).

D.15.a. The HMO's current community rating documentation.

D.15.b. Certification by a member of the American Academy of Actuaries that the community rates are appropriate for FY 2013 and are neither excessive nor unfairly discriminatory.

D.15.c. Documentation supporting any rating adjustments for differences in membership demographics between the anticipated FY 2013 enrollment and that assumed in the community rates.

D.15.d. Documentation supporting any rating adjustments for differences in benefits between the GBP plan and that assumed in the community rates.

D.15.e. Documentation supporting the reasonableness of all trend assumptions.

D.15.f. Amount of the administrative fee included in the HMO's proposed premium rates and an allocation of the fee by component.

D.15.g. Documentation supporting the recognition of ERS' premium and maintenance tax/fee exemption.

D.15.h. Documentation indicating how investment income has been considered in developing the proposed rates.

The HMO using Method 2. (from Section III.D.7. above) are required to provide the above documentation items (a) through (h) above and item (i) below.

D.15.i. Verification that the HMO's experience period enrollment used in the rating matches ERS' enrollment records.

The HMO using Method 3. (from Section III.D.8. above) are required to provide the above documentation items (a) through (i) above and items (j) through (p) below.

D.15.j. Documentation supporting any rating adjustments for differences in membership demographics between the experience period and that projected for FY 2013.

D.15.k. Documentation supporting any rating adjustments for differences in benefits between the experience period and those required for FY 2013.

D.15.l. Complete Utilization and Cost Data tables covering the experience period utilized in rating for each separately rated service area.

D.15.m. Documentation indicating that all program expenses, including capitated expenses, reflects GBP-specific utilization.

D.15.n. Documentation for any credibility formula used in developing the proposed ACR rates in the event the GBP enrollment is not large enough to be fully credible.

D.15.o. Documentation supporting any estimate of the HMO's liability for unpaid claims used in the determination of the ACR rates.

D.15.p. Disclosure of any rating margins used in the derivation of the proposed premium rates.

E. Rate Structure for Application

Proposed rates are to be guaranteed for the 12-month period beginning September 1, 2012 through August 31, 2013 (FY 2013) for each of the service areas for which the HMO proposes to offer services to GBP Participants. The required rating relationships are described on the Rate Application exhibit.

ERS shall pay the HMO for COBRA Participants based on the chart below that reflects how the revised rate structure for COBRA Participants corresponds to the rate structure for employees and retirees:

FY 2013 Rate Structure

COBRA Participant Category	**Applicable Rate Category**
Spouse Only	Member Only
Child Only	Member Only
Children Only	Member & Child(ren)
Spouse & Child(ren)	Member & Child(ren)

F. Rate Proposal Application FY 2013

F.1.

Proposed GBP Rates
Open Access
09/01/12 – 08/31/13

_____
(Name of HMO)

Using the following rate application chart, provide proposed monthly premium rates with or without prescription drugs guaranteed for the 12-month period September 1, 2012 through August 31, 2013 (FY 2013). All premium rates are derived from the Member Only rate based on the applicable rating formula. Complete separate charts for each separately rated service

area. If the HMO is submitting separately rated service areas, provide a listing of the counties included in each region. In general, ERS will consider only complete counties within the HMO's service area. If partial counties already exist within a currently participating HMO's GBP-approved service area, then those partial counties will be considered for approval.

Rating Category	Monthly Rate with prescription drugs	Monthly Rate without prescription drugs
(1) Member Only		
(2) Member & Spouse [a]		
(3) Member & Child(ren) [a]		
(4) Member & Family		
(5) Spouse Only [b]		
(6) Children Only [b]		
(7) Spouse & Children [b, c]		

a. Rates used for surviving spouses of deceased retirees only. COBRA rates are described earlier in this section. ERS adds 2% administration fee to these COBRA rates.
b. Cross-check: (7) = (5) + (6)
c. Cross-check: Monthly Rate is divisible by four (4)

NOTE: The HMO shall include one (1) Rate Proposal for Application exhibit for each separately rated service area submitted in its Application.

NOTE: ERS intends to compare the HMO premium rates versus the cost of providing benefits through its self insured plan. The premium rates proposed by the HMO must provide savings to the State in order for the HMO to be eligible for consideration. ERS will continue the process of evaluating the HMO's proposed rates using ERS' own geographic, demographic and health status selection assumptions. Based on this analysis, ERS will determine whether the proposed premium rates provide adequate savings to the State.

d. The GBP provides coverage for bariatric surgery which is considered cost-neutral to the HealthSelect plan. (See Benefits listed in the Bariatric Guidelines as referenced in Appendix N). Indicate if the HMO would be able to provide coverage for bariatric surgery at no additional premium to the GBP.

F.2.

Proposed GBP Rates

Gated Access

09/01/12 – 08/31/13

_____

(Name of HMO)

Using the following rate application chart, provide proposed monthly premium rates with or without prescription drugs guaranteed for the 12-month period September 1, 2012 through August 31, 2013 (FY 2013). All premium rates are derived from the Member Only rate based on the applicable rating formula. Complete separate charts for each separately rated service area. If the HMO is submitting separately rated service areas, provide a listing of the counties included in each region. In general, ERS will consider only complete counties within the HMO's service area. If partial counties already exist within a currently participating HMO's GBP-approved service area, then those partial counties will be considered for approval.

Rating Category	Rating Formula	Monthly Rate with prescription drugs	Monthly Rate without prescription drugs
(1) Member Only	N/A		
(2) Member & Spouse [a]	2.15 x (1)		
(3) Member & Child(ren) [a]	1.77 x (1)		
(4) Member & Family	(3) + (2) - 1		
(5) Spouse Only [b]	(2) – (1)		

(6) Children Only [b]	(3) – (1)		
(7) Spouse & Children [b, c]	(4) – (1)		

a. Rates used for surviving spouses of deceased retirees only. COBRA rates are described earlier in this section. ERS adds 2% administration fee to these COBRA rates.
b. Cross-check: (7) = (5) + (6)
c. Cross-check: Monthly Rate is divisible by four (4)

NOTE: The HMO shall include one (1) Rate Proposal for Application exhibit for each separately rated service area submitted in its Application.

NOTE: ERS intends to compare the HMO premium rates versus the cost of providing benefits through its self insured plan. The premium rates proposed by the HMO must provide savings to the State in order for the HMO to be eligible for consideration. ERS will continue the process of evaluating the HMO's proposed rates using ERS' own geographic, demographic and health status selection assumptions. Based on this analysis, ERS will determine whether the proposed premium rates provide adequate savings to the State.

d. The GBP provides coverage for bariatric surgery which is considered cost-neutral to the HealthSelect plan. (See Benefits listed in the Bariatric Guidelines as referenced in Appendix N). Indicate if the HMO would be able to provide coverage for bariatric surgery at no additional premium to the GBP.

G. HMO Provider Reimbursement Arrangements

Indicate how the following network providers are reimbursed.
Indicate with an "X" if the reimbursement mechanism is applicable.

Primary Care Physician _____
Capitation _____
Discounted Fee-for-Service _____
Discounted Fee-for-Service with withhold _____
Fee Schedule [1] _____
Other [2] _____

Specialty Care Physician
Capitation _____
Discounted-Fee-for-Service _____
Discounted Fee-for-Service with withhold _____
Fee Schedule [1] _____
Other [2] _____

Hospital
Capitation _____
Fee Schedule [1] _____
DRG _____
Per Diem [3] _____
Discounted Fees _____
Other [2] _____

Behavioral Health Facility
Capitation _____
Fee Schedule [1] _____
DRG _____
Per Diem [3] _____
Discounted Fees _____
Other [2] _____

Pharmacy
Retail Dispensing Fee _____
Retail Average Wholesale Price ("AWP") Brand Discount _____
Retail Generic Pricing _____
Mail Order Dispensing Fee _____
Mail Order AWP Brand Discount _____

Mail Order Generic Pricing	_____
Rebates as a % of Total Drug Costs Per Year	_____

Footnotes:

(1) Provide detailed explanation; e.g., if RBRVS is used, explain derivation and relationship to Medicare RBRVS.
(2) If "Other" category is used, provide a complete explanation of such reimbursement mechanism.
(3) If Per Diem is used, list categories of per diem, e.g., normal delivery, medical, surgical, etc.

IV. Communication Requirements

This Article describes the HMO's requirements in communicating with potential Participants, agency benefit coordinators ("BC"), employers, ERS staff, and other constituents, as further described herein. The HMO shall administer its plan in a manner consistent with all applicable state and federal laws, regulations and rules of ERS, and at the direction of the ERS Board, its Executive Director, and ERS staff. The cost of the requirements described herein shall be recovered by the HMO only by making provision for such expenses in the HMO's *Financial Requirements and Rate Proposal* in Article III.

The HMO's communication materials designed for GBP Participants cannot, and the HMO represents and warrants that it shall not, advertise or promote coverage, services, products or materials, other than those relating to the HMO's participation in the GBP. Prior approval of all communication material's design and content shall follow a formal process that requires ERS' documented authorization. In all cases, the HMO is not allowed to disseminate materials or information relating to the GBP program without prior written ERS approval. The final materials used by the HMO shall not differ in form or utility from those approved by ERS.

A. General Information

In all cases, the HMO communication materials, whether disseminated via the Internet, written, or in oral form, shall be approved by ERS prior to dissemination. The HMO is required to submit to ERS for prior approval draft copies of all proposed marketing materials to include, but not be limited to: power point presentations, scripts for presentations, newspaper/press releases, billboard, television, and radio advertisements for GBP AE or for any other GBP-specific purpose (as required in the latest version of the *Marketing Guidelines for GBP & ERS Vendors, located in the Style Guide and Usage Manual*, Appendix F). The final materials used by the HMO shall not differ in form or utility from those approved by ERS.

A.1. **Prohibition.** During AE, and ongoing communication process, the HMO shall not discuss, advertise, distribute, or in any manner allude to coverage, products, or materials other than those explicitly relating to the HMO's participation in the GBP. This product marketing prohibition also applies to the GBP-specific website to be used by GBP Participants.

A.2. ERS shall review and approve all communication materials designed for GBP members and GBP employers or that references the GBP. The HMO shall provide this material electronically in a format that allows for online editing. The HMO shall have the ability to customize said material to ERS' specifications. The HMO shall not distribute these communication materials until they have gone through a formal review process at ERS and have received ERS' documented approval authorization. Following this approval, the HMO may not alter the materials in any way.

A.3. In addition to GBP-specific materials, ERS may suggest refinements to other materials and will work with the HMO to modify materials as needed. These include operating documents such as Explanation of Benefits ("EOB"), claim approval and denial letters, other claims processing documents and promotional items.

A.4. **HMO Training Requirement.** The HMO's Account Team shall have designated resources available to provide training as needed to ERS staff, employers and GBP Participant members. Training may be conducted in person in individual or group settings or via webcast or conference call. Training related to the HMO internal operations shall be provided to ERS Customer Benefits and Benefit Contracts staff upon ERS' request. Staff training shall occur randomly throughout the year based on changes to operations or plan design and as ERS determines to be necessary. The HMO should have resources sufficient to provide fifteen (15) full days of training each year. ERS must approve training agenda and materials for external training. Training will be designed to meet specific learning goals. The HMO should be able to provide web-based training, in addition to in-person training.

A.5. **Plain Language Requirement.** The HMO is responsible for a wide variety of communication materials explaining the plan to eligible employees, retirees, and their dependents. ERS requires all HMOs to comply with TDI's plain language requirements as outlined in the Texas Administrative Code, Title 28, Part I, Chapter 3, subchapter G § 3.602, and as it may be amended in the future for all communication materials related to the HMO, Material

submitted to ERS for approval should be at the 8th grade reading level with limited use of jargon. The material shall conform to ERS' branding and communication guidelines. In addition, the material shall be subject to editing and customization, including legal disclaimers and other standard language.

A.5.a. Communication to Participants in the HMO shall be clear and understandable, using terminology familiar to Participants, customized, as required by ERS, to comport with the benefit plan design and approved by ERS prior to dissemination. All HMO communication materials shall meet Americans with Disabilities Act ("ADA") requirements for accessibility.

A.5.b. Communication material shall be available in both print and electronic forms. Certain material, such as provider directories, may be made available electronically, only as long as printed materials can be provided upon request to Participants. Accommodations shall be made for individuals with visual and/or hearing impairments, including the development, productions, and deployment of all communication materials to include web information.

A.6. **HMO Communication Materials.** ERS' Communications and Research Division ("CAR") shall assign a communications account manager ("CAR divisional designee") to manage communication material review and approval. HMO shall assign a communications representative to work with the CAR divisional designee. This representative must be familiar with the applicable GBP program(s). The HMO shall regularly review, revise and update, where necessary, all information contained on its website that relates to or may be utilized by any GBP Participants. All communications materials must be approved by the CAR divisional designee at least fifteen (15) business days prior to HMO sending, disseminating or otherwise providing such written or oral communications to any person or entity. On occasion, the HMO may obtain approval from CAR for a faster turn-around time, but this will be solely at CAR's discretion.

A.6.a. **Communication/Marketing Material Review Process.** Communication materials are considered "approved" when a final "printer's proof" or "test email" is delivered to ERS and subsequently approved by the CAR divisional designee, in writing. The HMO may not alter printer's proof in any way without ERS' permission.

A.7. **Advertising and other communications.** The HMO is required to obtain ERS approval for all proposed newspaper, web, social media, billboard, television, and radio advertisements used to promote GBP benefit programs.

A.7.a. The HMO's failure to receive ERS' approval for the use of GBP-specific communication materials prior to dissemination may result in a monetary assessment as referenced in the *Performance Assessments* in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

A.8. **Media Relations, Public Information and Outreach.** As an HMO for the GBP, the HMO may receive inquiries from interested third parties relating to the HMO's program administration, benefits and/or services. Although information about and generated under this Contract may fall within the public domain, the HMO shall not release information about or related to this Contract to the general public or media verbally, in writing, or by any electronic means without prior approval from the ERS Assistant Director ("AD") of Benefit Contracts, or designee, unless the HMO is required to release requested information by law.

ERS reserves the right to announce to the general public and media:

- award of the Contract;
- Contract terms and conditions;
- scope of work under the Contract;
- deliverables and results obtained under the Contract;
- impact of Contract activities; and
- assessment of the HMO's performance under the Contract.

Except where ERS approval has been granted in advance, the HMO shall not seek to publicize and shall not respond to unsolicited media queries requesting announcement of Contract award, Contract terms and conditions, Contract scope of work, government-furnished documents ERS may provide to the HMO to fulfill the Contract scope of work, deliverables required under the Contract, results obtained under the Contract, and impact of

Contract activities. If contacted by the media about this Contract, the HMO agrees to notify the ERS AD of Benefit Contracts, or designee, in lieu of responding immediately to such media queries.

A.8.a. **Media Inquiry Process.** The HMO shall verbally respond immediately to any media inquiries acknowledging receipt of query and provide the media with an expected timeframe for the HMO response based upon the HMO's understanding of the media request and an estimate of time required to respond.

A.8.b. If an HMO identifies that an inquiry is directly related to a GBP program and/or GBP program Participant, the HMO shall immediately provide a high priority written notification to the AD of Benefit Contracts, or designee, outlining all details related to the media's inquiry and all known facts of the related circumstances. GBP Participant information is considered confidential under Texas law.

A.8.c. If the case is GBP related, ERS will provide the HMO with:

a. specific instructions on how to manage the media inquiry moving forward;
b. direction regarding the handling of the Participant related issue(s) and/or complaint(s); and
c. if appropriate, provide the HMO with an ERS directive on Operational or Customer Service Representative ("CSR") internal control modifications necessary to avoid problem recurrence.

A.8.d. If the HMO determines that neither a GBP program nor GBP program Participant is impacted, the HMO may respond as appropriate and agrees to provide ERS' AD of Benefit Contracts with a copy of the response information no less than 48 hours from dissemination.

A.9. **Quality Control.** The HMO shall ensure that all communication materials submitted to ERS will reflect quality production, accuracy, timeliness, and thorough review. All GBP-approved benefit and legal documents, website, GBP-specific media responses, required reports (to include *ad hoc* reports), and dated materials shallinclude, but not be limited to, reflect the following criteria:

- Appropriate Plan Year;
- Accurate data related exclusively to the GBP, unless otherwise specified by ERS; and
- Contain GBP-specific language.

A.9.a. All such materials shall be provided within the required time lines as directed by ERS staff and/or its consultants and may not be released to outside sources without prior ERS consent.

A.9.b. The HMO's failure to provide accurate, timely and GBP-specific communication materials may result in a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

A.9.c. Following ERS' review and once edited materials have been provided to the HMO, the HMO shall conform all documents as reflected by the ERS designated deliverable dates. If the edits, or other mutually agreed upon resolution of those edits, have not been completed by the ERS designated due date, the HMO may risk a monetary assessment as required in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

A.10. **Participant Requests for Communication Materials.** The HMO shall, at its expense, respond to all Participant requests for mailed materials no later than three (3) business days following a Participant's request.

B. Agency/Higher Education Institution Communications

B.1. The HMOs approved by the Board for PY 2013 should be prepared to attend a meeting following Board approval to discuss the HMO's customer service, communications requirements, and AE meeting responsibilities.

B.2. **Agency/Institution Contacts.** There are approximately two hundred seventy-five (275) agencies of the State and higher education institutions that employ GBP Participants. Many agencies/institutions have staff dedicated to benefits enrollment and education, called a Benefits Coordinator ("BC"). The HMO shall have resources dedicated to responding to BCs

and other agency/higher education institution contacts. The HMO shall provide escalated customer service as well astraining and educational presentations/materials to agencies/higher education institutions throughout the year.

B.2.a. The HMO shall process requests from agencies/higher education institutions for communication materials for their employees. The HMO shall also process requests from individual retirees for printed communication materials upon request. In addition, the HMO may be asked to provide materials to employee and retiree associations, such as the Retired State Employees Association, Executive Women in Texas Government, the Texas Association of State Human Resource Managers, the Texas Public Employees Association and the Texas State Employees Union, at the HMO's expense. The cost of the requirements described herein shall be recovered by the HMO only by making provisions for such expenses in the HMO's *Financial Requirements and Rate Proposal* in Article III.

B.3. **Presentations and Events.** The HMO shall have a GBP knowledgeable representative available to attend numerous ERS-sponsored events throughout the year to include:

- AE fairs (additional resources will be needed during this 30-day period);
- Wellness fairs;
- Benefit seminars hosted by ERS throughout Texas;
- Annual retiree conference;
- Various association events and conferences; and
- Benefit Webinars.

B.3.a. In addition to ERS-sponsored events, the HMO shall provide at least one (1) GBP knowledgeable representative to attend the following employer sponsored and miscellaneous events to include, but not be limited to:

- Benefit fairs;
- New employee orientations hosted by employers; and
- Annual employer conference.

B.3.b. The HMO shall provide no fewer than one (1) GBP knowledgeable representative at each fair in the proposed coverage area who is well versed in the products and services to be offered to GBP Participants.

B.3.c. The dedicated resource must be an experienced presenter able to communicate effectively to large groups. Some events will require the representative to set up and staff an information table to offer GBP approved communication materials and individualized customer service.

ERS' CAR divisional designee will designate those events for which the HMO's attendance is required. The HMO acknowledges and accepts that additional obligations and enhancements to these requirements may become necessary should benefit plan changes or other circumstances warrant.

B.4 **Enrollment Campaign.** The HMO shall create custom communication materials for each enrollment campaign. This material includes, but is not limited to:

- An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events;
- Targeted enrollment communication brochures;
- Welcome letter to new Participants;
- Brochures explaining plan changes and updates; and
- General plan information.

C. HMO Communication Materials

C.1. All of the following information shall be included with the materials submitted for application in the format required in the latest version of the *Marketing Guidelines for GBP & ERS Vendors*, located in the *ERS Style Guide and Usage Manual*, Appendix F, and in the latest version of the *ERS Brand Guidelines,* Appendix M, and accessible on the CD-ROM in Word or Excel format, (no PDF documents will be accepted, with the exception of sample marketing, financial statements and audited financial materials).

C.2. The HMO shall have the ability to provide customizable communication materials.

Communication materials include, but are not limited to:

- Evidence of Coverage;
- Benefits Book, if applicable;
- Brochures and newsletters;
- HMO GBP-specific website;
- Presentations Scripted responses used by customer service representatives;
- IVR scripting;
- Participant communication and general information pieces;
- AE and Welcome Letters;
- Provider directory, including a specific disclaimer stating that the list of providers is subject to change;
- Fact Sheet with HMO Schedule of Benefits;
- News releases/Contract signing announcements;
- Annual HIPAA exemption notice and benefit changes summary;
- Articles for ERS newsletters;
- News updates for ERS website;
- Wellness, disease management, and cost-management pieces;
- Value-add benefits pieces;
- Publications listing with audience and publish target dates;
- Token giveaways for enrollment fairs, events; and
- Other related statements.

The HMO shall disseminate only GBP-specific approved materials at all events. Disseminating unapproved material, or material that is not customized for GBP Participants, could result in the levying of *Performance Assessments* as referenced in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

Any cost for these forms and other communication-related materials should be included as a part of the HMO's proposed fees. ERS shall retain the right to change or modify such material to accommodate ERS' specific needs.

C.3. The HMO shall design and/or print certain ERS communication materials on behalf of ERS. These materials are in addition to the communication materials that the HMO must produce as part of the contract and must be approved by ERS in advance of such printing in accordance with ERS' previously described format review process. Each year, the HMO will secure a print/fulfillment vendor on ERS' behalf and invoice ERS when the printing job is completed.

C.3.a. These tasks include, but are not limited to:

- Setting print/fulfillment bid specifications with assistance from ERS staff;
- Sending print/fulfillment bid specifications to prospective vendors;
- Receiving bids from prospective vendors on printing/fulfillment;
- Answering questions (with assistance from ERS staff) from prospective vendors on print/fulfillment bid specifications;
- Selecting an economical print/fulfillment vendor based on bid specifications;
- Conducting or attending periodic meetings on ERS print job with ERS staff and vendor;
- Serving as intermediary between ERS staff and vendor;
- Communicating with ERS staff and vendor in a timely fashion about printing and distribution specifications and deadlines;
- Comparing vendor invoices with the original bid, providing sign off, and obtaining sign off from ERS staff;
- Obtaining clarification (if needed) on vendor invoices;
- Submitting selected printing invoice to ERS staff for final approval;
- Paying printing vendor after invoices are approved by ERS; and
- Submitting HMO invoice to ERS for reimbursement.

C.4. **Confidential Information.** Materials that contain protected health information or other confidential information such as the Participant ID number must be mailed in an envelope or other mailing service device designed to secure the confidential information from casual viewers.

C.5. **Evidence of Coverage.** The HMO understands, agrees and acknowledges that the Contract between ERS and the HMO shall control over the EOC in connection with the contractual relationship between ERS and the HMO.

The HMO is required to produce a printed EOC for PY 2013, as well as to publish it on its GBP-specific website. The HMO shall submit a proposed EOC on a separate CD-ROM (in Word or Excel document, no PDF documents will be accepted) and include a sample ID Card in its Application materials. The HMO's currently participating in the GBP shall submit a version with tracked changes of their proposed EOC with the RFA response using their current GBP EOC as the starting point. The tracked change version shall indicate ALL proposed revision.

C.5.a. An HMO's failure to provide a tracked change version of their proposed EOC for the upcoming plan year may result in a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract. Once the EOC has been reviewed by ERS and all edits made, the EOC shall be submitted to TDI for approval. All EOC modifications required by TDI shall be provided to ERS, as well as any subsequent EOC revisions occurring during the plan year. The HMO shall inform ERS in writing once the EOC has received TDI approval. ERS requires that printed copies of the TDI approved EOC be immediately available to requesting Participants within three (3) business days of TDI approving the document, but no later than forty-five (45) calendar days following the start of the Plan Year. The final published EOC posted on the HMO's GBP-specific website shall not differ from that which was approved by TDI and provided to Participants in printed form.

C.5.a.i. The EOC shall include an identical copy of the Summary of HMO Benefits, as described in this document, a complete list of limitations and exclusions, including all plan provisions and the TDI-approved member complaint and appeal process. The HMO is required to include the GBP-specific eligibility rules as found in the Board of Trustee Rules, TX. Admin. Title 34, Part 4, § 81.5.

C.5.a.ii. **EOC Approval/Delivery Requirements.** A proposed, final draft of the HMO's EOC for PY 2013 shall be published and reflected in the HMO's test website available thirty (30) days prior to AE. The HMO's EOC revisions, as requested by ERS, shall be complete and all information accurately reflected on the live HMO website by the first business day of July or the HMO risks a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.5.a.iii. The HMO shall submit its finalized EOC to TDI so that one (1) CD-ROM version (in Word or Excel format, PDF documents will not be accepted) of the HMO's PY 2013 EOC shall be received by ERS' Benefit Contracts division no later than forty-five (45) calendar days following the start of the Plan year.

- **New Enrollees.** The EOC shall be mailed to all new enrollees who request a printed copy within five (5) business days after the HMO receives the Participant's request. For all other purposes, the EOC's publication on the HMO's website shall be provided as required in this section.

- **Current HMO Membership.** Within thirty (30) days following TDI approval, the EOC and applicable amendments shall be published on the HMO's website and shall be mailed within five (5) business days to all currently enrolled Participants if a printed copy is requested.

C.6. **Annual Enrollment or Welcome Letter.** A Welcome Letter should contain information about the HMO. For currently participating HMO's, an AE letter announcing any benefit charges from the previous year, including any formulary changes, shall be mailed to the current membership one (1) week prior to the start of the new plan year. The Welcome Letter shall contain instructions on how to access information and forms using the web, and include the customer service address, phone numbers, and hours of operation. The HMOs shall not utilize a postcard or flyer format for the Welcome Letter. For new GBP HMO's, the Welcome Letter should provide Participants with general information about the HMO's health and pharmacy benefit designs, including customer service address, phone numbers, and hours of operation. The HMO Welcome Letter should be available at the same time the two-page Fact Sheets are available to BCs.

C.7. **Fact Sheet.** The Fact Sheet shall consist of no more than two (2), front and back, 8.5 x 11 size pages. Sample Fact Sheets shall be included with the HMO's response. Once the Fact

Sheet contents are approved by the CAR divisional designee, and mailed directly to Medicare eligible Participants and other direct pay Participants by the HMO within five (5) business days upon request. The HMO agrees to reflect all Fact Sheet Information on the GBP-specific website and as further outlined herein.

The Fact Sheet shall include, but not be limited to, the following information in the order listed:

- The HMO's Customer Service contact information, including the phone number, email and physical address, hours of operation, and ERS' website address.
- An EXACT replication of the Summary of Benefits as illustrated in the RFA.
- A brief description of the main GBP benefits and reference to ERS' website.
- A reference to ERS' AE website noting it shall provide a listing of statewide enrollment fairs and their dates.
- Reference website information providing those specific ERS AE fairs that the HMO will be attending.
- Instructions on how to select a PCP and reference to ERS' website.
- Identify the HMO's Pharmacy Benefit Manager ("PBM") and its Customer Service phone numbers and ERS' website address.
- Identify and provide a brief description of the Disease Management program(s) offered by the HMO to GBP Participants. The information provided shall, at a minimum, include how a Participant may access more information concerning the program(s) and the process for enrollment.
- If appropriate, briefly describe any "Value-Added" products and include ERS' disclaimer.
- Identify the HMO's Wellness programs.
- Health Risk Assessments.

C.8. **Identification ("ID") Cards.** The HMOs shall issue an ID card to all eligible Participants, for both health and pharmacy benefits. If the HMO assigns its own ID Number to each Participant, it shall be capable of cross-referencing the HMO-assigned ID Number to the Participant's ERS employee ID number. The HMO shall not reference any web address other than ERS' and is required to provide a toll free customer service number. The HMO's shall submit an electronic example (on a CD-ROM, PDF document will not be accepted) of the proposed GBP ID card with the HMO's Application. Failure to produce GBP-specific Identification Cards as outlined herein may result in a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.8.a. Pursuant to TIC § 1369.153, an issuer, i.e., the HMO, of a health benefit plan that provides pharmacy benefits to Participants shall include on the front of the card:

- The name of the entity administering the pharmacy benefits if the entity is different from the HMO issuer;
- The group number applicable to the Participant;
- The identification number of the Participant, which may not be the Participant's social security number;
- The bank identification number necessary for electronic billing;
- The effective date of the coverage evidenced on the card; and
- The copayment information for generic and brand-name prescription drugs.

In addition to the above referenced information, the issuer of the HMO shall include on the identification card of each Participant:

- The logo of the entity administering the pharmacy benefits if the entity is different from the HMO issuer; and

- A telephone number for contacting an appropriate person to obtain information relating to the pharmacy benefits provided by the plan.

C.8.b. The HMO is not required to issue a separate pharmacy benefits ID card if the HMO administers its own pharmacy benefits; however, the health benefits ID card shall contain the information required in Section IV.C.8.a. above.

C.9. **Provider Information.** No provider may be listed on the HMO's website or distributed to the program Participants through the health plan's customer service unless a signed Contract with the provider is in place. In the event the HMO provides incorrect information and a Participant seeks medical treatment based on that information, the HMO agrees to recognize and be financially responsible for any services rendered by that provider, under the terms of the Contract, as if the provider had been under Contract.

C.10. **Provider Directories.** The HMO shall not be required to provide printed versions of its Provider Directories, but copies (or materials which become stale dated at the time of printing) shall be provided to the GBP Participant upon request and such hard copy material(s) shall be received by the Participant no later than seven (7) business days from the date of request. Also a published Directory shall be accessible at all times online.

C.11. **Member and Consumer Information Sources.** The HMO shall have a variety of tools and information sources for GBP Participants. This includes, but is not limited to, the following:
- New Participant and HMO and GBP AE information;
- Examples of cost scenarios to help members understand how an HMO works; and
- Non-web information similar to web tools for those without web access.

C.12. **GBP Custom website.** The HMO shall publish and maintain a custom website for GBP Participants and prospective Participants in a format prescribed by ERS. Neither the HMO nor its subcontractors can advertise or link to products or services without the express prior written permission of the CAR divisional designee. The HMO's failure to provide the custom website as outlined below may result in a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.13. The GBP website shall be directly linked to the ERS homepage. The GBP website shall be in final form and linked as required by ERS no later than the first business day of June of each year or as otherwise directed by ERS. An HMO's failure to provide the GBP-specific website as outlined below may result in a monetary assessment as reflected in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.13.a. **Proposed website materials.** The HMO shall provide ERS with a test site for review thirty (30) business days prior to the go-live date. The URL address, all screen shots, and instructions on how to access the HMO's test website are required for submission with the HMO's bid response materials. For HMO's currently participating in the GBP, it will be necessary to provide separate links from the ERS website for FY 2012 and the proposed test website being established for FY 2013. All links and web pages shall clearly identify the plan year for which the information applies.

C.13.b. **All HMO "Test" websites.** The HMO shall provide a fully developed GBP-specific test website, capable of being linked to the ERS Internet home page. Following ERS' approval of test websites and prior to being linked to the ERS website, the HMOs shall provide documentation of a test plan, test scripts (e.g., to ensure all links are working), completion of testing, and final sign off. The HMO's test website shall transition from a test phase to fully operational and be linked to the ERS website with all information and components as reflected below no later than thirty (30) business days prior to AE or risk a monetary assessment as required in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract.

C.13.c. The HMO's GBP-specific web Home page shall include the following primary access links:
- The HMO's Privacy Plan;
- Customer Service contact information;
- Benefits summary;
- Pharmacy Preferred Drug List;

- Mail Order Prescription Service;
- Provider Look-Up and/or Provider Directory;
- Disease Management Services (as defined herein);
- Wellness Services (as defined herein);
- On demand real time provider information and search capabilities; and
- Search function.

C.13.d. The HMO's GBP-specific homepage shall include both the GBP health plans logo and the ERS logo as required by the latest version of the *Marketing Guidelines for GBP & ERS Vendors*, located in the *ERS Style Guide and Usage Manual*, Appendix F, and the *ERS Brand Guidelines*, Appendix M, and specified below:

D. HMO Website Content

All content for the HMO GBP-specific website shall be approved by ERS prior to publication. The final materials used by the HMO shall not differ in form or utility from those approved by ERS.

D.1. The HMO GBP-specific website shall provide self-service transactions for Participants to:
- View the PCP selection and an 18-month history of claims, if applicable;
- View a deductible and coinsurance maximum total paid to date;
- View and print a claims EOB;
- Print a temporary ID card and claim form;
- Compare treatment costs;
- Complete and submit a Health Risk Assessment;
- Locate a PCP based on specific geographic requirements;
- Lodge a service complaint, escalate unresolved complaints, and to request a telephone call back within one (1) business day;
- Communicate with customer service representatives using live chat;
- Search the full website using a key word and/or phrase; and
- Provide a "return to home" button, which returns the viewer to the ERS PY 2013 home page.

D.2. **Plan Year Information.** The GBP home page shall include the following information:
- Information that welcomes new Participants and introduces the Participant to the HMO and summarizes the basic coverage benefits;
- Direct link to ERS' website. The HMO shall indicate the current dates for the HMO and GBP AE and remove all references to the HMO and GBP AE no later than September 1st of that plan year or as directed by ERS;
- The HMO shall indicate each AE fair that the HMO will attend;
- Accessing Emergency Care; and
- Helpful Phone Numbers and websites.

D.2.a. **Link to the HMO's Privacy Plan**

D.2.b. **Link to the Customer Service Page is** to include the following information:
- Phone numbers and hours of operation;
- Physical address of plan site;
- Link to the HMO's Complaint Process;
- An email address or a link to a mailbox for Participants to send customer complaints and questions directly to the HMO. The HMO should respond to email complaints/inquiries with no more than a 24 hour (business days) turnaround. A tracking system for email complaints shall be in place similar to the tracking of telephone complaints to provide to ERS;
- The HMO's Transition of Care procedures and form (if the form is applicable);
- Any applicable interactive forms; i.e., Claim form, Mail Order Pharmacy, and/or Supplemental Insurance form. If ERS provides a copy of the Supplemental Insurance Form, then it is required that this form be linked from the Customer Service Page;
- A Member Handbook is preferred, but not required if not applicable to the HMO's delivery of care; and
- A Link to the HMO's Appeals/Grievance Process.

D.2.c. **Link to Benefits is** to include the following information:
- AE or Welcome Letter;

- Fact Sheet;
- A Summary of HMO Benefits; and
- The EOC, including any necessary riders to comply with the Summary of HMO Benefits; The EOC shall contain the Summary of HMO Benefits and all exclusions as required by TDI. The current plan year website, including the EOC, shall be available until September 1, 2012. Following TDI's approval, the EOC for FY 2013 shall be published on the website within thirty (30) business days and a copy shall be provided to ERS on a CD-ROM no later than October 1, 2012.

D.2.d. **Link to Pharmacy Preferred Drug List is** to include the following information:

- A complete listing of covered drugs, indicating which ones are classified as formulary name brands and generic, in alpha order by drug name;
- Copayment schedule, including plan year deductible;
- Mail Order link to the HMO's prescription drug mail order service or a process for ordering drugs by mail through the HMO's website, including the necessary forms and customer service telephone numbers for Participants. A statement shall be included explaining that up to a ninety (90) day supply is available for the mail order copayment; and
- GBP-specific language that precedes the Pharmacy Formulary Information.

D.2.e. **Link to Provider Look-Up and/or Provider Directory is** to include the following information:

- Instructions on selecting a PCP; and
- The Provider Look-up shall be updated in real-time. Users should be able to search by ZIP code and obtain a map and directions to the provider's office. It should indicate that the provider is: a PCP, a specialist, or ancillary provider, e.g., physical therapist, and indicate provider number, network affiliation; i.e., independent vs. group practice, and if he or she is accepting new patients. Each PCP shall have an assigned unique office or provider code number. The HMO shall include a disclaimer that providers are subject to change.

D.2.f. **Link to Disease Management Services is** to include the following information:

- List those Disease Management programs currently provided;
- Provide a description for each Disease Management program referenced;
- Indicate how GBP Participant may get more information on any offered program(s); and
- Provide enrollment information/form.

D.2.g. **Link to Wellness Services is** to include the following information:

- A list of the Wellness programs currently provided;
- A description for each Wellness program referenced;
- Provide a Health Risk Assessment form and directions for use;
- Indicate how GBP Participants may get more information on any offered program(s); and
- Provide enrollment information/form.

E. Web Specifications

E.1. **HMO Website Technical Specifications.** Providing information to state and higher education employees, retirees and their dependents is ERS' primary focus in its web page design. The HMO shall adhere to all website access, format, content, and technical requirements outlined in both the ADA, and Section 508 of the Workforce Rehabilitation Act of 1973 ("Section 508") in order to accommodate the needs of all individuals accessing GBP information.

E.1.a **Section 508 Requirement.** The HMO is required to comply with Section 508 accessibility standards. Section 508 requires that when state agencies develop, procure, maintain, or use electronic and information technology, they shall ensure that their information technology allows state employees and members of the public with disabilities to have access to and use of information and data that is comparable to the access to and use of information and data by state employees and members of the public who are not individuals with disabilities, unless an undue burden would be imposed on the state agency. In other words, all visitors to the ERS website should get a full and complete understanding of the information contained on the site, as well as the full and complete ability to interact with the site. Exceptions to this rule are only acceptable on a case-by-case basis and shall be approved by ERS.

E.1.b To validate the HMO's Section 508 compliance, the HMO shall provide a report with its RFA response evidencing its organization's Section 508, Level 1, compliance.

E.1.c **HMO's Internet Availability.** The HMO providing Internet access to GBP Participants guarantees that the Internet Availability Rate for each Fiscal Year shall be 99.5% or greater. "Internet Availability Rate" means the percentage of available hours that the HMO's GBP-specific Internet site is operational, excluding scheduled and pre-approved maintenance time, measured on a Plan Year basis, as reflected in Appendix G, *Performance Assessments*.

The HMO shall correct inaccuracies within ten (10) days of being notified by ERS, as reflected in Appendix G, *Performance Assessments,* or face implementation of other legal remedies available to ERS in the Contract.

V. Operational Specifications

This Article describes the HMO's operational specifications. The HMO shall administer the Plan in a manner consistent with all applicable state and federal laws and regulations, as well as ERS' administrative rules and at the direction of ERS' Board, its Executive Director, and staff. The cost of the requirements described herein may be recovered by the HMO only by making a provision for such expenses in any proposed premium rates in the HMO's *Financial Requirements and Rate Proposal* in Article III.

The HMO shall submit their "group number" and provide a list of lead contacts to both the ERS Communications and Research and Benefit Contracts division(s) by the first working day of the month following Board selection. The HMO agree that it shall cooperate with ERS and be flexible in working with ERS to ensure a smooth implementation.

The HMO must provide a technical contact that will provide support to ERS' Information Systems Division for Electronic Data Interchange issues. ERS will work with the HMO on these requirements following Contract award.

The Contract will include *Performance Assessments* and other legal remedies to ensure proper administration of the HMO Plans as outlined in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

A. Implementation Operational Requirements

A.1. The HMO shall provide all services specified in this RFA including, but not limited to, the following:

A.2. **Implementation Plan.** The HMO shall provide in their application for review and approval by ERS, a detailed proposed Implementation Plan, which shall include, without limitation the following:

- A Detailed description and manner in which all work is to be performed;
- A list of sample reports relevant to HMO reporting-specific GBP reports will be determined following Contract award;
- A detailed description of all activities the HMO expects ERS to perform related to the Implementation Plan;
- Schedules of meetings between the HMO and ERS to facilitate the transition; and
- Scheduled updates and/or amendments to the Implementation Plan, at least monthly, to reflect mutually agrfeed upon changes as additional work is defined.

A.3. **Account and Implementation Teams.** No later than the fifteenth (15th) business day following Board selection, the HMO shall provide to the Benefit Contracts AD, or designee, a thorough listing of the HMO Account and Implementation Team contacts assigned to support the HMO's Contract. The list shall identify an account "key point of contact" responsible for the implementation, coordination, and maintenance of the business relationship and continuity pertaining to all business matters in support of the Contractual Agreement.

The HMO's Implementation and Post-Implementation Account Management Teams contact list should reflect key contact information (resume, office, fax, and cell phone numbers, email and physical addresses) for each HMO Account and Implementation Team representative. The HMO shall ensure a smooth transition in the event of a change in the HMO for complete continuity, without exception, of all ERS communication processes and requirements as follows:

- The HMO shall inform, via email notification, the AD or designee of Benefit Contracts, in advance of any planned periods of unavailability by the Team's key point of contact.
- In any instance where a Team "key point of contact" is not available to ERS, the HMO shall immediately secure and provide details of alternate coverage sufficient to meet ERS' expectations.
- Should staffing adjustments of additional team members become necessary to support the account functions, the HMO shall dedicate such appropriate staff as required by and acceptable to ERS.

A.4. **Implementation Team.** The HMO shall provide an Implementation Team to coordinate and expedite all Contract requirements as outlined and prioritized by the AD or designee of Benefit Contracts to ensure complete continuity, without exception, of all interactive HMO functions, deliverables, and objectives prior to and during the Contract's onset. At minimum, the Implementation Team shall have a dedicated Project Manager and back-up Project Manager with availability to ERS staff throughout the Implementation Period. Should staffing adjustments or additional team members become necessary to support implementation functions, the HMO shall dedicate such appropriate staff as required by and acceptable to ERS. The HMO shall provide brief summary resumes with this RFP response of the proposed Account and Implementation Team's points of contact for ERS.

A.5. **Implementation Project Manager.** The implementation project manager shall serve as ERS' primary contact throughout the Implementation Period, and shall have the legal authority to make binding decisions for the HMO, and be accessible to ERS seven (7) days a week and twenty-four (24) hours per day during the Implementation Period. The Implementation Plan shall be attached to the Contract as an exhibit in the form most up-to-date at the time of Contract execution and may be modified thereafter by agreement of the parties.

A.6. The HMO acknowledges that it is impossible or impractical to estimate with any degree of certainty the impact or damage that the failure of particular Implementation activities may have on the GBP and/or its Participants. Therefore, the HMO agrees that Implementation failures, judged by ERS to have adversely harmed the GBP and/or its Participants, may immediately subject the HMO to the Liquidated Damages as described in the Contract and *Performance Assessments* provisions as reflected in Appendix G, or implementation of other legal remedies available to ERS in the Contract.

B. Post-Implementation Operational Requirements

B.1. **Account Management**

The HMO shall establish and maintain throughout the term of the Contract an account management team that will work directly with ERS staff. This team may include, but is not limited to, a designated account executive, a customer service manager, a medical director, a practicing attorney, a consulting actuary, a person responsible for preparing reports, and a management information system representative. Approval of the account management team rests with ERS. The HMO's account management team shall provide all services specified in this RFA, including, but not limited to the following:

B.1.a. The HMO shall provide an Account Executive Team and make staffing adjustments, as required by and acceptable to ERS. The results from the formal performance evaluation of the assigned account management team may be used in this determination. An ERS Account Executive Team shall be established no later than thirty (30) calendar days following Board selection, and be available Monday through Friday from 8:00 a.m. to 5:00 p.m., central time, excluding national holidays.

B.1.b. The HMO shall provide a minimum of two (2) per fiscal year face-to-face Account Executive reviews to ERS on the utilization and performance of the GBP Program. The reviews shall include, but not be limited to, a presentation of the following information:

- Health program statistical outcomes;
- Industry trends and best practices;
- Plan recommendations; and
- Other cost saving recommendations.

B.1.c. **Meetings.** The HMO shall develop meeting agendas, coordinate meetings and provide documentation of actions in the form of meeting minutes for designated meetings with ERS at a scheduled time agreed upon by ERS and the HMO to include, but not be limited to:

- Implementation, if applicable;
- Operational;
- Analytical;
- Information Systems; and
- Communications, etc.

B.1.c.i. The HMO shall utilize ERS' meeting agenda template and provide meeting agendas one (1) day prior to scheduled meetings.

B.1.c.ii. The HMO shall provide the meeting minutes within four (4) business days after the day of the scheduled meeting for ERS' review and approval.

B.1.d. ERS strongly believes that the account service relationship is the critical link in developing and maintaining a strong working relationship dedicated toward the achievement of plan objectives. As such, the HMO shall be committed to providing ERS with service attention that is at the highest levels in the industry, and fully consistent with ERS' expectations. ERS shall define the criteria for measurement and evaluation of service performance.

B.1.e. The Carrier shall notify the Director of Benefit Contracts, in writing, no less than ninety (90) calendar days prior to anticipated major changes likely to impact the GBP Program. Carrier shall receive prior written approval from ERS' authorized representative prior to making any changes as addressed in this section.

B.1.f. In addition to the above requirement, the HMO shall notify ERS' Benefit Contracts Division, in writing, thirty (30) business days prior to implementing material changes in policies, servicing methodologies, business, and key personnel connected with the ERS account.

B.1.g. The HMO shall provide general administrative, legal and statistical support to assist ERS in the operation of the GBP Program and shall recover any associated costs by making provision for such expenses in the HMO's *Financial Requirements and Rate Proposal*, Article III.

B.1.h. The HMO shall provide ERS with priority positioning for delivery of *ad hoc* system service requests and/or issue resolutions. As reflected in Article X, *Organizational Information* Section X.C.7., the HMO shall designate a Technical Consultant ("TC") to lead the management of all technical issues, including, but not limited to system service requests. The TC shall ensure that all ERS system requests and issues are thoroughly analyzed and given priority positioning to ensure prompt resolution. The HMO shall provide competent, focused attention to ERS' system requests/issues. The HMO shall use its best efforts to implement all ERS system requests and to correct all ERS system issues as soon as reasonably practicable, but in no event later than thirty (30) calendar days or sooner from receipt of ERS' written notification to the HMO of the request/issue. ERS shall fully supply any and all information reasonably necessary for the HMO to complete the requested services as outlined herein. If an ERS request cannot be implemented by the HMO within thirty (30) calendar days from the date of ERS' request, then the HMO shall provide ERS with a written explanation as to why the issues are not capable of being resolved within this time frame and provide a written plan for implementation, to include a timeline for resolution, within five (5) business days from receipt of the HMO's written notification as noted above. This section does not apply to disaster recovery matters, which are covered specifically in the Contract.

An example of a system issue includes, but is not limited to:

Eligibility and/or Benefit modifications shall be reviewed, responded to, and approved by the HMO within fifteen (15) business days of such request. If changes to the modifications are required, the HMO shall notify ERS and set up weekly updates until ERS agrees that the modifications meet ERS' operating requirements. After eligibility and/or benefit modifications have been mutually agreed upon, the HMO shall complete the eligibility and/or benefit project, including required testing, within forty-five (45) calendar days from ERS' approval.

B.1.i. In addition to the TC, the HMO shall provide ERS with access to a designated Clinical Consultant and/or Medical Consultant to advise and support ERS on analyzing emerging clinical and utilization trends within the scope of reviewing both standard and *ad hoc* reports.

B.1.j. The account management team shall be thoroughly familiar with virtually all of the HMO's functions that relate directly or indirectly to the GBP account.

B.1.k. The HMO shall provide GBP with priority placement in all aspects of Contract performance provided by the HMO.

B.1.l. The HMO agrees to allow ERS to complete a formal performance evaluation of the assigned account management team annually as deemed appropriate by ERS.

B.1.m. ERS requires the HMO to meet with ERS staff and/or Board of Trustees as requested to discuss the status of the GBP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit the GBP and its members.

B.1.n. The HMO is expected to present actual GBP claims experience and offer suggestions as to ways the benefit could be modified in order to reduce costs or improve the health of GBP members. Suggestions must be modeled against actual GBP membership and claims experience to determine the financial impact as well as the number of members impacted.

B.1.o. The HMO shall also present benchmark data by using the health plan's entire book of business, a comparable client to the GBP, and/or some other industry norm.

B.1.p. The HMO shall provide a high quality and experienced customer service unit. The health plan staff members shall be fully trained in the GBP health benefit designs, and the HMO shall have the ability to track and report performance of call center matrices.

B.1.q. The HMO shall provide ERS access to a dedicated/designated Reporting and Analytical team to advise and support ERS to include, but not be limited to:

- Create statistical reports;
- Develop templates for ERS data; and
- Benchmarking analysis.

C. The HMO Customer Service Call Center

The HMO shall provide all Customer Service Call Center functions within the United States, and preferably in the state of Texas.

C.1. **Call Center/Customer Service Unit.** The HMO shall establish and provide for staffing of one (1) customer service unit designated exclusively to ERS' GBP Program. The unit shall be adequately staffed to manage GBP-related questions and provide for resolution of complaints, clarifications, and escalated issues.

C.1.a. The hours of operation for the HMO's customer service unit shall be, at a minimum, Monday through Friday from 8:00 a.m. to 7:00 p.m., central time.

C.1.a.i. **Call Center Specialists.** The HMO shall designate as many Call Center Specialists as necessary whose sole responsibility shall be to respond to and resolve, within a reasonable timeframe as determined by ERS, plan-related customer service needs. ERS and the HMO shall jointly monitor and adjust staffing levels to ERS' sole satisfaction as work and service requirements demand. The HMO warrants and represents that it shall provide thorough training of additional team members in support of the ERS program. Any training deficiencies noted by ERS shall be immediately rectified by the HMO to ERS' satisfaction.

C.1.a.ii. **Back-up Staffing.** The HMO shall designate additional staff, as needed or at ERS' request, to update and maintain HMO-related records and accounts. This staff will also provide additional support for the HMO's customer service team.

C.1.a.iii. **Call Center Management Criteria.** The HMO shall establish toll free lines (telephone and facsimile). The HMO shall also employ appropriate and adequate customer service staff to maintain *Performance Assessments* for average speed to answer, abandonment rate and blockage rate to comply with TDI standards as referenced in Appendix G, or implementation of other legal remedies available to ERS in the Contract. The HMO shall provide in its Application the methodology and sample source documents utilized by the HMO to arrive at the reporting requirements for the call center metrics referenced in Appendix Q.

C.1.a.iv. **Access for Hearing Impaired.** The HMO's Call Center shall be equipped with Telephone Device for the Deaf ("TDD") or Teletype ("TTY") in order to serve the hearing impaired population.

C.1.a.v. **Language Accessibility.** The HMO's Call Center shall have at least two (2) member service representatives who are bilingual in English and Spanish and provide Limited English

Proficiency ("LEP") support or have a language translation organization available for such support.

C.1.a.vi. **Benefits Coordinator ("BC") Access**. The HMO shall provide BCs with a special number or access code that permits them to have propriety access to the HMO's Call Center supervisors. The HMO can satisfy this "hotline" requirement by expediting calls to this special number in front of the general queue. Additionally, BCs and dedicated ERS staff shall be provided with a web portal to electronically access Participant eligibility status and through which they may escalate GBP requests to a Call Center supervisor.

C.2. **Enrollment Verification.** To assist the HMO's in verifying enrollment, ERS provides online access to its enrollment system, PeopleSoft. Online access is available through the HMO's Internet provider and shall be operational thirty (30) business days prior to the go-live date. Staff trained on ERS' enrollment system shall be available during all customer service open hours.

C.2.a. ERS may implement a minimum enrollment standard for the HMO. Under such a standard, the HMO that does not develop a sufficient GBP Participant level over a specified period of time will not be eligible for renewal. Details on this minimum enrollment standard shall be provided to the participating HMO should ERS elect to implement such a standard.

C.2.b. Accept oral verification of a GBP Participant's coverage by an authorized representative of ERS. Coverage shall be updated in the HMO's system prior to receipt of the next ERS weekly/monthly enrollment information.

C.3. **Audit.**

C.3.a. ERS may contract with an auditing firm to conduct periodic audits of the HMOs participating in the GBP. The HMO shall be required to cooperate with and support the efforts of the Auditors. Neither ERS nor the Auditors will be required to indemnify the HMO for any costs incurred in connection with these audits.

C.3.b. ERS, or any of its duly authorized representatives, shall have access to any GBP-related information during the term of the Contract and until the expiration of seven (7) years after the final payment is made under the Contract. ERS shall have access to and the right to examine any pertinent books, documents, papers, and records of the HMO involving transactions relating to the Contract. In the event any claim, dispute, or litigation arises concerning the Contract, the period of access and examination described above may continue until the disposition of such claim, dispute, or litigation has been deemed final.

C.4. The HMO shall assist ERS in the administration of the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Public Law 99-272. The HMO shall administer coverage for those categories of Participants who have lost or shall lose coverage as a result of a qualifying event as defined in Title X of Public Law 99-272 (COBRA). Any such Participant is entitled to elect to continue coverage under this Contract in accordance with the provisions set forth in COBRA, and as administered by ERS, in accordance with its administrative practices. ERS and/or the employing department shall handle enrollment of Participants in COBRA continuation coverage and collection of premiums.

During any interim period between cancellation of insurance due to a qualifying event and enrollment in COBRA continuation coverage, the HMO shall provide to any qualified beneficiaries under COBRA continuation coverage, on a fee-for-service basis, the identical services that are available to a non-COBRA GBP Participant, and will, upon receipt of confirmation of COBRA enrollment from ERS, refund to the COBRA Participant all fees paid by the Participant less any appropriate copayment amounts.

A qualified beneficiary who has elected to continue coverage in accordance with COBRA, may permanently move outside of the HMO's service area and maintain his/her HMO coverage in accordance with state requirements. However, coverage may be limited to emergency services only outside of the service area.

C.5. **Other Continuation Coverage**

- The HMO shall provide state mandated continuation coverage, pursuant to Section 1271.301-306 TIC, upon termination of a Participant's group coverage and/or termination of any period of COBRA continuation coverage.
- ERS shall send notification to all COBRA Participants thirty (30) days prior to completion of the COBRA coverage.
- The notification shall advise the Participant that they shall contact the HMO to determine the specifics regarding their option to either continue coverage for six (6) months or apply for the HMO's conversion policy, if one is available.
- If the Participant elects to take the six (6) months of continued coverage, the HMO shall direct the Participant to ERS for forms completion. ERS shall continue to collect the premium and report the coverage to the HMO for those Participants.
- Participants electing the HMO's conversion policy, if one is available, shall deal directly with the HMO following the termination of COBRA coverage.

C.6. **Medical Support Order.** The HMO shall support the Medical Support Ordered ("MSO") dependent coverage. Special situations exist, such as the medical support of a dependent by court order. Under the HMO Contract, dependents residing outside the HMO service areas have coverage for non-emergency treatment only if rendered through the HMO provider network. Non-emergency care received outside the HMO service area, even when received in a locale in which a student is residing for educational purposes, is not reimbursable. Coverage for dependents who have coverage as a result of an MSO is an exception to this provision. In compliance with Chapter 1504, TIC, as amended, the HMO shall provide routine and emergency coverage for medical services outside the service area for MSO dependents (children) through the Contract term.

ERS also permits a spouse protected by a temporary MSO to continue insurance coverage until a pending divorce is final. ERS shall report the termination date of the spouse's coverage.

C.7. **Coordination of Benefits and Medicare.** The HMO shall comply with the GBP procedures for the Coordination of Benefits ("COB") process. See Article VII, *Summary of HMO Benefits*, for specific COB procedures.

D. HMO Program Reporting

D.1. **Actuarial Reporting**

D.1.a. As previously noted, ERS retains a consulting actuary on insurance matters. The consulting actuary assists and advises the ERS Board and staff on benefit plans design, Application review, and rating analysis. ERS staff or the consulting actuary may, from time to time, request the HMO to provide additional information specific to the GBP. The HMO shall cooperate with and act in good faith in working with ERS and/or the consulting actuary and shall be prepared to respond to these requests promptly.

D.2. **Annual Reporting Requirements.** The HMOs shall be required to submit GBP utilization and cost data on an annual basis using an ERS-prescribed format by January 15th following the end of the fiscal year. For example: by January 15, 2014, participating HMOs shall be required to provide utilization and cost data for the experience period September 1, 2012 through August 31, 2013. The HMO is required to provide the required experience information for the previous fiscal year regardless of whether or not the HMO continues as a participating HMO under the GBP. ERS' Vendor website contains an example of the required information and data formats along with instructions for completing the tables. The example of the required information is located at: https://www.ers.state.tx.us/Community/Vendors/UC_Data_Tables/

D.2.a. The participating HMO shall also be required to provide an annual report via CD-ROM that shows the number of GBP Participants assigned to each of the HMO PCPs. The report shall include the PCP's last name, first name, license number (issued by the Texas Board of Medical Examiners), office, ZIP Code and the number of GBP Participants assigned. For example:

Table 2- Report Example

Last	First	License	ZIP Code	Number of

Name	Name	Number		GBP Participants
Brown	John	A7777	78701	5
Doe	Jane	B8888	75238	20
Smith	Joe	C9999	77041	10

D.3. **Quarterly Reporting - Disease Management.** The HMO shall be in compliance with § 1551.219, TIC, as it relates to Disease Management. Further, the HMO shall report to ERS, on at least a quarterly basis, administration adherence and related expenses/savings to the GBP as applicable to the statute. The data shall include the entire previous quarter, and shall be received via email by the 20th of the following month after quarter end. ERS does not require a specific format for this report.

D.4. **Monthly Reporting Requirements.** ERS requires the HMO to provide the following reports as reflected in Sections V.D.4.a. – V.D.4.c. below using either GBP-specific or book of business statistics. The data shall include the entire previous month, and shall be received in the ERS-prescribed format via email by the 20th of the following month. Failure to provide the required data may result in a monetary assessment as required in the *Performance Assessments*, Appendix G, or implementation of other legal remedies available to ERS in the Contract. The required data and format are subject to change as required by ERS. The current requirements are:

D.4.a. **Monthly Administrative Performance Report.** This document reflects the specific Contract performance areas upon which the HMO must report each month. The last tab of the document reflects the calculation and methodology used to identify the reported measure. On an annual basis, the HMO will be responsible for providing ERS with the source document in order to allow ERS the opportunity to certify that the self-reported data is accurate. A sample monthly administrative performance report is referenced in Appendix O.

ERS shall utilize information reported by the HMO to proactively monitor trends and to identify/address variances on targeted HMO performance requirements. ERS shall specify the reporting timelines and formats. Some formats shall include a column, indicating a performance standard for the item being reported, that ERS shall use as a benchmark to monitor compliance and to analyze the reported statistics. The standard to be reported is based on availability in the following order of priority:

1. Stated in the Contract;
2. Defined by TDI;
3. As required by applicable statute or regulation;
4. HMO internal standard; or
5. Generally accepted industry standard.

To ensure the accuracy of the self-reported information and reliability of the HMO's internal operational controls, the HMO shall provide documentation verifying the statistics. The document type and due date shall be specified by ERS.

The statistics required to be reported by the HMO include, but are not limited to:

- The number of written and emailed complaints received from GBP Participants, and the average length of time to resolve those complaints. Complaints shall be resolved within thirty (30) calendar days.
- The number of and percentage of ID cards mailed within five (5) business days of the HMO's receipt of enrollment data from ERS or Participant request.
- The number of and percentage of EOCs mailed within five (5) business days of the HMO's receipt of enrollment data from ERS or Participant request.
- Answer time, in seconds, for calls in the queue.
- Average call-blockage rate.
- Provider network additions and terminations, by primary care, specialty and facility.
- GBP-specific dollars recovered through fraud investigation activity.

D.4.b. **Monthly Provider Network Additions/Terminations Detail Report.** This information is utilized by ERS to proactively monitor and respond to changes in the provider network. The following data elements are required in the ERS-prescribed format: Provider Name, Provider Specialty, Full Provider Address, Date Provider Added To or Terminated from the Network.

To ensure the accuracy of the self-reported information and reliability of the HMO's internal operational controls, the HMO shall provide documentation verifying the statistics. The document type and due date shall be specified by ERS and is not intended to convey proprietary and confidential provider contracting information.

D.4.c. **Monthly Premium and Claim Report.** The HMO shall provide ERS' Benefit Contracts Underwriting division with a monthly comparison of paid/billed premiums to the paid claims for the month. The specific claims data to be reported shall include:

- In-patient hospital confinements;
- Out-patient services;
- Physician fee-for-service;
- Capitation;
- Prescription Drugs; and
- Total.

D.5. ***Ad Hoc* Reports.** From time to time ERS may, on an *ad hoc* basis, request that the HMO prepare customized reports on a timely basis at no additional cost to the GBP.

E. Other Administrative Requirements

E.1. **Site Visits**

At ERS' discretion, agency personnel may conduct site visits at ERS' sole expense. The HMO may be asked to assist ERS staff with arranging and identifying travel and lodging arrangements that shall be in compliance with the state of Texas travel guidelines.

E.2. **Identification ("ID") Cards**

E.2.a. The HMO shall send ID cards to all new Participants, including dependents, who enrolled during AE within fifteen (15) business days of the transfer of the final enrollment file at the end of AE. A draft copy of the ID card shall be included in the HMO's response. The HMO shall also be capable of accepting a Participant's PCP selection via SFTP during AE and establishing the PCP for the Participant for a September 1st effective date. If the HMO has not received the Participant's PCP information with the enrollment file data, the HMO shall assign a PCP. A letter shall be included with the ID card instructing the Participant to contact the HMO to change or add the PCP, if necessary.

E.2.b. Subsequent to AE, the HMO shall issue ID cards within five (5) business days of the successful transfer of the enrollment file to the HMO. For on-going ID cards, the HMO shall send new ID cards to all eligible Participants when a change is reported within fifteen (15) business days after the HMO's receipt of the enrollment information. Once initially distributed, the ID cards do not need to be replaced unless changes are made to Participant's name or covered dependents or PCP information.

E.2.c. In order to facilitate the issuance of the ID cards, the HMO shall assign each PCP a unique office code or Provider ID number. The HMO shall use the same Office Code/Provider ID number in its printed material and website. The HMO shall use the Office Code/Provider ID number layout below.

Table 1 - Office Code/Provider ID Number Record Layout (Field Names – 218 bytes)

Column	Field Name	Format	Length
1	XBA_EMPL ID_NBR	X	11
12	XBA_HLTH_CAR_CD	X	2
14	XBA_PTCPT_LAST_NM	X	40
54	XBA_PTCPT_FIRST_NM	X	20
74	XBA_PTCPT_MID_NM	X	20
94	XBA_PCP_NPI	X	10
104	XBA_DPEN_LAST_NM	X	40
144	XBA_DPEN_FIRST_NM	X	20
164	XBA_DPEN_MID_NM	X	20
184	XBA_DPEN_PCP_NPI	X	10

F. Early Retiree Reinsurance Program ("ERRP")

The HMO shall provide information and/or services to or on behalf of ERS related to ERS' participation in the federal Early Retiree Reinsurance Program ("ERRP") established by Section 1102 of the Patient Protection and Affordable Care Act and administered by the U.S. Department of Health & Human Services ("HHS") in 45 C.F.R. Part 149. The HMO will be requested to execute the Data Exchange and Services Supplement with regard to ERRP. See Appendix P.

VI. Information Systems Requirements

A. ERS Systems Requirements

A.1. Data Processing Interface

A.1.a. **Enrollment/Eligibility.** ERS is responsible for determining the eligibility of its Participants in the GBP and for reporting coverage to the approved HMOs. ERS provides a 100% weekly and a first day of each month enrollment file via SFTP. The HMO shall verify the capability of accepting enrollment via SFTP. The HMO's corresponding enrollment records shall be updated within forty-eight (48) hours of availability of the SFTP file to reflect any adjustments based on the data provided by ERS, inclusive of terminations reported in arrears. A monthly Carrier Premium Payment report is mailed to each HMO and a separate 100% enrollment detail file is available from ERS' server.

GBP Participants are responsible for their own AE choices. The Participant's selections shall be processed and reported to the HMO in ERS OnLine format in the 100% Weekly Carrier Interface. The HMO shall accept and process the AE reporting in order to timely issue Participant ID cards as reflected in Sections IV.C.8.a.- IV.C.8.b. The HMO shall be prepared to work with ERS to implement automated enrollment (i.e., via telephone and Internet) and accept enrollment via verbal instruction from an ERS authorized representative. Although the HMO is currently required to accept enrollment via SFTP on a daily basis, future enhancements are likely to require the HMO to accept enrollment on a real-time basis.

ERS also provides the HMOs with the opportunity to view ERS' enrollment system through Web access. ERS shall determine the appropriate security and encryption to be used in the delivery of data to all HMOs. The HMOs are required to utilize the enrollment information to assist in the verification of coverage. Each approved HMO shall be prepared to access ERS OnLine via Web access one (1) week prior to the start of AE. Each approved HMO shall have at least two (2) staff members available for training on the use of the new system prior to the beginning of the AE period. Each HMO shall have staff proficient with the ERS OnLine system available during all customer service hours. The HMOs shall expend the necessary funds that shall be included in the proposed rate, to provide electronic access to ERS' enrollment system by all departments involved in customer service, claims adjudication and eligibility and enrollment administration.

ERS shall report future effective dates for changes during AE. The HMO shall be prepared to accept reporting of future effective dates by the first business day in August.

For the purpose of responding to this RFA, the HMO may recover costs involved in the adaptation of their system requirements to those set forth by ERS only through the proposed premium rates.

A.1.b **File Layouts.** The enrollment file layouts that ERS uses to report to the HMO on a weekly and monthly basis are included as Appendix E.

A.1.c. **Web Access.** ERS provides the HMO with the opportunity to view ERS' enrollment system through web access. The HMO shall be prepared to access ERS OnLine via web access no less than thirty (30) business days from the go-live date. The HMO shall utilize the enrollment information to assist in the verification and reconciliation of eligibility. The HMO shall provide Customer Service staff proficient with web access during all ERS designated customer service hours.

For the purpose of responding to this RFA, the HMO shall recover any costs involved in the adaptation of its system requirements to those set forth by ERS only through Article III, *Financial Requirements and Rate Proposal.*

A.1.d. **File Interface.** The HMO shall be fully capable of accepting and processing all File Interfaces forty-five (45) business days before the go-live date. ERS will define the file layouts as specified in Appendix E.

A.1.e. **Information Security.** The HMO shall comply with the Privacy Act of 1974, Computer Matching and Privacy Protection Act of 1988, TBCC and information security standards as outlined in Tex. Admin. Code Title 1, Part 10, § 202. Further, the HMO shall comply with the requirements for handling and use of personal information. The execution of the Data Security and Breach Notification will be required prior to final execution of a Contract.

A.1.e.i. The HMO shall ensure the confidentiality, integrity, and availability of Participant and Program information through the utilization of mutually agreed upon industry best practices coordinated with the Information Security Officer of ERS.

A.1.e.ii. The HMO shall establish a Secure Sockets Layer ("SSL") and/or Transport Layer Security ("TLS") layer below the standard SFTP protocol to encrypt the control and/or data channels. SSL/TLS protocols are to be utilized to prevent unauthorized disclosure of personal identifying information. The HMO shall be fully capable of accepting and implementing all Program information via SFTP within a site-to-site VPN tunnel.

A.1.f. **Internet Access.** To protect the confidentiality of Participant information, the HMO shall provide access to any information reasonably related to the GBP's HMO plans, its Participants, and the services, coverage, benefits, supplies and products specified hereunder using secure point-to-point V*irtual Private Network* ("VPN") to ERS and its designated representatives.

A.1.f.i. Such access, at a minimum, shall give ERS the ability to view, download and print such information. Thus, any information regarding the services, supplies or products that the HMO shall perform, deliver or provide in connection with the GBP's HMO plan, shall be fully accessible and available to ERS via secure, encrypted point-to-point VPN.

A.1.g **Encrypted Data Files.** The HMO shall maintain duplicate or back-up computer encrypted data files maintained securely in connection with all GBP-related HMO and Participant data in a secure, hardened facility which provides environmental and access controls. The HMO shall utilize 256Bit AES encryption standard for tapes or equivalent backup medium. Decryption keys shall be access controlled and provided to ERS upon demand.

A.1.g.i. All computer data files of the Plan, as maintained by the HMO, shall at all times remain the property of ERS notwithstanding the fact that such records may be stored upon or within one (1) or more computer or data retention systems owned, operated, or leased by the HMO.

A.1.g.ii Electronic communications include, but shall not be limited to, email and file transfers, between the HMO and ERS that shall be encrypted to protect Participant's confidential information.

A.1.h. **Multi-Factor Authentication.** The HMO shall provide non-repudiation services up to and including second factor authentication on all transactions.

A.1.i. **Identity Theft Enforcement and Protection Act.** Texas Business and Commerce Code 521.001, *et seq*. A person cannot obtain, transfer, possess, or use another's personal identifying information without consent in order to get something of value in another's name. Businesses must take reasonable steps to safeguard customers' personal identifying information and must notify customers of any electronic security breach involving their sensitive personal information.

A.1.j. **Security Breach.** The HMO Carrier shall comply with the Data Security and Breach Notification as attached hereto as Appendix K with regard to Security Breaches. In addition, the HMO Carrier shall comply with the BAA as attached hereto as Appendix L**.**

A.1.k. **Data Files.** The HMO shall maintain a complete and accurate reporting system, and provide for the retention, maintenance, and storage of all Program and Participant records for appropriate reporting to ERS. The HMO shall securely maintain all such records throughout the term of the Contract, and for at least seven (7) years or as dictated by statute following the end of the Contract, and shall make such records accessible and available to ERS for inspection and audit upon ERS' request.

A.1.l. **Data/Records Availability.** At all reasonable times, ERS or its representatives shall have access to ERS and GBP records. To the extent that any such records are to be maintained

upon a computer system or any other data retention system which is not owned by the HMO, the HMO shall provide ERS with assurances from the owner of such computer facilities, satisfactory to ERS, of continued availability and security of such records at all times. ERS must be permitted to personally inspect such facilities and systems.

A.1.m. **Data/Records Retention.** The HMO shall maintain records in accordance with the Contract. In the event the HMO is scheduled to destroy records, the HMO shall contact ERS for approval prior to the destruction of the payment records. If ERS approves destruction, verification of the destroyed records shall be required at ERS' direction.

A.1.n. **IVR System.** The HMO shall coordinate with ERS to provide all annual updates and/or equipment re-configurations in anticipation for each AE period.

A.1.o. **Mobile Devices.** All laptop computers, mobile devices and external storage devices which contain, process, or interact with ERS data shall be encrypted at rest. If ERS data is to be transmitted using a mobile device or laptop computer, the transmission shall be encrypted as well.

A.2. **ERS Internet Specifications.** In addition to ADA and Section 508 requirements, the HMO shall adhere to the following website guidelines:

- The HMO's web page shall be compatible with a wide spectrum of web browsers, including, but not limited to:
  - Microsoft Internet Explorer IE v6 or newer SP 1 ("Service Pack");
  - Netscape 7.0;
  - Mozilla Firefox 3.5 or newer;
  - Apple Safari 4.0 or newer;
- If providing a PDF document, assure ADA and Section 508 compliance;
- Warn user if "cookies" are used; however, do not use permanent "cookies";
- When linking to an external file (i.e., PDF, Word, etc.), reflect the file size and type;
- List ERS-approved security and privacy policies on the HMO's GBP-specific Home page;
- Reflect the ERS logo or appropriate branding on the HMO's GBP-specific Home page as specified by ERS for each plan year;
- Create text for all links used that makes sense when read out of context. For example, avoid "click here";
- The HMO shall maintain Single Sign-On ("SSO") capabilities for security access;
- Each page of the HMO's website shall have a link back to the GBP-specific Vendor Home page; and
- The HMO's website shall use SSL wherever Participant's Personally Identifiable information is presented.

A.3. **Testing Prior to Rolling Out Program Changes.** The HMO shall provide testing environments for all circumstances utilized prior to rolling out program changes that run the logic to achieve predicted outcomes of programming prior to pushing-out a new process or enhancement/modification of an existing program.

A.4. **XML.** Standardized method of extracting content on the HMO websites, through "feeds." The HMO shall be prepared to provide ERS with XML-tagged content.

A.5. **Single-Sign-On ("SSO").** ERS expects that the selected HMO shall act in good faith and cooperate with ERS in the implementation of a single sign-on environment with respect to ERS' external website and the HMO's website. As further described in the Contractual Agreement, ERS Participant records are confidential by law, and ERS maintains other records and information that the HMO shall have access to and which the HMO must keep confidential. Additionally, the Contractual Agreement contains prohibitions on using GBP Participant information for marketing purposes. The HMO must cooperate with ERS in implementing a single sign-on environment that complies with these provisions of the Contract.

VII. Summary of HMO Benefits

This Article describes the required benefits to be provided by the HMO.

A. Benefits

Uncertainty regarding the budget as well as the cost of insurance for the next fiscal year requires ERS to remain flexible concerning program benefit design, these specifications notwithstanding. As a result, it may be necessary to modify the benefits. ERS reserves the right to negotiate with the applicant HMO(s) to provide a benefit program that matches funding capability. Nevertheless, any HMO's selection shall be based on applications submitted in accordance with these specifications, including follow-up discussions and negotiations. Therefore, the HMO should submit its best rate application based on these specifications.

In response to this RFA, the HMO should submit rates in accordance with the Summary of HMO Benefits found in this section. No deviations from these required benefits will be allowed. ERS may, however, request the HMO to submit proposed rates for an SBP. If the ERS Board adopts the SBP to be effective September 1, 2012, ERS will notify all approved HMOs of the revised plan design following approval by the Board. The HMO may not include vision care (eyewear) or dental care benefits or other services not approved by ERS in its marketing materials (both printed and electronic).

ERS' In-Vitro Fertilization Rider Rejection Form should be attached as Appendix I to the RFA, indicating that such coverage has been offered and rejected.

B. Disease Management

All HMOs participating in the GBP shall be in compliance with Section 1551.219, TIC, as it relates to Disease Management. Further, the HMO shall be capable of reporting to ERS, on at least a quarterly basis, administration adherence and related expenses/savings to the GBP as applicable to the statute. ERS defines Disease Management Services to be those services established to assist an individual in managing a disease or other chronic health condition such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS. The HMO shall provide patient self-management education, provider education, evidence-based models and minimum standards of care, standardized protocols and participation criteria, and physician-directed or physician-supervised care.

C. Wellness

ERS requires each HMO to provide Wellness programs including Health Risk Assessments ("HRA") to all HMO Participants that will promote and encourage enrollees to intentionally select a lifestyle characterized by personal responsibility, moderation, and maximum personal enhancement of physical, mental, emotional and spiritual health. ERS defines Wellness Services to be those services provided by an organization or individual in addition to those for which they are contractually bound that provide good physical and mental health. Wellness programs may include: diet and weight loss, smoking cessation, stress management, and parenting, along with health risk appraisals, high blood pressure screening, and programs to aid in the prevention of certain disease stages.

D. "Value-Added" Services

The HMO may offer "Value-Added" services as defined herein only if approved by ERS prior to being offered to GBP Participants. ERS defines "Value-Added" services to be those services that add value to an enrolled population that are provided by an organization or individual which are in addition to, and other than, those services for which the HMO is contractually bound. Examples may include, but are not limited to, education programs and discounts on products and services, such as glasses and contact lenses, gym memberships, and alternative medicine.

E. Member Complaint and Appeal Process

The HMO's complaint procedure shall be in compliance with all applicable state of Texas statutes and TDI rules, as amended.

F. Coordination of Benefits ("COB")

F.1. The HMO shall collect other insurance information for the purposes of COB. The HMO is entitled to coordinate benefits with any group plan (other than HealthSelect) under which a GBP Participant has coverage. The HMO is not relieved of the duty to provide covered services as a result of such coordination of benefits. If a GBP Participant is eligible to receive benefits under another group plan, including Medicare, for services provided at the HMO's expense, the HMO shall coordinate benefits as described below.

F.2. **Medicare Part A.** It is estimated that virtually all retired state agency and university employees and retirees eligible for Medicare are enrolled in Part A. Certain community/junior colleges do not participate in Social Security, although the employees of such institutions hired on or after April 1, 1986, participate in Medicare. As a result, some of their present and future retirees do not have Medicare Part A coverage. Some of the higher education retirees not covered by Social Security, however, will have Medicare Part A as a result of previous employment or through their spouse's coverage. With respect to all GBP retirees, the HMO shall provide benefits secondary to Medicare Part A, if the retiree is enrolled in Medicare Part A. If the retiree is not enrolled in Medicare Part A, the HMO shall pay primary benefits.

F.3. **Medicare Part B.** It is estimated that over 80% of those eligible for GBP retiree insurance are enrolled in Medicare Part B.

F.3.a. For employees who retired and were Medicare eligible before September 1, 1992, the HMOs shall provide benefits secondary to Medicare Part B, if the retiree is enrolled in Medicare Part B. If the retiree is not enrolled in Medicare Part B, the HMOs shall pay primary benefits. The HMO may not require Part B coverage as a condition of enrollment for those retirees eligible for Medicare before September 1, 1992. This also applies to the retiree's spouse, regardless of the spouse's age on September 1, 1992.

The HMO shall pay benefits as if the retirees under age 65 who receive Social Security disability benefits purchased Medicare Part B. The HMO shall provide only secondary benefits as if Part B coverage is in force, even if Part B is not purchased by the eligible Participant. Although the HMO should not require eligible Participants to purchase Medicare Part B coverage, in those instances where Participants are eligible for Medicare Part B coverage, the HMO shall pay benefits on a secondary basis as though the eligible Participants in fact are enrolled in Medicare Part B.

F.3.b. For employees who retired and became Medicare eligible on or after September 1, 1992, the HMO shall provide secondary benefits as if the retiree were enrolled in Medicare Part B, whether or not the retiree is actually enrolled in Medicare Part B. The HMO shall provide only secondary benefits for any GBP Participant eligible for Medicare coverage as a result of end-stage renal disease whether or not the Participant elects Medicare Part B coverage.

F.4. **COB Method.** Any individual who has Medicare as their primary coverage will not have greater out-of-pocket expenses than an individual who does not have Medicare as their primary coverage, with the exception of those who became Medicare eligible since September 1, 1992, in which case the HMO may pay secondary benefits even if the individual is not enrolled in Medicare Part B. The HMO shall coordinate benefits secondary to Medicare in the following manner:

Part A: The HMO shall pay all of the Medicare Part A deductible, and any applicable copayment.

Part B: The HMO shall pay the difference between the Medicare allowed amount and the Medicare paid amount, and the appropriate copayment, if the provider accepts Medicare assignment.

The HMO shall pay the difference between the billed amount and the Medicare paid amount, and the appropriate copayment if the provider does not accept Medicare assignment.

Please note: that the condition of the COB method has been changed from previous years. The HMO shall be responsible for paying the applicable/appropriate copayment. ERS will no longer accept an HMO who does not pay any applicable or appropriate copayment.

F.5. **Medicare Part D.** The HMO shall make available to ERS any data required by the Centers for Medicare and Medicaid Services ("CMS") under Medicare Part D for purposes of any retiree drug subsidy or any other purpose. The HMO acknowledges that ERS will report and collect all Medicare Part D subsidy reimbursements associated with Medicare Part D members insured under the HMOs offered through the GBP. The HMO is required to provide the following:

- System modifications as required to meet CMS eligibility reporting on a monthly basis;
- Expanding dataset coding to indicate if the member is eligible or has Medicare Part D coverage;
- Produce a monthly Medicare Part D claims file and submit the file to ERS or its designated agent. The claims file will flag a Medicare Part D Participant and will indicate all drugs for that Participant that is Medicare Part D subsidy eligible;
- The HMO shall report to ERS all manufacturer rebate information necessary to comply with CMS requirements regarding Retiree Drug Subsidy. The HMO shall report to ERS on 100% of the manufacturer rebates paid for Part D drugs, including the portion of such rebates retained by the HMO's PBM; and
- The HMO shall be prepared to provide additional reports and information as required by ERS or CMS. These requirements will be provided by ERS to each GBP participating HMO as necessary.

F.5.a. Any fees associated with this process shall be recovered solely through the HMO *Financial Requirements and Rate Proposal* quoted with this RFA.

F.6. Our intent is to offer enrollment in a Medicare Advantage Preferred Provider Organization Program to Medicare Advantage eligible retirees for whom Medicare is primary. Should the Participant elect to move back to a HMO during the plan year, separate out-of-pocket expense limits should not apply.

G. Summary of HMO Benefits for Plan Year 2013[1]

Benefit Description	Member Pays PY2013
Plan year out-of-pocket coinsurance maximum (per person)	$2,000
Plan year out-of-pocket copayment maximum (per person)	None
Lifetime maximum	None
Physicians and Lab Services	
*Physician office visit Primary Care Physician (if applicable)	$25
*Specialist office visit	$40
*Routine physicals - One per plan year for adults: periodic for children, or as directed by the primary care physician (if applicable)	$25
*Diagnostic x-rays, mammography, and lab tests	20%
High Tech Radiology (CT Scan, MRI, and Nuclear Medicine) Outpatient testing only	$100 copayment plus 20%
*Immunizations - For children 0 to 6 years of age	No charge
*Immunizations - For children 7 years and older, and adults	No charge
*Well woman exam - One per plan year	No charge
*Vision, speech, and hearing screenings - For all enrolled Participants	20% without office visit, $40 plus 20% with office visit
*Colorectal Cancer Screening - subject to language in 13.4.13.2 of the Description of Benefits (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
*Exam for Detection and Prevention of Osteoporosis - subject to language in 13.4.13.3 of the Description of Benefits (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
*Cervical Cancer Screening - subject to language in 13.4.13.5 of the Description of Benefits (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Speech and hearing testing - For all enrolled Participants	20% without office visit, $40 plus 20% with office visit
Speech therapy and rehabilitative therapy, including physical and occupational therapy - Covered as any other illness and not subject to any maximum	20% without office visit, $40 plus 20% with office visit
Allergy testing	20%
Allergy serum	20%
Allergy serum administration - When allergy shot is administered **without** an office visit	20%
*Routine eye exam - One per plan year	$40
Office surgery and procedures (all office surgeries, excluding vasectomies and tubal ligations)	20%

Maternity care - Physician services, including diagnosis of pregnancy, pre- and post-natal care, and delivery (including delivery by C-section) - ***see "Hospital Services" for inpatient charges***	$40 for first office visit
Family planning	$40
Vasectomy and tubal ligation	20%
Infertility benefits	50%
Hospital Services	
Inpatient hospital - Semi-private room and board or intensive care units	$150 per day copayment per admission, 5 day max. $2,250 max. per person per year plus 20%
Outpatient day surgery	$100 copayment plus 20%
Other inpatient charges, including medically necessary surgical procedures. Includes orthognathic surgery. Guest trays, cots, telephone, maternity kits, paternity kits, and other personal items not covered.	$150 per day copayment per admission, 5 day max. $2,250 max. per person per year plus 20%
Blood and blood products - Inpatient and outpatient	20%
Private duty nursing - Based on medical necessity	20%
Outpatient facilities, including pre-admission testing and/or treatment room	20%
Emergency care - In-area and out-of-area covered at listed copayment. If hospitalized, copayment is applied to hospital confinement.	$150 copayment plus 20%
Urgent care	$50 copayment plus 20%
Skilled nursing facility (based on medical necessity) - Covered up to 60 days per plan year	20%
Hospice care - Inpatient and outpatient (based on medical necessity)	20%
Home health	20%
Private duty nursing	20%
Other Medical Services	
Hearing aids (repairs not covered)	Plan pays $500 per ear every 3 years
Hearing aid batteries - Not subject to any maximum amounts	20%
Dental - Restoration and correction of damage caused by external violent accidental injury to healthy, natural teeth, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.	20%
Durable Medical Equipment - Includes medically necessary purchase and/or rental. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. (Repairs are covered if not due to neglect or abuse.) This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code.	20%

Prostheses - Artificial devices, surgical or non-surgical, which replace body parts, including arms, legs, eyes and cochlear implants are covered. Replacements and repairs are covered by medical necessity. Prosthetic devices, orthotic devices, and professional services related to the fitting and use of these devices are included, if services are pre-authorized and provided by a contracted provider.	20%
Organ Transplants - Covered as any other illness for kidney, cornea, liver, heart, heart-lung, lung, pancreatic-kidney, bone marrow, and other organ transplants that the HMO determines to be not experimental and/or not investigational according to current medical plan guidelines. Donor expenses are covered. Artificial organs (e.g. heart) not covered.	$150 per day copayment per admission, 5 day max. $2250 max. per person per year plus 20%
Ambulance - Professional local ground or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition	20%
Behavioral Health Care Benefits	
Inpatient mental health	$150 per day copayment per admission, 5 day max. $2250 max. per person per year plus 20%
Inpatient serious mental illness - Covered as any other illness	$150 per day copayment per admission, 5 day max. $2250 max. per person per year plus 20%
Inpatient chemical dependency - Covered as any other illness (based on medical necessity)	$150 per day copayment per admission, 5 day max. $2250 max. per person per year plus 20%
Outpatient mental health	$40
Outpatient serious mental illness - Covered as any other illness	$40
Outpatient chemical dependency - Same as any other illness and not subject to any maximums	$40
Prescription Drugs	
Plan Year Deductible	$50
If a brand-name medication is dispensed when a generic is available, member will be responsible for the generic copayment plus the cost difference between the generic and the brand-name medication.	
Participating Retail Pharmacy - **Tier 1, Tier 2, & Tier 3**	
Up to 30-day supply per prescription or refill of **Non-Maintenance** medication	$15/$35/$60
Up to a 30-day supply per prescription or refill of **Maintenance** medication	$20/$45/$75
Infertility drugs	50%
Up to a 30-day supply of insulin for one copayment	$15/$35/$60

Up to a 30-day supply of each diabetic oral agent for one copayment	$15/$35/$60
The supply of necessary disposable syringes for the insulin supply for one copayment	$35
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 30-day supply.	20%
Mail Order Pharmacy - Tier 1, Tier 2, & Tier 3	
Up to a 90-day supply per prescription or refill for one mail order copayment	$45/$105/$180
Oral contraceptives up to a 90-day supply for one mail order copayment	$45/$105/$180
Infertility drugs	50%
Up to a 90-day supply of insulin for one mail order copayment	$45/$105/$180
Up to a 90-day supply of each diabetic oral agent for one mail order copayment	$45/$105/$180
The supply of necessary disposable syringes for the insulin supply for one mail order copayment	$105
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 90-day supply.	20%

Pre-existing conditions are covered as of 12:01 a.m. September 1, 2012 and lifetime benefit maximums are unlimited.

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Footnotes:

1. This Summary of HMO Benefits reflects the current benefit plan structure and is subject to change as required by state and federal laws, rules and regulations or if ERS deems it to be in the best interest of ERS, the GBP, its Participants, and the state of Texas. All state mandated services shall be provided for in the HMO's Evidence of Coverage whether included in or omitted from this Summary of Benefits. The Summary of the HMO Benefits itemizes the services required by Chapter 1551, TIC, generally, by the TIC and by the rules of the TDI. The Summary of the HMO Benefits is not intended to identify **all** services required by the TIC, TDI; however, the following benefits should be listed:

    a. Well-child care from birth per TIC section 1271.154;
    b. Screening test for hearing loss for newborns per TIC section 1367.103;
    c. Tests for detection of prostate cancer per TIC section 1362.003;
    d. Tests for detection of colorectal cancer per TIC section 1363.003;
    e. Coverage for hospital stays following performance of a mastectomy and certain related procedures per TIC section 1357.054;
    f. Coverage for reconstructive surgery after mastectomy per TIC section 1357.004;
    g. Benefits for detection and prevention of osteoporosis per TIC section 1361.003;
    h. Coverage for craniofacial abnormalities per TIC section 1367.151-153;
    i. Telemedicine per TIC section 1455.004;
    j. Anesthesia for dental procedures in a hospital setting per TIC Chapter 1360;
    k. Coverage for certain benefits related to brain injury per TIC Chapter 1352;
    l. Coverage for prescription contraceptive drugs and devices and related services per TIC section 1369.104;
    m. Coverage for inpatient stay following childbirth per TIC section 1366.055;
    n. Coverage for special dietary formulas for individuals with Phenylketonuria (PKU) or other heritable diseases per TIC section 1359.003;
    o. Coverage for certain amino acid-based elemental formulas per TIC section 1377.051;
    p. Coverage for off-label drug use per TIC Chapter 1369;
    q. Coverage for fibrocystic breast conditions per TIC section 544.201-204;
    r. Eligibility for benefits for Alzheimer's disease per TIC Chapter 1354;
    s. Coverage for cervical cancer per TIC Chapter 1370;

t. Coverage for certain tests for early detection of cardiovascular disease per TIC section 1376.003;
u. Coverage for routine patient care costs for enrollees participating in certain clinical trials per TIC section 1379.051; and
v. Coverage for autism spectrum disorder from date of diagnosis until the enrollee completes nine years of age per TIC section 1355.015.

2. Routine eye exam means an eye exam by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:
- External examination of the eye and its structure;
- Determination of refractive status; and
- Glaucoma screening test.

It does not include a contact lens exam, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.

3. Infertility Benefits do not include sterilization reversal, transsexual surgery, gender reassignment, intra-fallopian transfer and related services, artificial insemination, or *in-vitro* fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures. Pharmaceuticals are covered at 50% copayment.

4. Certain oral surgeries mean maxillofacial surgical procedures limited to:
- Excision of neoplasm, including benign, malignant and premalignant lesions, tumors, and nonodontogenic cysts.
- Incision and drainage of cellulitis.
- Surgical procedures involving accessory sinuses, salivary glands and ducts.
- Coverage for temporomandibular joint ("TMJ") shall be in compliance with Chapter 1360, TIC. Excludes oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves.

5. The diabetes benefit is as listed in Section 1358.051 of the TIC and includes benefits for diabetic equipment, diabetes supplies, and diabetes self-management training programs as follows:

<u>Diabetic equipment</u>: (20% copayment)
a. Blood glucose monitors, including monitors designed to be used by blind individuals.
b. Insulin pumps and associated appurtenances.
c. Insulin infusion devices.
d. Podiatric appliances for the prevention of complications associated with diabetes.

<u>Diabetic supplies</u>:
a. Insulin and insulin analogs (covered under pharmacy benefit).
b. Syringes (covered under pharmacy benefit at the Tier 2 copayment).
c. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels (covered under pharmacy benefit).
d. Glucagon emergency kits (covered under pharmacy benefit).
e. Test strips for blood glucose monitors (20% copayment).
f. Visual reading and urine test strips (20% copayment).
g. Lancets and lancet devices (20% copayment).
h. Injection aids (20% copayment).
i. Alcohol wipes (20% copayment).

<u>Diabetic self-management training programs:</u> (same as office visit copayment)
a. Training provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.
b. Additional training is provided after a diagnosed significant change in the member's symptoms or condition that requires changes in the self-management regime.
c. The Food and Drug Administration approves periodic or episodic continuing education training as warranted by the development of new techniques and treatments for the treatment of diabetes.

6. ERS defines orthotics as pertaining to the feet; therefore, services or supplies for routine foot care, insoles, or shoe inserts of any type are not covered, except when prescribed for a diagnosis of or related to the treatment of diabetes or circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. Orthotic devices, and the professional services relating to the fitting and use of those devices, are covered if the services are pre-authorized and provided by a contracted provider.

7. Restrictions on mental health benefits are not applicable to expenses incurred for the treatment of "serious mental illness" as defined in Section 1355.001, TIC. At a minimum, coverage for autism spectrum disorder must be provided from the date of diagnosis until the enrollee completes nine years of age as described in Section 1355.015, TIC.

8. Pharmacy Benefits: ERS allows the use of a formulary provided it offers a broad spectrum of high quality drug therapies. Vitamins are not covered except those that require a prescription by law and have no non-prescription equivalent.

9. Weight reduction programs, services, supplies, surgeries, or gym memberships are not covered, even if the Participant has medical conditions that might be helped by weight loss, or even if prescribed by a physician.

10. **All Applicable Copayment and Deductible Resets**

10.a. **Break in Coverage.** The prescription drug deductible and the inpatient out-of-pocket maximum per person per plan year should be reset for a Participant designated as a new hire. This would include an employee who left state or higher education employment and experienced a break in health insurance coverage. This Participant would be considered a new employee and the prescription deductible and the inpatient out-of-pocket maximum should be calculated the same as for a new employee.

10.b. **COBRA/Dependent Coverage.** Participants under COBRA and dependents who were previously covered but are now directly insured under the GBP shall not be requested to satisfy a new prescription deductible and inpatient out-of-pocket maximums as soon as their coverage becomes effective as a directly insured GBP Participant.

VIII. Service Area Requirements

The HMO may elect to submit an Application for any or all Texas counties for which it has been approved by TDI. It is not required that the proposed service area be contiguous between counties.

The example below illustrates the format to be used when submitting counties on the service area CD-ROM. The CD-ROM should be either dBase IV or Excel format. The format may not be altered. The HMO shall submit a service area CD-ROM listing all counties for its proposed service area(s). If the HMO proposes to use regional rating or a non-contiguous service area, the HMO shall identify which counties are associated with each regional rate or non-contiguous service area. When submitting the service area CD-ROM, separate files are required for each regional rate area or non-contiguous service area.

A. Service Area

A.1. In general, ERS will consider only complete counties within the HMO's service area. If partial counties already exist within a currently participating HMO's GBP-approved service area, then those partial counties will be considered for approval. Subsequent RFAs may require the HMO to submit a complete county in order for that county to be considered. In submitting the proposed service area, the HMO shall follow the instructions included below.

A.2. Counties in which hospitals and physicians are limited or non-existent shall be reviewed and ERS shall determine if the network limitation shall impact the availability and accessibility for the GBP Participants.

A.3. Counties in which there are hospitals and physicians but the HMO has not contracted with or does not offer those Health Care Providers as part of the proposed provider network, may not be considered for approval.

B. Documentation

Supporting data for each service area submitted shall include:

B.1. A copy of TDI's date stamped approved service area documentation for the HMO. **NOTE:** Only service areas approved by TDI on or before March 1, 2011, are to be submitted in the HMO's Application.

B.2. Map(s) boldly outlining each proposed service area.

B.3. Provide a listing of the counties for each proposed service area in separate folders on the CD-ROM.

Table 3 - Service Area Description of Fields

Filler Text "**"	Filler Text
County Name	Name of the county to be included in the proposed service area.

The file should be saved as text or Excel format.

C. List of Texas Counties

Anderson	Colorado	Gonzales	Kerr	Nolan	Taylor
Andrews	Comal	Gray	Kimble	Nueces	Terrell
Angelina	Comanche	Grayson	King	Ochiltree	Terry
Aransas	Concho	Gregg	Kinney	Oldham	Throckmorton
Archer	Cooke	Grimes	Kleberg	Orange	Titus
Armstrong	Coryell	Guadalupe	Knox	Palo Pinto	Tom Green
Atascosa	Cottle	Hale	La Salle	Panola	Travis
Austin	Crane	Hall	Lamar	Parker	Trinity
Bailey	Crockett	Hamilton	Lamb	Parmer	Tyler
Bandera	Crosby	Hansford	Lampasas	Pecos	Upshur
Bastrop	Culberson	Hardeman	Lavaca	Polk	Upton
Baylor	Dallas	Hardin	Lee	Potter	Uvalde
Bee	Dallam	Harris	Leon	Presidio	Val Verde
Bell	Dawson	Harrison	Liberty	Rains	Van Zandt
Bexar	De Witt	Hartley	Limestone	Randall	Victoria
Blanco	Deaf Smith	Haskell	Lipscomb	Reagan	Walker
Borden	Delta	Hays	Live Oak	Real	Waller
Bosque	Denton	Hemphill	Llano	Red River	Ward
Bowie	Dickens	Henderson	Loving	Reeves	Washington
Brazoria	Dimmit	Hidalgo	Lubbock	Refugio	Webb
Brazos	Donley	Hill	Lynn	Roberts	Wharton
Brewster	Duval	Hockley	Madison	Robertson	Wheeler
Briscoe	Eastland	Hood	Marion	Rockwall	Wichita
Brooks	Ector	Hopkins	Martin	Runnels	Wilbarger
Brown	Edwards	Houston	Mason	Rusk	Willacy
Burleson	El Paso	Howard	Matagorda	Sabine	Williamson
Burnet	Ellis	Hudspeth	Maverick	San Augustine	Wilson
Caldwell	Erath	Hunt	McCulloch	San Jacinto	Winkler
Calhoun	Falls	Hutchinson	McLennan	San Patricio	Wise
Callahan	Fannin	Irion	McMullen	San Saba	Wood
Cameron	Fayette	Jack	Medina	Schleicher	Yoakum
Camp	Fisher	Jackson	Menard	Scurry	Young
Carson	Floyd	Jasper	Midland	Shackelford	Zapata
Cass	Foard	Jeff Davis	Milam	Shelby	Zavala
Castro	Fort Bend	Jefferson	Mills	Sherman	
Chambers	Franklin	Jim Hogg	Mitchell	Smith	
Cherokee	Freestone	Jim Wells	Montague	Somervell	
Childress	Frio	Johnson	Montgomery	Starr	
Clay	Gaines	Jones	Moore	Stephens	
Cochran	Galveston	Karnes	Morris	Sterling	
Coke	Garza	Kaufman	Motley	Stonewall	
Coleman	Gillespie	Kendall	Nacogdoches	Sutton	
Collin	Glasscock	Kenedy	Navarro	Swisher	
Collingsworth	Goliad	Kent	Newton	Tarrant	

IX. Provider Network Requirements

A. Network Requirements

Based on the Application responses, an evaluation shall be made of the HMO's ability to organize and operate high quality, cost-effective HMO provider networks in accordance with this Article. The HMO's ability in connection with the following shall be considered:

1. Provider credentialing;
2. Fee contracting;
3. Utilization management; and
4. Quality review.

A.1. **Accessibility and Availability.** The HMO shall offer complete flexibility in a Participant's selection of a PCP, within the selected network. The HMO shall provide documentation on a CD-ROM using the ERS-required format (included in this Article) to demonstrate that its proposed provider network contains a sufficient number of Health Care Providers to serve GBP Participants. Separate documentation shall be provided for the proposed network as listed below in Sections IX.C – IX.C.5. below.

The availability and accessibility of Health Care Providers, as well as provider duplication, are major aspects of the HMO review process. ERS shall utilize GeoAccess software as one (1) of its tools to determine provider network availability and accessibility in accordance with TDI's access rules. ERS may also use its own discretion in reviewing provider networks. Each HMO shall submit documentation of its TDI-approved provider network as of February 1, 2011, in the prescribed ERS format. The provider network shall have a sufficient number of PCPs, specialists, and pharmacies to serve the GBP Participants. All Health Care Providers included in the proposed network shall have signed Contracts in place on or before February 1, 2012.

ERS shall analyze the accessibility of the HMO's provider network to service the needs of its GBP Participants. To measure that accessibility, this RFA requires each HMO to submit a GeoNetworks® Provider Network Accessibility Analysis within TDI's standards.

Any HMOs offering a gatekeeper product shall still be required to utilize a PCP to direct the provision of health care services to a Participant utilizing the network that shall direct and coordinate a Participant's health care, except in the case of an annual routine vision exam or services provided by an OB/GYN. A Participant will be allowed to change PCPs, and such changes will be effective no later than the first of the following month. The HMO may limit PCP changes to one (1) per month. Network providers shall collect the applicable copayment from all GBP Participants.

Any determination or interpretation of Participant eligibility and effective dates shall be made solely by ERS and may include retroactive membership and effective date determinations due to such occurrences as administrative error, terminated employees whose employment has been reinstated due to legal or administrative action, and other situations deemed appropriate by ERS. The HMO warrants and represents that ERS, the GBP and the state of Texas shall be held harmless and indemnified if a GBP Participant's coverage and eligibility is retroactively terminated. ERS shall rely on its own Medical Board to determine eligibility of handicapped dependents for continued coverage beyond age 26. Federal health care reform amended §§ 2713 and 2714 (among other provisions) of the Public Health Service Act (42 U.S.C. 300 gg *et seq*.). Section 2713 relates to preventative health services and § 2714 requires group health plans (among others) "that provide dependent coverage of children to continue to make such coverage available for an adult child until the child turns 26 years of age." If the applicable federal health care reform laws and regulations remain unchanged, the requirements of § 2713 relating to preventative health services will become effective September 1, 2011, and, pursuant to § 2714, children who lost coverage, were never eligible for coverage, or who never enrolled for coverage and were not eligible under the plan's existing age limits as of August 31, 2011 will be given notice and an opportunity for special enrollment on or before September 1, 2011. Since federal health care reform does not currently mandate dependent changes until September 1, 2011, existing state law continues

to apply to the GBP. The Executive Director of ERS has exclusive authority by law to determine all questions relating to enrollment and eligibility.

B. Provider Contracts (all the provisions survive the termination of the Contract)

B.1. The HMO shall maintain adequate protections, whether through guarantees, subordinated debt, required surplus contributions by stockholders, or Health Care Provider(s) contracts containing indemnification and hold harmless provisions, or by any other means or combination thereof, whereby Health Care Provider(s) may not seek from GBP Participants, ERS or the state of Texas payment of debts that are the responsibility of the HMO, and whereby ERS, the state of Texas and GBP Participants are protected from any obligation for payments which are the responsibility of the HMO.

B.2. If any Health Care Provider(s) requests that a GBP Participant waive his rights to not be liable for payments owed by the HMO, requests that the GBP Participant agree to pay for services that are the HMO's responsibility, or initiates any actions whatsoever, including correspondence, telephone calls or personal visits, to collect payments from ERS, the state of Texas or any GBP Participants for payment of services rendered over and above allowable copayments, excluding services not covered under this plan, the HMO or its successor shall initiate and maintain such action necessary to stop the Health Care Provider(s) or his employee, agent, trustee, or successor in interest from maintaining any action against ERS, the state of Texas or any GBP Participant to collect or otherwise take any responsibility for any amounts owed to Health Care Provider(s) by the HMO.

B.3. ERS shall have the right to review all arrangements or agreements between the HMO and Health Care Provider(s).

B.4. The HMO shall defend, indemnify and hold harmless the GBP, GBP Participants, ERS and the state of Texas against any and all claims, costs, damages, lawsuits, settlements, judgments, penalties, and expenses (including attorney's fees) of whatsoever kind or nature arising out of the failure, inability, or refusal of the HMO, its agents, employees and/or subcontractors to pay Health Care Provider(s) for covered services or supplies and for any alleged malpractice or malfeasance of the HMO, its agents, employees and/or subcontractors or any of its Health Care Providers. The Contract will elaborate on this requirement.

B.5. In the event the HMO terminates its Contract with any participating PCP, Health Care Provider(s), or hospital, the HMO shall notify affected HMO Participants in writing. The written notice will include the name of the terminating physician or group, the names of other Health Care Provider(s) available to the Participants, and the effective dates of the changes.

B.6. The HMO shall ensure that its Health Care Provider(s) do not directly market to GBP Participants.

B.7. The HMO shall make reasonable accommodation to Participants changing from one (1) plan to another when it has been determined by ERS that the Participant and eligible dependents shall change health plans. The HMO shall develop (if necessary) a transitional benefits procedure, provide Participants with their HMO's transitional benefit procedures and assist the Participant by answering questions.

C. Provider Accessibility & Availability Format

For each service area included in the HMO's Application, the HMO shall provide one (1) Provider Network CD-ROM for *each service area* containing four (4) separate files. One (1) file for each of the following four (4) proposed provider networks: hospitals, primary care physicians, speciality care physicians, including ancillary providers, and pharmacies. As an example, an HMO submitting an Application for three (3) different service areas shall submit three (3) separate CD-ROMs. Each CD-ROM shall contain four (4) separate folders, one (1) folder per each of the four (4) required networks as mentioned above.

Failure to properly identify the data may result in a delay in the review of the Application. NOTE: The documentation required is more detailed than what is generally listed in an HMO's provider directory.

The HMO should direct any questions regarding this section to the IVendor mailbox at ivendorquestions@ers.state.tx.us.

C.1. **Formatting Requirements**

C.1.a. The format may not be altered. **No other format will be accepted. The required format is a fixed-length Excel spreadsheet.**

C.1.b. All required data fields shall be completed. If not, the application will **not** be considered complete. **Blank records, abbreviated names or extra fields are not acceptable.**

C.1.c. Only those specialty codes provided by ERS are valid, as listed in this Article.

C.1.d. Format Examples – (fixed length Excel spreadsheet)

Below is the listing of the data required for each provider type to assist the HMO in creating the CD-ROM(s).

C.2. **Reporting of Hospitals.** The following format **shall** be used to create the hospital network CD-ROM(s). The hospital network shall be submitted in a separate file on a separate CD-ROM for **each** SERVICE AREA included in the Application.

Table 5 - Hospital Network (6 Fields - Fixed Length)

ITEM NO.	FIELD NAME	START POSITION	FORMAT	LENGTH	FIELD DESCRIPTION
1	TAX ID #	1	Numeric	9	Federal Tax Identification
2	NAME	10	Character	50	Hospital Name
3	ADDRESS1	60	Character	30	Hospital Street Name
4	ADDRESS2	90	Character	30	Additional Street Information
5	CITY	115	Character	25	Hospital City Location
6	ZIP	140	Numeric	5	Hospital STREET Address ZIP Code

C.3. **Reporting of Primary Care Physicians.** The following format **shall** be used to create the primary care physician network CD-ROM(s). The primary care physician network shall be submitted in a separate file on a separate CD-ROM for **each** SERVICE AREA included in the Application.

Table 7 - Primary Care Physicians Network (12 Fields - Fixed Length)

ITEM NO.	FIELD NAME	START POSITION	FORMAT	LENGTH	FIELD DESCRIPTION
1	LICENSE #	1	Character	5	Physician's Medical License
2	LAST NAME	6	Character	50	Physician's Last Name
3	FIRST NAME	56	Character	30	Physician's First Name
4	MI	86	Character	2	Physician's Middle Initial
5	ADDRESS1	88	Character	30	Primary Street Address of Physician's Office (NO P. O. Boxes)
6	ADDRESS2	118	Character	30	Additional Address Information (Suite #, Floor, etc.)
7	CITY	148	Character	25	Physician's City Location
8	ZIP	173	Numeric	5	Physician's STREET Address ZIP code
9	SPEC	178	Character	3	Use the values for Specialty type: **FP**=Family Practice, **GP**=General Practice, **IM**=Internal Medicine, **PD**=Pediatrician, **OBG**=OB/GYN if used as a PCP
10	STATUS	181	Character	1	O=Open Practice, C=Closed Practice
11	AFF	182	Character	1	Affiliated with a group: Y=Yes or N=No
12	GROUP	183	Character	30	Name of group practice

C.4. **Specialty Care Physicians, including Ancillary Providers.** The following format **shall** be used to create the specialty care physician network CD-ROM(s). The specialty care physician/ancillary provider network shall be submitted in a separate file on a separate CD-ROM for **each** SERVICE AREA included in the Application.

Table 9 - Specialty Care Physicians Network (10 Fields - Fixed Length)

ITEM NO.	FIELD NAME	START POSITION	FORMAT	LENGTH	FIELD DESCRIPTION
1	LICENSE #	1	Character	5	Physician's Medical License number assigned by the Texas Board of Medical Examiners or the Ancillary Provider's license number
2	LAST NAME	6	Character	50	Physician's Last Name
3	FIRST NAME	56	Character	30	Physician's First Name
4	MI	86	Character	2	Physician's Middle Initial
5	ADDRESS1	88	Character	30	Primary Street Address of Physician's Office (NO P. O. Boxes)
6	ADDRESS2	118	Character	30	Additional Address Information (Suite #, Floor, etc.)
7	CITY	148	Character	25	Physician's City Location
8	ZIP	173	Numeric	5	Physician's STREET Address ZIP code
9	SPEC	178	Character	4	See Table 10
10	AFF	182	Character	1	Affiliated with a group: **Y**=Yes or **N**=No

Table 10 – Specialty Codes

Specialty Code	Specialty Description
AI	ALLERGY AND IMMUNOLOGY
AN	ANESTHESIOLOGY
CD	CARDIOVASCULAR DISEASE
D	DERMATOLOGY
EM	EMERGENCY MEDICINE
GE	GASTROENTEROLOGY
GS	GENERAL SURGERY
GYN	GYNECOLOGY
N	NEUROLOGY
NEP	NEPHROLOGY
NP	NEUROPATHOLOGY
NPM	NEONATAL-PERINATAL MEDICINE
NTR	NUTRITION
OBG	OBSTETRICS & GYNECOLOGY (Not a PCP)
ON	ONCOLOGY
OPH	OPHTHALMOLOGY
ORS	ORTHOPEDIC SURGERY
ENT	OTOLARYNGOLOGY
PSY	PSYCHIATRY
PM	PHYSICAL MEDICINE & REHAB
PUD	PULMONARY DISEASES
RHU	RHEUMATOLOGY
UR	UROLOGY
OTH	ALL OTHER SPECIALTIES
ANCL	ANCILLARY PROVIDER

C.5. **Pharmacies.** The following format **shall** be used to create the pharmacy network CD-ROM(s). The pharmacy network shall be submitted in a separate file on a separate CD-ROM for **each** SERVICE AREA included in the Application.

Table 11 - Pharmacy Network (8 Fields - Fixed Length)

ITEM NO.	FIELD NAME	START POSITION	FORMAT	LENGTH	FIELD DESCRIPTION
1	NCPDP#	1	Character	5	The unique number assigned to each pharmacy
2	NAME	6	Character	50	Pharmacy Name
3	ADDRESS 1	56	Character	30	Pharmacy street address
4	ADDRESS 2	86	Character	30	Building name, Suite# or Floor
5	CITY	116	Character	25	City where pharmacy is located
6	ZIP Code	141	Character	7	Street address ZIP Code of pharmacy
7	AFF	148	Character	1	Affiliated with a major chain: Y = Yes N = No
8	AFF NAME	149	Numeric	30	Group Name

X. Organizational Information

A. Information required of the HMO responding to the RFA

A.1. The HMO's full legal name, physical/email address(es), and telephone/facsimile numbers.
Full Legal Name:
Physical Address:
Email Address:
Telephone Number:
Facsimile Number:

A.2. Provide the HMO's Tax Identification Number.

A.3. What is the organizational type of the responding HMO?

☐ Group ☐ IPA ☐ Staff ☐ Mixed

A.4. What is the HMO's incorporation status?

☐ For profit ☐ Not-for-profit / Non-profit
☐ Publicly owned ☐ Privately owned

A.5. In which state was the HMO's incorporation or formation?

A.6.a. Date of Certificate of Authority from TDI.

A.6.b. Provide a copy of the HMO's Certificate of Authority.

A.6.c. If the HMO is licensed through TDI, as an HMO, the HMO shall include a copy of the HMO's current license(s) from these entities.

A.7. Is the HMO required to maintain any other license(s)? If so, describe and confirm the validity of any valid license(s).

A.8. Has the HMO ever had its certificate of authority or license to conduct business in Texas revoked? ☐ Yes ☐ No

If yes, explain.

A.9. Provide the date that HMO services were first provided by the HMO.

A.10. Are managed health care services federally qualified? ☐ Yes ☐ No

A.11. Has the HMO provided GBP-specific health care services at some time in the past?
☐ Yes ☐ No

If yes, when?

A.12. Provide the name, title, mailing/email address(es), telephone/facsimile numbers and biographical summary for ***the person authorized to execute this Application*** and any subsequent Contract, that may be awarded. **This person shall be at least a company vice president or higher level in authority.**

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13. Provide the name(s), title(s), physical/email address(es), telephone/facsimile numbers and biographical summary for the **individual(s)** responsible for the preparation for the data submitted within this RFA.

A.13.a. ***Person responsible for RFA compilation***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.b. ***Customer Service***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.c. ***HIPAA***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.d. ***Technology (IS)/Security***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.e. ***Eligibility File Management***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.f. ***Claims***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.g. ***Provider Network Information***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.h. ***Pharmacy Information***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.i. ***Financials***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.j. ***Website***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.k. ***Marketing Materials/Communications***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.l. ***ERS Account Liaison***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.13.m. ***Call Center Operations Manager***

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.14. Provide the firm/attorney name(s), title, mailing/email address(es), telephone/facsimile numbers and the biographical summary for the person who shall serve as the ***HMO's Legal Counsel*** and/or all such information as it relates to any outside law firm retained by the HMO for purposes of the HMO's RFA Application or Contract performance.

Firm Name:
Attorney Name:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.15. Provide the name, title, mailing/email address(es), telephone number/facsimile numbers and biographical summary of the ***individual*** responsible for preparation of the HMO Financial Requirements and Rate Proposal submitted in Sections III.F.1 and III.F.2..

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:
Biographical Summary:

A.16. Provide the name(s), title(s), and corporate affiliation to the HMO's firm of ***ALL officers and all directors, or principals, as applicable.*** *List each in the following format:*

Name:
Title:
Corporate Affiliation:

A.17. Does the HMO propose to utilize subcontractors in the performance, delivery and provision of services, coverages, benefits, equipment, supplies and products requested hereunder?
☐ Yes ☐ No

A.17.a. If applicable, provide the information below for each subcontractor and specify what services may be performed by each subcontractor.

A.17.b Name:
Mailing Address:
Physical Address:
Email Address:
Telephone Number:
Facsimile Number:
Services Performed:

A.18. Confirm the HMO's understanding, acknowledgement and agreement that the HMO shall be fully liable and responsible for the performance of any subcontractor that the HMO utilizes to perform any of the services, coverages, etc. required under the RFA and Contractual Agreement, and that all services performed in support of the RFA and Contractual Agreement be solely executed in the United States. ☐ Confirm

A.19. Provide a company-wide organizational chart reflecting employee name(s) and title(s) for the HMO and any subcontractor(s) (if applicable) to be utilized in support of this Contract. Chart should also identify those positions open but not yet filled.

HMO organizational chart:
Subcontractor organizational chart:

A.20. Describe the staff (including numbers of full-time equivalent employees) that the HMO and any subcontractor shall utilize to perform, deliver and provide the services, coverages, benefits, equipment, supplies and products requested herein.

HMO staff description:
Subcontractor staff description:

A.21. How many of these employees are located in Texas? Describe the functions these employees perform.

Number of HMO staff in Texas:
Description of HMO staff functions:
If applicable, number of Subcontractor staff in Texas:
If applicable, description of Subcontractor staff functions:

A.22. Provide a list of individuals who shall comprise the HMO's proposed Account Management Team and submit brief resumes, as applicable, for each team member.

A.23. Provide a list of individuals who shall comprise the HMO's proposed Implementation Team and submit brief resumes, as applicable, for each team member.

A.24. Provide a brief resume(s) identifying key personnel for the HMO's subcontractor who shall be responsible for any administrative and/or managerial functions of the Contract which shall include a listing of the HMO-related duties and length of time contracted with the HMO.

Subcontractor personnel resumes:

A.25. The HMO shall confirm that its subcontractors are licensed and shall have been providing services for the HMO at least since March 1, 2011.

A.26. Confirm that ALL relevant personnel's licensure(s), including subcontractors if applicable, shall be validated and current throughout the entire term of the Contract. ☐ Confirm

A.27. Provide the name, mailing/email address(es), telephone/facsimile numbers and contact person for the professional associations to which the HMO belongs.

Name:
Mailing address:
Email address:
Telephone number:
Facsimile number:
Contact person:

A.28. The HMO shall identify five (5) major employers or carriers for which the HMO currently provides HMO benefits and/or managed care services. For these five (5) employers or carriers, the HMO shall provide the company name, primary contact, title, and telephone/facsimile numbers of the employer or carrier's representatives who are familiar with the services identified, the number of employees and dependents for whom health care benefits are administered and the annual health claims paid. Provide the percent of the HMO's total business these employers or carriers represent.

Note: The HMO's response to this request officially authorizes ERS to contact these employers, carriers or any other entity to discuss the services that the HMO has provided and authorizes the employers to provide such information to ERS, and shall release and hold harmless ERS and the employer of any and all liability whatsoever, in connection with

providing and receiving all such information. **The HMO may not provide sponsoring, or parent organizations, subsidiaries, or subcontractors as references.**

A.28.a. Company Name:
Account primary contact:
Title:
Email address:
Telephone number:
Facsimile number:
Type of relationship:
Number of Employees:
Number of Dependents:
Percentage of Business Employers represents:

A.29. For the last five (5) years, provide the information for the five (5) major organizations/entities that have terminated the HMO services for Cause by providing the information listed below. Do not include any entity terminated due to mergers or acquisitions.

Note: The HMO Application to this request officially authorizes ERS to contact these organizations/entities to discuss the services and other considerations that the HMO has provided, and authorizes the organizations/entities to provide such information to ERS, and shall release and hold harmless ERS and the organizations/entities of any and all liability whatsoever in connection with providing and receiving all such information. **The HMO may not provide sponsoring, parent organizations, subsidiaries, or subcontractors as references.**

Company name:
Account primary contact:
Title:
Email address:
Telephone number:
Facsimile number:
Type of relationship:
Number of employees:
Number of dependents:
Percentage of your business this organization/entity represented:

A.30. Provide an outline for proposed client-based expansion, if any, for the HMO within the next two (2) years to include company name and anticipated enrollment. If expansion is anticipated, what steps will the HMO take to maintain quality service to the ERS HMO membership?

A.31. The HMO shall identify applicable errors and omissions policies and professional liability coverage, by providing copies of applicable declaration pages reflecting policy limits.

Policy Number:
Insurer's Name:
Policy Expiration Date:
Policy Limit Allocations:

A.32. Describe any settled or unsettled litigation, regulatory proceedings, inquires, and/or investigations completed, pending or threatened against the HMO and/or any of its related affiliates, officers, directors, principals, or parent companies performing any part of the services in connection with the Contract during the **past five (5) years prior to the date of Application submission. Identify the case number, date filed, full style of each suit, proceeding, inquiry, or investigation including, county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any. Response shall include the current status for all cases as of Application date regardless of prior reporting to ERS. The HMO shall not refer ERS to any third party websites or other sources in order for ERS to obtain this information. The HMO must address each aspect of the above paragraph in its Application to this question.**

Case Number:

Date Filed:
County, State, or Federal District:
Regulatory Body:
Brief Summary:
Current Status:

A.33. Provide the name, title, mailing/email address(es), telephone number/facsimile numbers of the ***individual*** responsible for preparation of the HMO Clarifications during the RFA evaluation period.

Name:
Title:
Mailing Address:
Email Address:
Telephone Number:
Facsimile Number:

B. Legal Disclosure Requirements

B.1. For the past ten (10) year period, describe any litigation, regulatory proceedings, investigations, and/or inquiries completed, pending or threatened against the HMO and/or any of its related affiliates, officers, directors or parent companies subcontractors and any individuals identified by the HMO who will be performing any services and providing coverages required under the RFA and Contractual Agreement. Identify the case number, date filed, full style of each suit, proceeding, inquiry or investigation including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution if any. The **HMO shall not refer ERS to any third party websites or other sources in order for ERS to obtain this information. The HMO must address each aspect of the above paragraph in its Application to this question.**

Case Number:
Date filed:
County and State, or Federal District:
Regulatory Body:
Brief summary:
Current status:
Resolution:

B.2. Provide a schedule and describe in detail previous contract implementation breakdowns, performance assessments, and contract disputes resulting in suit or settlement and/or contract breaches for the **past ten (10) years** (if any) by the HMO, and discuss all measures the HMO took to rectify the situation or remedy the breach. Please separate by governmental and non-governmental clients indicating the reason for the assessment and the amount paid. **List in most recent chronological order.**

Governmental:
Non-governmental:
Action taken to resolve issue:
Assessment amount paid:

B.3. Confirm that neither the HMO nor any of its affiliates, subsidiaries, employees, principals, directors, or officers, nor, to its knowledge, the HMO's agents, assigns, representatives, independent contractors, and/or subcontractors, who are involved, either directly or indirectly, in the HMO's performance of the Contract, are or may, in the time such parties become involved, be the subjects of any inquiry, investigation, suit, action or prosecution by any state or federal regulatory or law enforcement authority, including but not limited to such actions by the U.S. Department of Justice or the offices of any states' attorney general, the U.S. Department of Labor, Department of Health & Human Services, CMS, or any self-regulatory organization with oversight over an HMO or such parties concerning any violation of state and federal statutes, rules, regulations, or other laws.

B.3.a. During the past ten (10) years, describe any investigations, proceedings or disciplinary actions by any state regulatory agency, states' attorney general or any other law enforcement or applicable oversight body against the HMO and/or any of its related affiliates, officers,

directors and any person or subcontractor performing any part of the services or providing any of the coverages, supplies in connection with the Contract. Identify the full style of each disciplinary action, suit, action, proceeding or investigation including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any. **The HMO shall not refer ERS to any third party websites or other sources in order for ERS to obtain this information. The HMO must address each aspect of the above paragraph in its Application to this question.**

Case Number:
Date filed:
County and State, or Federal District:
Regulatory Body:
Brief summary:
Current status:
Resolution:

B.4. Does the HMO have any pending agreements, negotiations, and/or offers to merge or sell the HMO's organization? This should include any joint ventures or other financial arrangements regarding a pending change in ownership of the HMO's organization that could affect the services described in the HMO's Application or affect the HMO's organization's financial ability to meet its obligations under a Contract with ERS. ☐ Yes ☐ No

If yes, describe any pending agreements, negotiations, and/or offers to merge or sell the HMO's organization.

B.4.a. Does the HMO have any obligation or arrangement to purchase another firm that would involve substantial commitment of assets or capital? ☐ Yes ☐ No

If yes, disclose any obligation or arrangement to purchase another firm that would involve substantial commitment of assets or capital.

B.4.b. If applicable, outline the anticipated timelines for the actions reflected in the HMO's responses to Sections X.B.4. and X.B.4.a. above.

B.4.c. Confirm that the HMO shall notify ERS' Executive Director immediately upon reaching any form of binding agreement in connection with any merger, acquisition or reorganization of the HMO's management as permitted by applicable law. ☐ Confirm

B.5. Confirm that the HMO shall notify the Director of Benefit Contracts with any anticipated changes to the ERS' Account Management and/or Implementation Team(s) structure and the HMO's Senior Officers. ☐ Confirm

B.6. Does the HMO sell or report any data from its clients, either specifically or in aggregate, to any organizations? ☐ Yes ☐ No

B.6.a. If yes, disclose these arrangements and information shared, in detail.

B.7. Provide a copy of the HMO's fidelity and liability declarations page reflecting the required coverage limits as specified in the Contractual Agreement.

B.7.a If the HMO considers this document to be confidential and proprietary, place this on HMO's separate schedule as required in Section I.B.23. However, this document will need to be provided for appropriate evaluation of the HMO 's Application.

B.8. Describe the various types of insurance coverage and indemnification provided to protect clients, including for each insurance type:

- risks covered;
- carriers;
- levels;
- limits; and
- deductibles.

B.9. Describe the errors and omissions coverage and also provide the policy expiration date to be provided by the HMO.

B.10 Confirm that the HMO agrees to add ERS as an additional insured on each such policy.
☐ Confirm

C. Data and Information Services

C.1. Provide the name, title, mailing/email address(es), and telephone/facsimile numbers and biographical summary for the ***HMO's Privacy Officer***.

Name:
Title:
Mailing address:
Email address:
Telephone number:
Facsimile number:
Biographical Summary:

C.1.a. Is the HMO currently in compliance with all HIPAA requirements? ☐ Yes ☐ No

C.1.b. If yes, the HMO shall confirm that there have been no HIPAA violations alleged against the HMO. ☐ Confirm

If no, the HMO shall provide a full description of any HIPAA violations alleged against the HMO. The description shall include, but not be limited to:

a. The identity of the entity that made the complaint;
b. The date the complaint was made;
c. A description of the complaint;
d. The date the complaint was resolved; and
e. How the complaint was resolved.

C.2. Confirm that the HMO has the ability to transmit HIPAA-related data from and to its site via secured site-to-site VPN or other federally approved means of data transmission. ☐ Confirm

C.3. Confirm the HMO's ability to accept data via SFTP within site-to-site VPN tunnel. ☐ Confirm

C.4. Provide the name, title, mailing/email address(es), and telephone/facsimile numbers and biographical summary for the ***Security Compliance Officer***.

Name:
Title:
Mailing address:
Email address:
Telephone number:
Facsimile number:
Biographical Summary:

C.5. Confirm that the HMO has the ability to transmit encrypted data from and to its site via secured site-to-site VPN or other federally approved means of data transmission. ☐ Confirm

C.6. Confirm that the HMO is currently in compliance with the requirements of all state and federal Privacy rules and regulations. ☐ Confirm

C.7. For the five (5) year period preceding this Application, please provide a brief description of any violations alleged against the HMO with regard to any state or federal Privacy rules and/or regulations.

C.8. Provide the name, title, mailing/email address(es), and telephone/facsimile numbers and biographical summary for the ***HMO's Technical Consultant ("TC")*** contact for SFTP file management and system service concerns.

Name:
Title:
Mailing address:

Email address:
Telephone number:
Facsimile number:
Biographical Summary:

C.9. Related to the HMO's administrative and customer service support functions, what are the HMO's contingency plans and procedures for providing back-up service in the event of a strike, natural disaster, act of God, backlog, or other events that might interrupt, delay or shut-down service? Provide a brief description.

C.10. Provide a copy of the HMO's disaster recovery plan and/or business resumption plan. If the HMO considers this document to be confidential and proprietary, place this on your separate schedule as required in Section I.B.22. However, the HMO shall provide this document for appropriate evaluation of the HMO's Application.

C.11. Provide the results of the HMO's most recent test of the disaster recovery and/or business resumption plan.

D. Financial Reporting Requirements

D.1. Provide copies of the HMO's 2010 and 2011 audited financial statement.

D.2. For each year contracted, the HMO shall submit a copy of its annual audited financial statement, by the last business day of June, beginning June 30, 2012. Affirm that the HMO will provide financial statements as required. ☐ Affirm

D.3. Provide a copy of the HMO's 2010 NAIC annual statement including HMO Supplement (Exhibit VI – Supplemental Interrogatories) as reported to TDI related to GBP-specific data.

D.4. Provide a copy of the HMO's 2011 NAIC annual statement by March 15, 2012, including HMO Supplement (Exhibit VI – Supplemental Interrogatories) as reported to TDI related to GBP-specific data.

D.5. Provide a copy of the HMO's 2011 audited financial statement by June 30, 2012.

D.6. Provide the name and address of the sponsoring or parent corporation or others who provide financial support to the HMO.

D.6.a. Name:
Mailing Address:
Type of Support:
Maximum limitation:

D.7. Is the HMO's company a subsidiary or affiliate of another company? ☐ Yes ☐ No

If yes, provide full disclosure of all direct or indirect ownership and include an organization chart depicting the parent company, other companies owned by the parent company, and any subsidiary relationships.

D.8. Does the HMO have a sponsoring or parent company? ☐ Yes ☐ No

D.8.a. Does the HMO have any legal relationships or financial agreements with any other entity?
☐ Yes ☐ No

D.8.b. If yes, state the name and address of any sponsoring or parent organization or others who provide financial support to the HMO and please describe.

Full Legal Name:
Mailing Address:
Type of Support:
Type of Relationship:

D.8.c. Provide an indication of the type of support, i.e., guarantees, letters of credit, etc., if applicable.

D.8.d. Provide the maximum limits of additional financial support from other entities or persons, if applicable.

D.8.e. Provide a copy of the sponsoring or parent organization's most current audited financial statement, if applicable.

D.9. Provide a copy of the HMO's most recent Statements on Standards for Attestation Engagements ("SSAE16") or SAS 70 report or other outside auditor results pertaining to the accuracy/validity of the HMO's internal operational controls, if available, or explain why such report is not available.

If the HMO considers this document to be confidential and proprietary, place this on your separate schedule as required in Section I.B.23. However, the HMO shall provide this document for appropriate evaluation of the HMO's Application.

D.9.a. Provide a copy of the HMO's sponsoring or parent company's current SSAE16 or SAS 70, Level 2, report, or other outside auditor results pertaining to the accuracy/validity of the HMO's internal operational controls, if applicable. Explain why such report would not be available.

D.10. The HMO shall confirm compliance with the Sarbanes-Oxley Act of 2002, if applicable.

D.11. Provide copies of ratings and reports on the HMO issued by independent insurance rating organizations or similar entities, e.g. A.M. Best's, Moody's, NCQA, and Standard & Poor's, etc.

XI. Deviations

ERS shall interpret any lack of deviation as the HMO's full agreement to the provisions of the Contractual Agreement and RFA requirements unless specifically and unequivocally stated in detail under Section XI, Deviations in the HMO's Application. ERS shall interpret the HMO's Application to match the specifications herein except for deviations specifically noted and described in response to this item. Deviations will not become a part of the final Contract unless expressly accepted by ERS and agreed to by ERS in writing. In all cases, the RFA and all Contractual Agreement terms shall control. In the event of any conflict between the two, the terms of the Contractual Agreement shall prevail.

Deviations, which are strongly discouraged, must be specifically identified below in order to be considered. General references to or comparisons with a different standard shall not be considered as satisfactory identification of a deviation and shall be deemed void. The HMO understands and agrees that ERS is relying on the truth and accuracy of the HMO's Application, that the HMO shall comply with all requirements set forth throughout the entire RFA, and that ERS shall interpret the HMO's Application to match the RFA specifications, except for deviations specifically noted and described below.

A.1. Affirm that the HMO agrees to notify the ERS Executive Director immediately upon the public announcement of reaching any form of binding agreement in connection with any merger, acquisition or reorganization of the HMO's management.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.2. Affirm that the HMO shall comply with all of the ***Instructions*** described in **Article I** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.3. Affirm that the HMO shall comply with all of the ***Application Evaluation Criteria*** described in **Article II** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.4. Affirm that the HMO shall comply with all of the ***Financial Requirements and Rate Proposal*** described in **Article III** and be bound to the rates the HMO provides in response to the Financial Requirements and Rate Proposal section of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.5. Affirm that the HMO shall comply with all of the ***Communication Requirements*** described in **Article IV** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.6. Affirm that the HMO shall comply with all of the ***Operational Specifications*** described in **Article V** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.7. Affirm that the HMO shall comply with all of the ***Information Systems Requirements*** described in **Article VI** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.8. Affirm that the HMO shall comply with all of the ***Summary of HMO Benefits*** described in **Article VII** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.9. Affirm that the HMO shall comply with all of the ***Service Area Requirements*** described in **Article VIII** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.10. Affirm that the HMO shall comply with all of the ***Provider Network Requirements*** described in **Article IX** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.11. Affirm that the HMO shall comply with all of the ***Organizational Information*** described in **Article X** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.12. Affirm that the HMO shall comply with all of the ***Interrogatories*** described in **Article XII** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between the HMO's Application and these specifications. HMO Requested Deviation Detail:

A.13. While deviations to the Contractual Agreement are strongly discouraged, clearly identify any provisions found in the Contractual Agreement, referenced as Appendix B, to which the HMO is requesting a deviation. ERS is seeking an HMO that will agree to, and comply with, all provisions of the Contractual Agreement. ERS shall presume that the HMO agrees with and will execute the Contractual Agreement unless it clearly and unequivocally specifies any deviations thereto in the HMO's Application. In any event, ERS shall not be required to accept any deviations to the Contractual Agreement or to the terms of this RFA. Any such deviations must be specifically agreed to in writing by ERS before they shall form a part of the final agreement between ERS and the selected HMO.

A.13.a. Affirm that the HMO shall comply with all of the provisions in the ***Contractual Agreement*** provided in Appendix B of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation.

If applicable, enumerate and provide a detailed description of each Contractual Agreement deviation. HMO Requested Deviation Detail:

A.14. Affirm that the HMO shall comply with all of the provisions provided in ***Appendix G, Performance Assessments,*** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Appendix *G*, Performance Assessments, deviation. HMO's Requested Deviation Detail:

A.15. Affirm that the HMO shall comply with all of the provisions provided in ***Appendix K, Data Security and Breach Notification,*** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Appendix K, Data Security and Breach Notification, deviation. HMO Requested Deviation Detail:

A.16. Affirm that the HMO shall comply with all of the provisions provided in ***Appendix L, Business Associate Agreement,*** of this RFA.

☐ Affirm ☐ Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Appendix L, Business Associate Agreement, deviation. HMO Requested Deviation Detail:

XII. Interrogatories

Instructions: In order for the HMO Application to be considered and accepted, the HMO shall provide true and correct answers to all of the questions presented herein. Each question shall be answered specifically and in detail. **Reference should not be made to a prior response, or to another document, unless the question involved specifically provides such an option**. Be sure to refer to the earlier Articles of this RFA and Contract before responding to any of the following questions, so that the HMO has a complete understanding of all of ERS' requirements with respect to the bid. For purposes of the Contract and the RFA, "HMO" necessarily includes the HMO, its officers, directors, employees, representatives, agents, subsidiaries, affiliates and any subcontractors and independent contractors.

Answers to the questions included in this Article should be detailed enough to satisfactorily explain the HMO's position on each particular issue. It is the HMO's responsibility to respond to these questions in such a way that ERS has a full and complete understanding of the HMO's intent. **It is important that the HMO carefully define any key words or phrases used in answering these questions that are not otherwise defined in the Contract or the RFA. The HMO's Application shall use the terms defined in the Contract and the RFA only as they are so defined.** The HMO's Application shall use the terms defined in the Contract and the RFA only as they are so defined. Certain questions contained herein may require individualized responses to distinguish more than one (1) application area.

The HMO acknowledges, understands and agrees that its responses to these Interrogatories and all other provisions of the RFA are material and are being relied on by ERS in connection with the selection of the HMO to provide the services, benefits, equipment, coverages, supplies, products and other services as specified in the RFA.

A. General Information

A.1. Provide the commercial HMO enrollment and total enrollment in the proposed service area as of December 31, 2011.

Commercial enrollment:
Total enrollment:

A.2. Is the HMO currently participating in the GBP? ☐ Yes ☐ No

If yes, what is the percentage of total business that the GBP enrollment represents to the HMO? %

A.3. If applicable, identify all currently contracted health professionals maintaining a financial interest in the HMO.

A.4. Outline the extent and length of each relationship.

A.5. Describe any contractual relationships with affiliates that could present a conflict of interest with the HMO's role as a participating vendor in the GBP.

A.6. Briefly outline how the HMO is in compliance with the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy regulations and any procedures or systems developed to comply.

A.7. Does the HMO currently have the ability to provide Explanation of Benefits information electronically to the firm that administers the GBP TexFlex Health Care Reimbursement Account Plan? ☐ Yes ☐ No

If yes, describe the process.

If no, indicate if a process will be available by September 1, 2012.

A.8. Discuss the HMO's ability to develop an interface with the GBP's disability carrier to provide health claims data.

A.9. ERS is interested in the HMO's experience in working with clients to improve the cost efficiency of their health benefits programs. Describe the HMO's experience in providing cost containment enhancements to former or current clients.

A.10. In the event a Participant does not select a PCP, is the HMO capable of assigning a PCP?
☐ Yes ☐ No

If yes, describe the process.

B. Administration

B.1. In what manner does the HMO propose to administer benefits provided to GBP members? Include responses to the following:

B.1.a. Are all administrative services performed internally? ☐ Yes ☐ No

B.1.b. Where is the administrative facility located?

B.1.c. List the administrative services performed at this location.

B.1.d. If the HMO contracts with a management or service company for some or all of the HMO administrative services, what is the name of the company, the services provided, and the method of reimbursement?

Name of Company:
Services provided:
Reimbursement Method:

B.1.e. Provide the number of the HMO employees and/or support staff who administer the various aspects of the plan.

B.1.f. What is the turnover rate among the HMO administrative staff for the past two (2) years?

B.2. What is the structure of the HMO member services unit?

B.2.a. How is the member services unit accessed?

B.2.b. What are the member services unit hours of operation?

B.2.c. How are complaints managed within the member services unit?

B.2.d. Is the member services unit able to assist a member in choosing a PCP? ☐ Yes ☐ No

B.3. How does the HMO utilize automated interactive data systems to assist a Participant in choosing a PCP? Include a discussion of the methodology that it uses to coordinate the PCP with proximity to the Participant's residence, schedule, language, etc.

B.4. Can GBP member calls be managed and monitored separately from the remainder of the HMO's book of business? ☐ Yes ☐ No

B.5. Does the HMO provide access to automated, interactive data systems that would provide Participants with information regarding Health Care Providers? ☐ Yes ☐ No

If yes, are the automated interactive systems: ☐ Telephone ☐ Online ☐ Both

B.6. Does the HMO maintain an Internet website? ☐ Yes ☐ No

If yes, provide the URL. URL:

B.7. Are claims processed internally, by a third party, or both? ☐ Internal ☐ Third party ☐ Both

B.8. What is the average turnaround time for "electronic" claims submissions?

B.8.a What is the average turnaround time for "paper" claims submissions?

B.8.b. Where is the claims' processing facility located?

B.9. Describe the HMO's customer satisfaction survey process.

B.9.a. How often does the HMO conduct customer satisfaction surveys?

C. Utilization Review

C.1. How does the utilization review process that the HMO intends to apply to GBP Participants function? Include the following:

C.1.a. Is the utilization review performed by the HMO staff or through contract with a third party?

☐ HMO Staff
☐ Third Party

C.1.b. If through a Third Party, identify the following:

Third Party Name:
Address:
Contact Name:
Contact Telephone Number:
Email address:

C.1.c. What are the addresses and hours of operation for the facility or facilities from which utilization review activities shall be conducted?

Facility Address:
Hours of Operation:

C.1.d. Are licensed medical personnel on duty at all facilities during all hours of operation? ☐ Yes ☐ No

C.1.e. What credentials and/or qualifications are required for the HMO utilization review nurses and related personnel?

C.1.f. What percentage of utilization review referral and authorization requests are referred to the medical director? %

C.1.g. What is the process available to Health Care Providers for the appeal of denied claims?

C.1.h. What are the utilization review procedures performed by network Health Care Providers?

C.2. In what manner does the HMO conduct the following activities and how are the results of such activities used in the medical management process? Response should include:

C.2.a. Development of profiles of PCP practice and referral patterns.

C.2.b. Monitoring of frequently used services.

C.2.c. Review of physician coding patterns.

C.2.d. Examinations of average cost per encounter by PCPs.

C.3. What is the methodology that the HMO uses in establishing medical protocols for the HMO managed care network?

C.3.a. Which protocols are used in the management of Participant health care?

C.3.b. How are the protocols used?

C.3.c. In what manner does a Health Care Provider obtain approval to deviate from the protocols when treating a patient with complications?

C.3.d. How does the HMO communicate the results of such activities to Health Care Providers?

C.3.e. How are the results used to modify practice patterns?

C.4. How does the HMO detect and investigate overcharges, fraud, abuse, unnecessary hospital confinements, unnecessary medical treatment, excessive drug use or other abuse?

C.5. What are the procedures and systems the HMO uses to detect and investigate Participant, employee and Health Care Provider fraud or related issues, and how is such a process utilized in connection with the GBP?

C.6. What is the organizational relationship that exists between corporate, regional and local medical management?

C.6.a. What are the distinct responsibilities that pertain to each level?

Corporate
Regional
Local

C.6.b. What are the functions handled at each level? Include any arrangements involving medical protocol committees, utilization review groups, etc.

Corporate
Regional
Local

C.7. What is the size and expertise of the medical management staff assigned to each network location?

C.7.a. Which of the above personnel is staff versus contract?

C.7.b. Which of the above personnel are full-time versus part-time?

C.7.c. What are the general responsibilities of each staff member?

Staff:
Contract:
Full-time:
Part-time

C.7.d. Where is this staff located?

Staff:
Contract:
Full-time:
Part-time

D. Network Management

D.1. What are the proposed counties for each Service Area included in the HMO's Application?

D.1.a. Of the proposed counties in the service area, please advise if the HMO service was provided in a full or partial county.

D.1.b When did the HMO begin serving each of these areas?

D.2. Does the HMO have more than one (1) provider network available? ☐ Yes ☐ No

If yes, what are the different network options and how do the network options impact the proposed premium rates?

D.3. If the HMO provides more than one provider network, identify the network that the HMO proposes be used by GBP Participants.

D.4. Does the proposed network include any hospitals used for patient stabilization or emergency care and not for general hospital coverage? ☐ Yes ☐ No

If yes, which hospitals are used only for patient stabilization or emergency care?

D.5. How does the HMO manage the provider network?

D.5.a. Does the HMO own the network or is it leased from another entity? ☐ Owned ☐ Leased

If leased from another entity, what is the name of that entity?

D.6. What is the contractual relationship between the HMO and the owner of the leased network?

D.6.a. If the HMO contracts with a management company, outline the details of the arrangement.

D.7. Article IX describes the network documentation requirements. Disclose any network medical facility in which the HMO organization, any subsidiary or any affiliated organization maintains a majority ownership and/or controlling interest.

D.8. Does the HMO have contracts with PCP groups that require that specialty care referrals be made to a specified subset of the network's specialists? ☐ Yes ☐ No

If yes, give details.

D.9. Does the HMO organization operate provider networks in other areas of the United States that would be available to GBP Participants working, living (retired), or visiting out-of-state? ☐ Yes ☐ No

If yes, list all areas served by the out-of-state network(s).

D.9.a. Is the HMO approved by TDI for reciprocity arrangements? ☐ Yes ☐ No

If yes, where?

D.9.b. Outline the specific reciprocity arrangements.

D.9.c. Is there a limit to the number of Participants living outside of Texas that the HMO would be able to cover in a reciprocity arrangement? ☐ Yes ☐ No

D.10. Discuss the network's methodology in evaluating patient access to practitioners.

D.11. What are the professional liability coverage requirements for each type of Health Care Provider including all provider facilities in the HMO network?

D.12. What is the HMO credentialing and re-credentialing process for all Health Care Providers? The HMO shall include an overall summary of National Committee for Quality Assurance ("NCQA") standards and guidelines.

D.12.a. How often does the HMO conduct the re-credentialing process?

D.13. Does the HMO utilize centers of excellence for the provision of certain high-cost, highly specialized procedures? ☐ Yes ☐ No

If yes, how are such facilities selected and credentialed?

D.14. Where are the centers of excellence located?

D.14.a. What procedures are referred to these facilities?

D.15. What is the fee and risk sharing arrangements that the HMO has with Health Care Providers in each network for which the HMO is submitting an Application? To assist in communication of this information, complete *HMO Provider Reimbursement Arrangements* located in Section III.H. (Check List item)

D.16. What minimum periods are included in the HMO Health Care Provider contracts concerning:

D.16.a. Provider's notice to not accept new patients?

D.16.b. Provider's intent to terminate?

D.16.c. HMO's intent to terminate?

D.16.d. Provider's required continuation of care to existing network Participants following provider's termination from the network?

D.17. Describe how the HMO is in compliance with continuation of coverage and conversion policies.

D.18. Does the HMO offer an individual conversion policy or a group conversion policy?

☐ Individual Conversion Policy ☐ Group Conversion Policy

Describe the policy offered.

D.19. What is the HMO's specific transitional benefits procedure?

D.20. What percentage of each network's physicians are Board certified?

D.21. What is the training/orientation process for the HMO network Health Care Providers? Address such issues as:

D.21.a. Participant eligibility.

D.21.b. Utilization review procedures.

D.21.c. Billing.

D.21.d. Quality improvement responsibilities.

E. Pharmacy

E.1. What is the HMO pharmacy contracting process and the HMO pharmacy network?

E.2. Does the HMO contract with a PBM? ☐ Yes ☐ No

If yes, provide the full name, address and account contact name and phone number for the PBM.

Name:
PBM Address:
Account Contact Name:
Phone Number:

E.3. Provide a detailed discussion of how the HMO will meet the requirements of Section VII.F.5. as they relate to Medicare Part D.

E.4. Does the HMO's pharmacy network allow a 90-day supply at retail? ☐ Yes ☐ No

E.5. What is the HMO's mail order pharmacy service?

E.5.a. Does the HMO have an Internet link to the mail order PBM? ☐ Yes ☐ No

E.5.b. Will Participants be able to order their refills over the Internet through the HMO PBM?
☐ Yes ☐ No

E.6. Separately describe the manner in which the HMO reimburses (a) retail, and (b) mail order pharmacies. This discussion should include a description of the methodology and parameters including specifics regarding ingredient cost reimbursement and AWP discounts and dispensing fees. Any difference in reimbursement between name brand and generic drugs should be detailed. The response to this question shall provide enough detailed information to allow ERS to fully understand

the HMO pharmacy reimbursement formula. A detailed response to this question is a necessary prerequisite for ERS selection.

Retail:
Mail order:

Provide a copy of the prescription drug formulary that the HMO proposes to use for the GBP.

E.6.a. How often is the formulary updated?

E.6.b. How does the HMO notify members of formulary changes?

E.6.c. What is the average formulary rebate, expressed as an amount per paid prescription, received during 2011?

E.6.d. In what manner are the anticipated formulary rebates considered in establishing GBP premium rates?

E.7. What is the HMO prescription drug Utilization Review program?

E.8. What are the HMO Prior Authorization programs for the PBM?

E.9. Does the HMO offer a Specialty Pharmacy program? ☐ Yes ☐ No

If yes, describe the program.

E.10. What is the name of the vendor providing Specialty Pharmacy program services?

E.11. What is the reimbursement basis for specialty medications?

E.12. What is the HMO process for determining the provider reimbursement for specialty (or injectable) medications?

F. Disease Management

F.1. What Disease Management program(s) can the HMO currently offer to the GBP?

F.2. How does the HMO currently administer its Disease Management program(s)?

F.3. How does the HMO identify members, initiate the management, and measure results of the HMO's Disease Management program(s)?

F.4. How is return on investment calculated for the Disease Management programs?

G. "Value-Added" Program

G.1. What "Value-Added" program(s) does the HMO currently have available to offer to GBP Participants?

G.1.a. If the HMO wishes to offer "Value-Added" options, what services would be included?

G.1.b. Are there any associated costs of the "Value-Added" services on a per capita basis?
☐ Yes ☐ No

G.1.b.i If yes, please provide the additional cost of the "Value-Added" services.

G.1.c. Provide any return on investment data for each "Value-Added" program offered and indicate how the return on investment has been calculated.

G.2. Discuss the differences between those "Value-Added" and Wellness programs offered by the HMO to GBP Participants.

H. Quality Assurance

H.1. What is the name of the designated senior executive responsible for the Quality Assurance ("QA") program?

H.2. What is the extent of the Medical Director's involvement in the QA program?

H.3. What is the extent of participating Health Care Providers' involvement in the QA program?

H.4. Discuss the quality of Clinical Care and Quality of Service issues as related to the QA program.

H.5. Provide a copy of the HMO's current published policies and procedures for the QA program.

H.6. What process does the HMO use for monitoring the QA program? Response should include:

H.6.a. Adequacies of patient care.

H.6.b. Average annual PCP turnover rates. Also provide an explanation on how the average annual PCP turnover rates are used in monitoring the QA program.

H.6.c. Member PCP transfer rates. Also provide an explanation on how the member PCP transfer rates are used in monitoring the QA program.

H.6.d. Health Care Provider satisfaction.

H.6.e. Adequacy of claims service.

H.6.f. Member satisfaction surveys.

H.6.g. How often surveys are conducted.

H.6.h. The most recent results of the survey.

H.6.i. Are Health Care Providers notified of the results? ☐ Yes ☐ No

H.6.j. Health Care provider compliance with expected utilization norms.

H.6.k. Disciplinary and sanctioning information.

H.7. Has the HMO network been reviewed by external agencies or industry organizations?
☐ Yes ☐ No

If yes, which ones?

H.8. What were the overall results of the surveys?

I. Independent Review Organization

I.1. How does the HMO use the Independent Review Organization ("IRO") process? Describe the HMO IRO process in detail.

J. Systems and Technology

J.1. Does the HMO warrant and represent that it has a disaster recovery plan in effect for its computer systems and equipment and that of any subcontractor upon whom the HMO relies in performing or providing any services or products to or on behalf of ERS? ☐ Yes ☐ No

If yes, provide a general description of the HMO's disaster recovery plan to include the date and results of the most recent test of the plan.

J.2. Provide the names and a description of the hardware and software systems that the HMO is currently using.

J.2.a. Provide the names and a brief description of the hardware and software systems that the HMO proposes to utilize to provide the required secured services proposed in Sections VI.A.1.e. – VI.A.1.i. of this RFA.

J.3. For each system, provide the following information:

J.3.a. When was this system implemented?

J.3.b. When was the system last updated?

J.3.c. Is there a future update being considered?

J.3.d. If so, when is the update anticipated?

J.4. What quality assurance processes are provided in the HMO's system to ensure accuracy in the application of claims processing? Provide a detailed description of the processes.

J.5. **Data interfaces:**

J.5.a. What is the HMO's standard interface protocol?

J.5.b. What flexibility does the HMO have with the HMO's standard approach?

J.5.c. Are the HMO's data files compatible with 834 format?

J.6. What measures does the HMO take to ensure the security of interfaces the HMO is sending/receiving to/from external sources (whether ERS or a third party)?

J.7. Please list and describe all security breaches the HMO's organization has experienced, including but not limited to, loss of equipment that contained client information, loss of files, and unauthorized access to your networks.

J.8. What technology investments has the HMO made over the past three (3) years to mitigate security breaches?

J.9. Is the HMO's system capable of supporting a User ID other than Social Security Number ("SSN")?

☐ Yes ☐ No

J.9.a. If the HMO's system can support a User ID other than SSN, can User ID be alphanumeric?

☐ Yes ☐ No

J.9.b. What are the HMO's minimum and maximum User ID lengths?

J.10. Briefly describe the HMO's back-up procedures for the system(s) to be used in the services proposed to ERS.

Information Security

J.11. How does the HMO manage physical security of its data center? (Who gets access, what are the hours?)

J.12. What technology is in place to manage network and server security? Provide a detailed description of the technology.

J.13. How does the HMO control access to ERS sensitive data? Provide a detailed description.

J.14. How does the HMO secure backup tapes? Who has access to them? (onsite and offsite)

J.15. How is the HMO's Application security managed and how is client data secured?

J.16. Does the HMO have a formal information security program in place? ☐ Yes ☐ No

J.16.a. If yes, does the HMO have dedicated resources for information security efforts? ☐ Yes ☐ No

J.16.b. Does the HMO have formal information security policies, procedures and standards? ☐ Yes ☐ No

J.16.c. Are employees required to periodically confirm their compliance with the HMO's information security policies? ☐ Yes ☐ No

J.16.d. Does the HMO have a user awareness campaign related to information security? ☐ Yes ☐ No

J.16.e. How does the HMO monitor compliance? Provide details of any outside security assessments.

J.17. Are the HMO's desktop and laptop computers encrypted to protect data in case of theft or lost?
☐ Yes ☐ No

J.18. How does the HMO protect the privacy of GBP Participants? Provide a detailed description.

K. Applied Behavioral Analysis

K.1. Does the HMO currently cover Applied Behavioral Analysis as a treatment for autism?
☐ Yes ☐ No

If yes, describe the HMO's coverage and is this coverage included in the HMO's premium rate.

XIII. Appendices

A. Signature Pages

B. Contractual Agreement

C. Enrollment, Demographic, and Premium Information

D. Specific GBP Eligibility Demographics and Enrollment File

E. Weekly/Monthly Carrier File Layouts

F. ERS Style Guide and Usage Manual

G. Performance Assessments

H. HealthSelect and PBM Claims Experience and Enrollment by County

I. In-Vitro Fertilization Rider Rejection Form

J. Glossary of Terms

K. Data Security and Breach Notification

L. Business Associate Agreement

M. ERS Brand Guidelines

N. Bariatric Guidelines

O. Sample Monthly Administrative Performance Report

P. ERRP Data Exchange and Services Supplement

Q. Call Center Metrics