



**Solicitation Information  
June 6, 2013**

**Addendum #3**

**RFP # 7464385**

**TITLE: MEDICAL & PHARMACY PLANS FOR THE STATE OF RHODE ISLAND**

**Submission Deadline: Monday, June 17th, 2013 at 2:00 PM (ET)**

- Below are responses to the vendor questions. The State will not respond to any additional questions.
- Attached is a .zip file entitled *Large Loss with Diagnosis (Statistical)*. Please click on the letter 'D' in the column labeled 'Info' to access this document.
- Attached are sign-in sheets for the non-mandatory pre-bid conference held on May 17, 2013.
- In order to make sure that implementation is completed before expiration of the current contract, the requirement in the Request for Proposals that the selected vendor[s] shall not move forward with implementation until such a time as the Division of Purchases issues a formal Purchase Order/Agreement is hereby amended: After tentative selection of a vendor[s], the selected vendor[s] shall immediately proceed with implementation at their own risk. Payment for any activities associated with implementation is subject to the State and vendor[s] entering into a mutually agreed upon contract, along with the issuance of a Purchase Order/Agreement. Additionally, notice of tentative selection will be posted on the Division of Purchases website and the evaluation memorandum and any other public documents will be made available for inspection at the time of tentative selection; not at the time of final award.
- Please continue to monitor the website on a regular basis for additional information, updates or changes.

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## Vendor Questions – Pre Bid Conference

1. Does the vendor need to submit a copy of the Rhode Island vendor certification form and a W-9 with each copy of the proposal?

RESPONSE: No, only one signed original of the RIVIP Vendor Certification Cover Form and a W-9 needs to be submitted with the original technical proposal.

2. MBE Requirements – Is MBE participation a percentage of the Administrative Fees?

RESPONSE: The State is looking for a minimum of 10% MBE participation. Please contact the State's MBE Office with any questions about MBE requirements.

3. There is a conflict on the submission date for the Geo Access; one place it states May 24<sup>th</sup> and in the other it states June 7<sup>th</sup>, which is it?

RESPONSE: Everything shall be submitted on the same final submission date including Geo Access currently now on June 17, 2013 at 2PM (ET).

4. What is the criteria and methodology that will be used for awarding the technical scoring? What is the scoring methodology for awarding the technical points?

RESPONSE: The criteria were identified in the RFP. The evaluation team will award points based on vendor responses meeting the needs of the State.

5. Who is on the evaluation team?

RESPONSE: Generally, the evaluation team will consist of State Employee stakeholders with subject matter experience, or with financial, purchasing or other relevant expertise that would add value to the review of proposals. The evaluation team has not yet been selected and this information will only become public after the selection(s) is made.

6. Minimum Requirements Section #2 – at least a million lives covered across vendor's health plan business: Is this national or Rhode Island or how is this determined?

RESPONSE: This requirement should be considered broadly and not just in Rhode Island. Additionally, the minimum requirement is changed to 500,000 lives.

7. Will there be an opportunity for follow-up questions once vendor responses are issued?

RESPONSE: The State believes the RFP and the responses to the vendor questions provide more than sufficient information for vendors to submit a comprehensive proposal without further delay. Therefore, the State will not respond to additional questions.

8. There are some technical issues with the drop down boxes in the pharmacy worksheets.

RESPONSE: The State has already posted an addendum with updated spreadsheets. If there are any additional technical issues, please email.

9. Checklist of worksheet files – Census files – please clarify what the State is looking for?

RESPONSE: This is strictly informational.

10. There are certain section number references that are stated in the questionnaire which are not consistent with the RFP Intro document; can you please clear up any discrepancies?

RESPONSE: The Intro (A-1) referenced is Part 1 – Questionnaire/Terms and Conditions which starts on page 2 of the pdf document “SORI 2014 Medical Pharmacy Cover Intro NDA – 05072013”.

11. Subcontracting Requirements – Section 13 – Sections in medical and pharmacy questionnaire also asks the same question. Does answering the questionnaire satisfy this requirement or does a vendor need to separately list subcontractors aside from the questionnaire answer?

RESPONSE: In addition to providing the answer to the questionnaire, the State requires all subcontractors that will be used to fulfill the proposed services to be clearly identified in the response to the RFP as well.

12. This RFP appears to cover populations I & II only. What about populations III & IV? Will the State issue another RFP for these populations?

RESPONSE: The Governor’s 2013 budget includes a proposal to move the Medicare population to a private Medicare exchange. If the proposal passes, vendors will be participating in a separate RFP for the Medicare population. If the proposal does not pass, the population will remain with the current vendor until further notice of an RFP.

### Vendor Questions –Received VIA Email

13. The dropdown box functionality in the PBM Questionnaire does not work. We are unable to view the available response options. Additionally, in the Medical Questionnaire, the following sections/questions call for text responses, however, only Yes/No dropdown responses are available.
- Section V, the CLAIMS OFFICE / SERVICE CENTER PERFORMANCE
  - Section VI, the HEALTH MANAGEMENT/ WELLNESS SERVICES INFORMATION question #3.1.& m
  - Can the State of Rhode Island send corrected response files?

RESPONSE: Corrected PBM questionnaire was posted on the RFP website on May 20, 2013. The Medical questionnaire will not be revised. Please provide your response in the “Explanation” box to the right of the Response box.

14. Certifications – The state is requiring that proposals submitted when the total amount may potentially exceed \$500,000 include a public copy available for public inspection under RI Gen. Law’s section 37-2-18(j). In the RFP section titled "Solicitation Information," Part 1 -- Questionnaire/Terms and Conditions, paragraph 12 indicates that "each Bidder may designate any portion(s) of its proposal the Bidder deems proprietary or confidential and which the Bidder believes to be exempt from disclosure, citing the specific statutory authority upon which it relies. A Bidder's assertion of exemption will not be binding on the Division, but will be considered in responding to an "Access to Public Records Request." If a Bidder does not appropriately designate confidential or proprietary portions of its proposal or fails to provide valid legal authority for such designation, all portions of the Bidder's proposal may be subject to disclosure." Based on the above requirement, can the public copy submitted in compliance with RI Gen. Laws section 37-2-18(j) contain portions which are redacted or sealed because deemed to be confidential or proprietary?

RESPONSE: A “public copy” is not required for this procurement. This procurement is a competitive negotiation process through a Request for Proposals in accordance with R.I. Gen. Laws § 37-2-19 (based on technical criteria and cost), not competitive sealed bidding through R.I. Gen. Laws § 37-2-18 (based on lowest cost) which requires a “public copy.” In accordance with State Procurement Regulation 6.3.1.3, at the submission deadline, the only information that will be made public at this time is the identification of vendors submitting proposals. The nature of the responses will not be subject to public disclosure until an award[s] has been issued.

15. Medical Technical Proposal – In the evaluation of the Medical Technical proposal, what specific criteria will be used to assess the possible 13 points for the Vendor Accountability and Performance Review?

RESPONSE: Responses to questions related to vendor accountability and performance will be reviewed and scored by the evaluation team. Questions will be weighted based on importance in meeting the needs of the State. Specific criteria will be established before the review team evaluates the bids.

16. Pharmacy Technical Proposal – In the evaluation of the Pharmacy Technical proposal, what specific criteria will be used to assess the possible 15 points for the Vendor Accountability?

RESPONSE: Criteria will be taken from RFP responses to the Vendor Financial strength and stability, vendor accreditations, reference sections as well as the cost questionnaire.

17. In the evaluation of the Pharmacy Technical proposal, what specific criteria will be used to assess the possible 15 points for the Administrative and Network Competencies?

RESPONSE: Account Management, Customer Service, Mail Order, Reporting, Appeals, as well as retail network disruption and access.

18. In the evaluation of the Pharmacy Technical proposal, what specific criteria will be used to assess the possible 20 points for Managing the Drug Mix?

RESPONSE: Generic Dispensing Rate guarantees, depth of clinical programs, clinical differentiation, specialty drug management, drug adherence.

19. Submitter's Checklist:

- The Specific Introduction worksheet (A-1) that bid respondents should use is not contained in the bid. Is the State requiring a specific format?

RESPONSE: The Intro (A-1) referenced is Part 1 – Questionnaire/Terms and Conditions which starts on page 2 of the pdf document “SORI 2014 Medical Pharmacy Cover Intro NDA – 05072013”.

- In the Checklist for Submission section the State is requiring vendors to include the Census, Claims & Enrollment, and Special Terms and Conditions files. What does the State want bidders to submit for these sections?

RESPONSE: The bidders do not need to submit anything for these worksheets. These are strictly informational.

- What does the State mean by Standard Setup Forms in the Rx Electronic File Attachment Section?

RESPONSE: Any documentation that a bidder might require the State to complete prior to the setup of the client's benefit (i.e. client requirements, benefit setup, file transfer, etc.)

- What is meant by an Electronic Account Management plan in the Rx Electronic File Attachment Section?

RESPONSE: A document outlining the bidder's Account Management plan for the State. The Account Management plan would include implementation and ongoing service, including the team that will be responsible for day to day service as well as strategic planning, executive sponsorship, and any additional levels of support available to the State.

20. Minimum Qualifications – We are unclear on the State's requirement that all qualified bid respondents must have at least one million covered lives across the Vendor's health plan book of business as of proposal submission date. Please provide an explanation.

RESPONSE: This requirement should be considered broadly and not just in Rhode Island. Additionally, the minimum requirement is changed to 500,000 lives.

21. Medical Questionnaire – Is the State requesting paper copies of provider directories, or the link to our web portal?

RESPONSE: A link to provider directories on the web portal will suffice.

22. Please provide clarification in which the State is requesting a real-time information system which supports the State's requirements for database maintenance and management reporting (i.e. The State has electronic access to the system to make changes name, correct DOB, modify enrollment, view claims, verify dependent coverage, etc.)

RESPONSE: The State would like access to an employer portal that will allow them to make real-time changes to employee information, enrollment information, dependent coverage information, produce eligibility and enrollment files, view claims status, etc.

23. The State is asking for the Customer Service telephone response time, and also asks for average speed to answer. We consider these to be one in the same. Please provide clarification.

RESPONSE: The Customer Service telephone response time measures the telephonic response time. The average speed to answer should include the response time for telephone, email or faxed questions.

24. In the General Plan Info V. #55 A, the RFP asks prospective vendors to identify their capabilities regarding electronic referrals for all plans requiring physician referral: a. The current vendor has an electronic referral process. Is this referring to PCP patient referrals to Specialists?

RESPONSE: While the State's plan does not have a PCP requirement for a referral, this would be included along with any PCP/Specialist referrals to other Specialists or inpatient/outpatient facilities.

25. In regard to Part 1, Medical RFP, Section IV #13, please provide an explanation of ad-hoc reporting; specifically, how many hours of work related to reporting do you estimate will be required per year?

RESPONSE: Ad-hoc reporting would be any report that requires parameters that do not fall within your standard reporting package or is needed at a time that falls outside your regular standard reporting timeframes. The State is not providing a minimum estimate of hours at this time.

26. In regard to Part 1, Medical RFP, Section IV #52a & b, please define SBC's.

RESPONSE: Summary of Benefits and Coverage

27. Both in the Minimum Qualifications and Section V. /Data Management of the Medical Questionnaire, there is a reference to real-time access to an enrollment and management information system. Is the State of Rhode Island looking for real-time access to a carrier's system, or will the carrier be required to access a State of Rhode Island enrollment/eligibility system?

RESPONSE: The State is looking for real-time access to a carrier's system.

28. In the Medical Questionnaire, Section IX (Patient-Centered Medical Homes), question #7, what does the State of RI want the percentages to be of? What is "primary care practice annual payment"? For example, are you asking for % of payments for #6F out of all PCMH payments made, or out of all payments for the specific practice, or out of all payments made to all providers in RI, or out of all payments made to all providers in our network, or out of some measure of PCP dollars, etc.?

RESPONSE: The State is looking for % of payments for #6F out of all PCMH payments made.

29. Pharmacy Questionnaire – PBM, III. Cost Questionnaire, Rebates #36, please provide further explanation of “offer of rebates”. The RFP requests rebates calculated as a 100% pass through.

RESPONSE: Your rebate offer should be a full pass through (100%) of manufacturer rebates with minimum guarantees for retail and mail order. The criteria for rebate definitions are included as questions in the bid requirement section of the RFP.

30. PBM pricing pages: Please confirm if the requested time periods (Y1, Y2, Y3) should be Year 1 and Year 2 to match with the 18 month periods as requested in the medical RFP.

RESPONSE: Confirmed

31. Please clarify what you're looking for in the following question in the PBM questionnaire (47. Customer Service, g): "You are able and willing to customize messaging for the State-specific plan design issues."

RESPONSE: The PBM should be able to create messaging on their customer service platform that representatives would be able to view, that are specific to the State’s plan design.

32. How does the State of Rhode Island define the specialty pharmacy list -- does it represent drugs paid under specialty drug pricing, drugs that are locked into a specialty pharmacy, or drugs on a specialty tier?

RESPONSE: Drugs paid under specialty drug pricing.

33. Some of the PBM questions refer to member cost share as "pay as generic" or "pay as brand". Our member cost share is driven by the benefit design including copayment by drug tiers. It is not driven by brand or generic indicators. Can the State of Rhode Island explain further their intent of the questions?

RESPONSE: Cost share would be expected to be paid according to plan design determined by the State. The plan design and drug tier should dictate actual member cost share.

34. Performance Guarantees – In the Operational Guarantee section regarding ID Card guarantees, there appears to be two separate ID Card timeliness metrics: 1) the first metric listed on the Operational Performance Guarantees grid and, 2) item “iv” in the “Implementation” section below the grid. Is it State’s the intent to have two separate metrics for ID Cards? Measure “1” has a 10-day timeframe and measure “iv” has a 15-day timeframe. They also have different percentages associated with them.

RESPONSE: The percentages in the Operational Performance Guarantees grid have the Proposed Amount at Risk. The penalties listed in the chart below are illustrative. The bidders should complete this chart with their final proposed amounts at risk for each item.

35. In the Operational Guarantee section regarding Eligibility Loading, is it the State's intent for the first eligibility load to be automated (for example, to go through an 834 process), or will the eligibility load be accomplished via a manual Excel file process?

RESPONSE: The State does not have a HRIS system and eligibility is maintained by the incumbent vendor. If there is a change in vendor, the initial eligibility will need to be transferred from the incumbent's system to the new vendor's system. Ongoing eligibility changes will be made by the State "real time" in the vendor's system.

36. In the Operation Guarantee section regarding Contract BAA completion, does the "PHI" file refer to enrollment file or claims file?

RESPONSE: This refers to any file that includes PHI including an enrollment file or a claims file.

37. In the Operation Guarantee section regarding Implementation Satisfaction, there appears to be two separate Implementation Satisfaction metrics: the second metric listed on the Operational Performance Guarantees grid and 2) item "vii" in the "Implementation" section below the grid. Is it the State's intent to have two separate metrics for Implementation Satisfaction?

RESPONSE: The percentages in the Operational Performance Guarantees grid have the Proposed Amount at Risk. The penalties listed in the chart below are illustrative. The bidders should complete this chart with their final proposed amounts at risk for each item.

38. What is the required format for the Wellness Performance Guarantees?

RESPONSE: The State has requested that the bidders provide performance guarantees that may be appropriate or will differentiate themselves from other competitors. The format is provided on row 7 of the worksheet.

39. Who are the State's vendor partners identified in the Wellness Performance Guarantees?

RESPONSE: Currently the State's disease management, health risk assessment, biometric screenings and online health programs are administered through UHC.

40. With regard to the Clinical Performance/Health Improvement Referral Guarantee, please identify the State of Rhode Island's health improvement programs and the associated vendors that we would be required to refer to.

RESPONSE: The State has the Rewards for Wellness program. The program includes annual health risk assessment, annual biometric screenings and cholesterol and glucose screenings every four years. The incumbent vendor provides a new online educational module specific to the State every year. The State also provides reimbursement for weight management. The State offers free telephonic smoking cessation programs. The State works with UHC to administer all of these programs. At this time, all of the State's Disease Management and Wellness programs are with UHC. It is expected that these programs will transition to the new vendor and will be administered as part of their overall services provided to the State.

41. Wellness:

- What is the current participation at the onsite biometric screenings?

RESPONSE: 5,800 employees. It is expected that these programs will transition to the new vendor and will be administered as part of their overall services provided to the State.

- What are the biometric values that are measured?

RESPONSE: Employees are screened for Blood pressure and BMI annually. Cholesterol and glucose are screened every four years.

- Where are the additional onsite wellness programs delivered to State employees (i.e. nutrition classes, smoking cessation classes...etc.)?

RESPONSE: The only onsite program is the biometric screening. There are certain sites that do Weight Watchers at work. The remainder of the programs is either telephonic or online.

- Will the State require the selected vendor to utilize Sovereign Bank?

RESPONSE: The State utilizes Bank of America. A change to a different bank would require State approval.

42. Rating:

- The RFP requests two – one year options following the initial 36 months. Are we to illustrate those fees, or just acknowledge that we are willing to offer the extension options? If we need to illustrate the extension fees, where on the fee exhibits would you like those illustrated?

RESPONSE: The State would like an acknowledgement that the bidders are willing to offer the extension options.

- Please provide current working rates with an itemization of each component (cost and description of cost).

RESPONSE: The State will not provide the working rates and its components due to the confidentiality of the cost information.

43. Data - Given that the RFP was released on May 7, 2013 and we did not receive the Medical data until May 10, 2013 and the Pharmacy data until May 15<sup>th</sup>, 2013, will the State extend the deadline for submission to ensure a level playing field for all respondents? We request an extension of 8 days, the number of days the data was unavailable. As such, will the State also extend the May 24<sup>th</sup> deadline for Network Access information by 8 days?

RESPONSE: The deadline for total submission is June 17, 2013 at 2PM (ET).

44. In the claims data provided, the provider payment information is the same for 2011 and 2012. Please resend the correct listings for 2011 and 2012.

RESPONSE: The correct 2012 incurred claims data was posted onto the RFP website on May 20, 2013.

45. Please provide the breakout of claims within “All other claim payments” for each year.

RESPONSE: This field shows all medical claims including MHSA claims and is exclusive of pharmacy claims. The State will not be providing any more additional claims detail.

46. Please provide claims broken out by in-network and out-of-network for each year.

RESPONSE: The in-network paid claims percentage is as follows for each year:

2010 – 97.2%  
2011 – 96.2%  
2012 – 95.7%  
YTD 2013 – 95.6%

47. Please provide the breakout of the claims reports indicating allowed versus submitted for each year.

RESPONSE: The State will not be providing any more additional claims detail. The information is not necessary for the purposes of the RFP.

48. Please provide explanation of what is included in the incurred claims listings. Are claims net of a certain specific pooling threshold or do the claims listings include all claims in total?

RESPONSE: The claims include all claims in total.

49. Please provide diagnosis and status (inactive and active) for large losses.

RESPONSE: The State will post the updated large loss reports with the diagnosis and status information. This information was posted at the same time as these responses. Please review all postings in the addendum.

50. What is the difference between the “ActiveOld” and “ActiveNew” membership in the membership files?

RESPONSE: “ActiveOld” refers to an old active plan that was in place prior to 2009 and was closed to new participants. “ActiveNew” refers to the current Active plan.

51. Discount Guarantees:

- In regard to the requested discount guarantees, how do the guarantees in #4 relate to the guarantees in #3? In other words, are these 2 different guarantees or does #4 roll up into the broader guarantee in #3?

RESPONSE: The guarantees in #4 roll up into the broader guarantee in #3.

- In regard to the requested discount guarantees, please define “physician discount”. Does that mean “professional” i.e. (include podiatrists, chiropractic, NPs, LICSWs, etc) and reserve “other services discount” for non hospital, non professional ancillary services (lab, DME)?

RESPONSE: “Physician discount” means all licensed professionals and “other services discount” is in reference to non-hospital, non-professional ancillary services such as lab, DME, etc.

- Please provide definitions of each of the four categories of claims for which you are requesting discount guarantees. For example, where do Skilled Nursing Facilities/Subacute Care, Home Health, Free Standing Diagnostics (lab and radiology) and Non –Physician Professional Claims belong?

RESPONSE: Inpatient Hospital is defined as any facility charge that is based on an inpatient admission to the facility. Outpatient Hospital is defined as any facility charge that is a “case” or a “procedure”. Physician is defined as professional charges. Other Services is defined as any charge that is non-hospital and non-professional.

The examples are as follows:

- ✓ SNF/sub-acute care goes to professional if from professional services. Cpt codes would help map to professional. Facility charges are going to exist too. If from facility, then put to IP Facility.
- ✓ Home Health goes to OP Facility.
- ✓ Free standing diagnostics/labs goes to OP Facility.
- ✓ Social worker is a good example of non-physician. Chiropractor is another. Any of those go to professional.

52. General:

- The Medicare population is not included in the RFP. Will there be a separate RFP for the Medicare population. If not, please explain.

RESPONSE: The Governor's 2013 budget includes a proposal to move the Medicare population to a private Medicare exchange. If the proposal passes, vendors will be participating in a separate RFP for the Medicare population. If the proposal does not pass, the population will remain with the current vendor until further notice of the RFP.

- Can you please provide the bi-weekly employee contributions by benefit plan and rating tier?

RESPONSE: The State will not provide this information. The information is not necessary for the purposes of the RFP.

53. Solicitation Information:

- Section 13.0 Vendor Responsibilities/Conditions Governing Subcontracting states that if the vendor intends to use any subcontractor, the vendor must clearly identify the subcontractor in the response to the RFP and provide documentation of their skill sets and applicable experience. Does completion of Section V., question #61 of the Medical Questionnaire and Section I., question #17 of the PBM Questionnaire satisfy this requirement?

RESPONSE: No. The State requires all subcontractors used to fulfill the proposed services for the State will be clearly identified in the response to the RFP.

- Please confirm that Minimum Requirement #8 is referring to section 13.0 Vendor Responsibilities (vs. 14.0).

RESPONSE: Confirmed.

54. Administrative Fees

- In the Reporting section of the Administrative Fee charts, please clarify the type of semi-annual reporting required for the Total wellness and preventive screening rates (i.e. does the wellness screening refer to biometric screening?).

RESPONSE: Wellness and preventive screening refers to any well-baby, well-child, or well-adult visits and preventive screenings such as mammograms, colonoscopies, etc.

- One of the Fee Component in the Administrative fee chart includes development, distribution (initial and ongoing), and printing of ERISA compliant SPDs. Does “distribution” include mailing the SPDs to all State of Rhode Island employee homes?

RESPONSE: The SPD is posted electronically and can be provided via paper upon request. When the State does an SPD change, the vendor is required to print a minimum amount of 250 hard copies for distribution.

55. Given the unanticipated delay in providing the data (including the not released pharmacy information), which is critical to developing financial proposals, will the State of Rhode Island consider extending the deadline for responses by the number of days data was unavailable?

RESPONSE: The deadline for total submission is June 17, 2013 at 2PM (ET).

56. Given the unanticipated delay in receiving the medical data and the fact that we do not have access to the Pharmacy data, we respectfully request the State of Rhode Island extend the deadline for responses (including the separate Geo Access deadline) by the number of days data was unavailable.

RESPONSE: The deadline for total submission is June 17, 2013 at 2PM (ET).

57. We request the following: 1) Detailed pharmacy claims data as soon as possible; 2) medical claims data from 2012; and final bid responses extended by the number of days the data was unavailable.

RESPONSE: Detailed pharmacy claims data and medical claims data from 2012 have been provided by the State. Per Addendum 2, the deadline for total submission is June 17, 2013 at 2PM (ET).

58. Pharmacy – Please clarify what is meant by a “non-preferred Specialty vendor” in the following heading: RETAIL (INCLUDING SPECIALTY FROM NON-PREFERRED SPECIALTY VENDORS).

RESPONSE: Meaning specialty drugs dispensed in an open network and not in your organizations exclusive specialty drug network or channel.

59. Can the Specialty provider be exclusive?

RESPONSE: Specialty drugs should be quoted for both your exclusive and non-exclusive networks.

60. If the Specialty provider cannot be specific, can any Specialty Rx's that are filled through retail channels be excluded from the Retail Financial Guarantee?

RESPONSE: No

61. Will Mail Order be exclusive?

RESPONSE: The plan is not mandatory mail.

62. What are you expecting to be part of the "Member Enrollment Packages"?

RESPONSE: Standard pharmacy enrollment materials inclusive, but not limited to ID Card, Mail Order enrollment materials, welcome letter, formulary detail, and lower cost alternative materials.

63. What is included in the Preferred Drug Formulary?

RESPONSE: The current formulary is an open formulary arrangement. The State works with the incumbent pharmacy vendor on a quarterly basis where as some exclusions to the formulary are made along with changes (up tier and down tier) are made.

64. Can you please provide the current Prior Authorization List, Quantity Limits, and Step Therapy programs?

RESPONSE: There are limited step therapy rules in place under the specialty pharmacy program and none for non-specialty drugs. There are limited prior authorization and quantity rules in place for non-specialty drugs.

65. What is the current Mail penetration?

RESPONSE: A detailed claims file was provided. Mail rates should be clear.

66. What is the current Generic Dispensing Rate?

RESPONSE: A detailed claims file was provided. Generic rates should be clear.

67. Can you please provide the most recent annual Drug Trends?

RESPONSE: Trend rates are not available.

68. What are the Top conditions within your Active and Early Retiree populations?

RESPONSE: Please review the large loss data and pharmacy claims data for this information.

69. Describe the current use of integrated data (medical and pharmacy claims) to drive disease management or improve pharmacy benefit?

RESPONSE: Currently medical claims, pharmacy claims, the online health assessment, and biometric screening results, are utilized to identify members for targeted outreach into clinical programs and to identify any potential gaps in care.

70. What current disease management programs are in place?

RESPONSE: Asthma, Congestive Heart Failure, Diabetes, Coronary Artery Disease. There are no disease management programs in place under the pharmacy plan.

71. What is the Pharmacy Network Philosophy (Narrow or Broad)?

RESPONSE: Broad

72. In regards to the PBM Questionnaire Tab, III 42c, please provide clarification, "You agree that the State can allocate up to 30% of the annual aggregate dollars at risk to any one performance guarantee?".

RESPONSE: We expect that the State should be allowed to allocate 30% of the total dollars you place at risk to any one pharmacy performance guarantee as listed in Question 44.

73. Please clarify total requested pharmacy fees at risk by indicated the percentage at risk.

RESPONSE: \$350K for Implementation fees at risk and \$20 per household annually for ongoing service, per the RFP.

74. Medical - In the paper copies of the Geo-Access, please confirm that we only need to include the pdf files of the reports and not the Access database tables. We plan to include the Access database tables only in the electronic copies of the RFP submission.

RESPONSE: That is correct.

75. Due to the size of the Provider Match files, we plan to only submit them electronically. We will submit paper copies of a summary. Please confirm that this is acceptable.

RESPONSE: That is acceptable.

76. Please confirm that the State would allow another carrier (not awarded the bid) to implement the additional innovative plan designs as stated in Part 1 - Questionnaire/ Terms and Conditions.

RESPONSE: That is correct.

77. In evaluating the Accessibility data, we have noticed that zip code 02889 is considered “urban” and requested to have 1 Hospital within 5 miles. Is this correct?

RESPONSE: That is correct.

78. If the drop down box includes only “No” and “Yes” can you indicate “Yes” and also include an Explanation?

RESPONSE: That is acceptable.

79. Please clarify clinical fees at risk, the 12 individual items in the RFP sheets adds up to 9.2% at risk, however, the heading requests 10% of fees at risk.

RESPONSE: The minimum total fee at risk of 10% is correct. The amount of fees at risk for items 1, 2, 3, 4, 7, 8 and 12 should reflect 0.91% each. The amount of fees at risk for items 10 and 11 should reflect 1.36% each. The amount of fees at risk for items 5 and 9 should reflect 0.46% each.

80. Please clarify the total requested wellness fees at risk by indicating the percentage at risk.

RESPONSE: The minimum total fee at risk is 5%.

81. We are having some difficulties working with the Provider Finder file due to multiple records for some providers. To assist us in providing the most accurate match and to facilitate discount guarantee discussions, please provide the 2011 and 2012 network utilization by PCP, Specialist, Inpatient Facility, and Outpatient.

RESPONSE: The State will not be providing any network utilization information by type of provider. The information is not necessary for the purposes of the RFP.

82. At the Bidders’ Conference on May 17, 2013, it was indicated that 2012 claims data had been included in the RFP. We went back to check the data that we received. While we see files/tabs labeled 2011 and 2012, the actual data in the file is the same for both years. Can you please resend the correct claims data for 2011 and 2012?

RESPONSE: The corrected claims data was posted on the website on May 20, 2013.

83. General Question - Section 4.3 of the RIVIP Bidder Certification Cover Form refers to the "General Terms and Conditions." Please confirm that this is the document entitled, "State of Rhode Island Procurement Regulations, Appendix A – General Conditions of Purchase, Amended regulations adopted June 20, 2011", available through the RIVIP website.

RESPONSE: Confirmed.

84. Section 5 of the RIVIP Bidder Certification Cover Form (Certifications and Disclosures) specifies a number of certifications a vendor must submit with a proposal. These certifications include several certifications regarding shareholders. Please confirm that if a vendor is a publicly traded company or a subsidiary of a publicly traded company, and therefore has no ability to make certifications or representations regarding its shareholders, it may make an appropriate modification to the certifications required by Section 5.

RESPONSE: For a publicly traded company, in terms of the certifications and disclosures of the Section 5 on the RIVIP Bidder Certification Cover Form, the Division of Purchases is not concerned with "Minority Shareholders" who do not exert a "Controlling Interest" over the policy and management of the organization.

85. Section 12 (Governing Conditions) of Part 1 – Questionnaire/ Terms and Conditions of the RFP includes certain Insurance Requirements. Included in these requirements is a requirement for a waiver of subrogation. Per insurance industry common practice, vendor's professional liability policy does not permit a waiver of subrogation (though its other policies do). Please confirm this is acceptable to the State.

RESPONSE: Yes, not having a waiver of subrogation for the vendor's professional liability policy is acceptable.

86. Part 1 Questionnaire – A-3: Minimum Qualifications of the RFP, line 12 refers to the State having real-time access to the State's enrollment system. Please confirm, is this requirement intended to mean that the State must have real-time access to the vendor's enrollment system, or that the vendor will have access to the State's enrollment system (view access only)?

RESPONSE: The State is looking for real-time access to a carrier's system for the State's population only.

87. In the Special Terms of the RFP, under Audit, there is a statement that third-party audit firms will sign an “Audit and Confidentiality Agreement” with the State. Please confirm that, upon request, such an auditor would also execute a confidentiality agreement with the vendor.

RESPONSE: Any confidentiality agreement proposed by the vendor to be signed by a third-party auditor would require written approval by the State.

88. The Payment Terms listed in the Special Terms of the RFP, as well as Section 19 of the General Conditions of Purchase, specify a 30-day payment term for services billed. Can the State please advise what its expected timing is for pharmacy claims reimbursements and what the current timing is for such reimbursements?

RESPONSE: The State currently makes claims payments within 5 business days of invoice. Administrative fees are paid within 30 days of invoice.

89. Section 2.0, Item 16, the requirement states “The vendor should be aware of the State’s Minority Business Enterprise (MBE) requirements, which address the State’s goal of ten percent (10%) participation by MBE’s in all State procurements.” Is the State requesting that 10% be attributed to the total administrative fees anticipated under the contract? In a traditional financial arrangement, administrative fees are not typically charged, therefore, how is the State requesting this requirement be met?

RESPONSE: The State is looking for a minimum of 10% MBE participation. Please contact the State’s MBE Office with any questions about MBE requirements.

90. Evaluation Team: How many individuals will be on the evaluation team and what areas of State government will be represented on the team? Can you please provide the names of the members of the evaluation team? Who will be the decision maker on the award of the RFP?

RESPONSE: Generally, the evaluation team will consist of State Employee stakeholders with subject matter experience, or with financial, purchasing or other relevant expertise that would add value to the review of proposals. The evaluation team has not yet been selected and this information will only become public after the selection(s) is made. The final decision will be made by the Division of Purchases.

91. Evaluation Process: How will points be assigned to each component of the technical and medical proposal? For example, the questionnaire is worth 20 points, will there be a certain percentage of points assigned for each response that the vendor may respond yes/no to, is there a certain % of points that the vendor will lose if they do not agree to something. In essence, how will the various questions, confirmations, requests and their associated responses be weighted?

RESPONSE: The evaluation team will assign points to responses to the RFP questions. Questions will be weighted based on the importance of the service to the State. It is possible that a vendor response that does not meet the needs of the State may receive zero points.

92. With the RFP, there is not specific section or questionnaire that requests information on the vendor's ability to demonstrate their integration story. Where should vendors that are providing an integrated medical and pharmacy quote include information and details on their integrated program? How will you evaluate the value of an integrated program for those vendors submitting an integrated medical and pharmacy response?

RESPONSE: The vendors can provide a summary of the value of an integrated program as an attachment. The State may or may not take this information into consideration during the evaluation process. There is a pricing sheet that should be used to demonstrate any financial value.

93. There are certain intangible services and capabilities that vendors may deliver that the State and its membership would benefit from a clinical and cost savings perspective. Do the vendor's have the ability to include these programs within the RFP response? If so, where should this information be included and how will these programs be taken into consideration when the RFPs are evaluated?

RESPONSE: The vendors can provide a summary of services and capabilities in addition to the requested programs as an attachment. The State may or may not take these additional programs into consideration during the evaluation process.

94. Will the vendor's executive summary/cover letter be taken into consideration when evaluating the proposal? If so, is there a scoring methodology for the evaluation of the vendor's Executive Summary.

RESPONSE: The executive summary/cover letter will not be scored but the vendor should still submit one with the proposal.

95. Can you clarify if vendors need to do anything different if they are submitting a proposal for the following two scenarios: a response for Medical Only and a response for integrated Medical and Pharmacy Services? Should the vendors be submitting two completely separate proposals since there would be a cost proposal for just the medical only rates and then a cost proposal for the medical/pharmacy rates or can the vendors complete the worksheets titled SoRI Admin Fees Med only and SoRI Admin fees MedRx and include them in the Cost Proposal? The response to the medical questionnaire would remain the same for the medical only proposal and the medical/pharmacy proposal so would two medical questionnaires need to be submitted for the response to the medical only and medical/pharmacy responses by the same vendor.

RESPONSE: The vendor submitting proposals for the two scenarios above would need to submit two separate cost proposals; SoRI Admin Fees Med Only and SoRI Admin Fees MedRx. The Financial and Performance Guarantees should stay the same regardless of the cost proposals. The State only needs one submission of the remaining RFP proposal items.

96. The medical only and the pharmacy only ASO fee exhibits request the vendor to include at no charge a full detailed claim extract and a full pharmacy detailed claim file. Confirm if the ASO fees should include the cost of these reports for vendors that are bidding on the integrated medical/rx scenarios since there would not be a need to share medical and pharmacy data if the program were to be integrated. Confirm for the medical only, if the vendors would only need to include the full pharmacy detailed file in their fees and not the full detail claim file as we assume the purpose of these data extracts is to pass data between the medical vendor and the pharmacy vendor for integration purposes. If there is another purpose for these data files other than integration between medical and pharmacy carriers, advise the purpose of these 2 claim files.

RESPONSE: The vendors bidding on the integrated Medical/Rx scenarios do not need to provide fees for the detailed claims file extracts. The vendors bidding on the Medical only would only need to include the full Pharmacy detailed file for integration with the Pharmacy vendor.

97. There is no mention of the number of bank accounts that vendors should include within their ASO fees. The State currently has four separate bank accounts should vendors assume the State would continue to require four bank accounts.

RESPONSE: The State has two bank accounts; One for the Active plan and one for the Retiree plan.

98. How will the State evaluate the vendor's reporting capabilities? Will the State be requiring the vendors to submit samples of the reports that they are requesting to be included in the ASO fees as described in the fee worksheets and within Section IV of the medical questionnaire and the Clinical Programs Savings and Reporting section within the PBM questionnaire?

RESPONSE: Not at this time.

99. With the PBM questionnaire, the State is requesting information on the vendor's financial strength and stability however, the same information is not requested within the medical questionnaire. Was this an oversight or should the medical vendor's be submitting this information as well?

RESPONSE: The State will be gathering the Medical and PBM vendor's financial strength and stability through validated third-party sources.

100. Subrogation – How will you evaluate the vendor's methodology and activities with respect to subrogation services? Can the vendor submit a detailed description of their subrogation services and if so where should we include this information.

RESPONSE: The vendors can provide a summary of the subrogation services as an attachment. The State may or may not take this information into consideration during the evaluation process.

101. Wellness Program Fees – Within the ASO worksheets, the State is requesting the vendor's include wellness program administration and services within the ASO fee. Should the vendors include a description of their wellness program capabilities and if so, where should this information be included? How will the State evaluate the vendor's wellness capabilities?

RESPONSE: The vendor can include a description of their wellness program capabilities as an attachment. The State may or may not take this information into consideration during the evaluation process. The evaluation of the vendor's wellness capabilities will rely mostly on the responses to the questions in the Medical questionnaire.

102. Network Discount Analysis: How will the State's utilization of services mix be taken into account when looking at each carrier's network discounts via Hewitt's tool?

RESPONSE: The Aon Hewitt discount database uses a standard utilization mix. If the State's actual utilization differs substantially from the norms then the actual utilization may be used.

103. Performance Guarantees – Operational PGs – There is a PG for member satisfaction of 85% satisfaction. Confirm if the member survey will be conducted by the vendor and should be included within the ASO fees.

RESPONSE: That is correct.

104. Operational PGs – Are these PGs just for the medical and the pharmacy PGs are just the ones included within Pharmacy questionnaire? When carriers are responding to the integrated scenario, there may be overlapping PGs such as ID card and eligibility, can the carriers combine those PGs. For example, there will be one ID card and one eligibility submission if the medical and pharmacy is integrated, if the medical ID card PG is met, the pharmacy ID card PG will be met.

RESPONSE: While there may be overlapping PGs, the Medical and Pharmacy PGs should be proposed separately.

105. Wellness PGs: Health Risk Outcomes – Clarify what data would be included in this report. Is this claims data related specifically to the participants in the State’s Wellness Program.

RESPONSE: Data on the report will be discussed and mutually agreed upon at a later date. The claims data should be specific to the participants in the State’s Wellness program.

106. Wellness PGs: Member Issues Log - All Programs: Clarify if this is specific to the State’s Wellness Program. If so, how is it expected that member issues will be received? Is it acceptable that this information will be captured by the vendor’s local service team per member phone calls, emails, and/or discussions at Health Fairs? Is it expected that the State of RI will forward member issues from the Wellness website?

RESPONSE: The log would be specific to the State’s Wellness program. The vendor would be administering the Wellness services offered and therefore will have direct contact with members. It is acceptable that the issues are captured by the local service team as described. The State will not forward member issues from the Wellness website, unless the state is unable to resolve the issue without the assistance of the vendor.

107. Wellness PGs: Monthly Utilization – Please clarify what all the programs this PG is referring to for example, Disease Management Programs, EAP. Case Management, etc.

RESPONSE: These reports will not refer to DM, EAP or Case Management. The reports will be specific to Wellness and defined with the successful bidder at a later time.

108. Wellness PGs: Participant Satisfaction – Is this PG specific to the State’s Wellness program or are there other programs (DM, EAP) that will also be required to be measured. Is there a specific method for the satisfaction survey that is required (ex. electronic or paper)? What qualifies as a “validated” satisfaction survey and who will be the third party vendor?

RESPONSE: The survey will be specific to Wellness program and there is no preferred method for the survey. The content of the survey will be discussed and mutually agreed upon by the State and the vendor at a later time.

109. Wellness PGs: Referrals – Please clarify who are considered the State of Rhode Island vendor partners. Please clarify what is meant by the “manner of referrals” i.e. telephonic, email, mail, and verbal. Please clarify whom is expected to be a part of these clinical calls. Are State of RI representatives on this call?

RESPONSE: The State currently uses the incumbent vendor to administer the health risk assessment, biometric screenings and online health programs. The State subsidizes Weight Watchers. The referrals to the DM, Case Management or EAP programs should include all referral types. Any referrals should be directly between the vendor and member.

110. Medical Questionnaire – Part 1 Questionnaire – A-3 Minimum requirements, #2 “At least one million covered lives across the Vendor's health plan book of business as of proposal submission date.” What is the definition of the vendor’s Health Plan? Would the vendor’s national BOB be sufficient?

RESPONSE: This requirement should be considered broadly and not just in Rhode Island. Additionally, the minimum requirement is changed to 500,000 lives.

111. Section II, Q4 . Use of Sovereign Bank is required for the State’s self-insured coverages. Confirm if the State is requesting to switch their banking arrangements from their current arrangement at Bank of America to Sovereign Bank

RESPONSE: The State utilizes Bank of America. A change to a different bank would require State approval.

112. Section IV, Reporting: Q5c, Disease Management/Wellness reports. Clarify what specific reports are being requested.

RESPONSE: These reports should include information regarding the number of reach-outs, engagements, participation, and completion of disease management programs or wellness tools/programs administered by the Medical vendor.

113. Section V, Member Services, Qs 21-23, 32 refers to a “designated member services team” and Qs 24, 28, 30, 31 refer to “customer service”. Please clarify the difference between the two.

RESPONSE: The designated member services team will be a local service team for member to visit or call into to discuss questions or issues. The customer service is referring to the vendor’s customer service team assigned to the State but can service other customers.

114. Section V, Member Services, Q32, There is access to member services via your organizations website. Clarify what type of member services contact is expected via website.

RESPONSE: The contact could include personal messages through the member’s account, email or instant chat if available.

115. Section V: Admin/Operational, Claims Office/Service Center Performance, Q58d. Clarify if the “average turnaround time” refers to claims processing

RESPONSE: That is correct.

116. Section V: Admin/Operational, Claims Office/Service Center Performance, Provide clarification regarding the difference in information being requested for average customer service telephone response time (Q58e) vs. average speed to answer (Q58h)

RESPONSE: The average customer service telephone response time addresses the telephonic response time. The average speed to answer should include the response time for telephone, email or faxed questions.

117. For questions 29-36 below, the RFP simply requests to respond by indicating you are including these services within the ASO fee and if not what the additional charge would be. Do the vendors have the opportunity to describe our services and capabilities? If so, where should this information be included and will the State be including the vendor’s capabilities in their overall scoring of the technical proposal.

RESPONSE: The vendor can provide a summary of services and capabilities as an attachment. The State may or may not take the summary into consideration during the evaluation process and scoring of the technical proposal.

118. Section VI: Health Management/Wellness Services Q3b. Large Case Management. How will the State evaluate the vendor's case management capabilities realizing there could be great differences in the level of clinical capabilities including but not limited to how a member can qualify for case management services and ability to manage the patient pre and post discharge?

RESPONSE: Aon Hewitt utilizes subject matter experts from their clinical practice to review the RFP responses and vendor capabilities. If more detail is needed it will be requested as part of vendor interviews.

119. Section VI: Health Management/Wellness Services Q3d. Disease Management. How will the State evaluate the vendors Disease Management capabilities including but not limited to criteria and methodology used to qualify for low, moderate, and high disease management programs, ability to effectively manage the member, identify gaps in care through the real time integration of medical/pharmacy data that will trigger outreach to members to close the gaps in care, and messaging used to communicate and continuous engage with this population.

RESPONSE: Aon Hewitt utilizes subject matter experts from their clinical practice to review the RFP responses and vendor capabilities. If more detail is needed it will be requested as part of vendor interviews.

120. Section VI: Health Management/Wellness Services Q3e. Maternity Management. How will the State evaluate the vendor's maternity management program and service provided by each vendor?

RESPONSE: Aon Hewitt utilizes subject matter experts from their clinical practice to review the RFP responses and vendor capabilities. If more detail is needed it will be requested as part of vendor interviews.

121. Section VI: Health Management/Wellness Services Q3h. Online Coaching programs. Is the State interested in specific programs and conditions for online coaching, if so, please advise. Or should the vendors include within the fee their entire suite of online coaching programs. How will the State evaluate the vendor's online coaching program capabilities knowing that some vendors may not offer the same online coaching programs?

RESPONSE: Vendors should include all online coaching programs in their fees and specifically identify each of the programs and options for the State to consider.

122. Section VI: Health Management/Wellness Services Q3 i. Telephonic Wellness/Lifestyle Coaching. Is the State interested in specific programs and conditions for telephonic coaching, if so, please advise. Or should the vendor provide charges for all their available telephonic coaching programs available. How will the State evaluate the vendor's telephonic wellness/lifestyle coaching services capabilities knowing that all vendors may not offer the same suite of telephonic wellness and lifestyle coaching programs?

RESPONSE: Vendors should include all telephonic Health Management/Wellness/Lifestyle coaching programs in their fees and specifically identify each of the programs and options for the State to consider.

123. Section VI: Health Management/Wellness Services Q3, j, Health Risk Assessment. How will the State evaluate the vendors HRA capabilities? Does the State require any specific tolls, benefits, and features as part of the RFP such as ability to upload the HRA results into vendor's predictive model, trigger messaging to low, moderate, and high-risk members for enrollment in clinical programs.

RESPONSE: Currently there is integration between the HRA and the DM/Case Management programs. This integration is something the State would like to continue.

124. Section VI: Evidence Based Plans Q5. Knowing that vendors may have different triggers that may generate a reminder mailing, how will you evaluate the vendor's reminder mailings. Does the State have specific triggers (i.e. immunization, mammograms) and gaps in care (i.e. lack of certain medication being obtained) that should be trigger the messaging?

RESPONSE: The State does not require specific triggers for the preventive care reminder or gaps in care messaging. The State would like to see what the vendor's standard preventive care and conditions for gaps in care messaging capabilities are.

125. Section VI: Health Management/Wellness Services Q3, l. 3-5 one-hour health presentations annually. Can you clarify what type of information would be presented and would it be to the Office of Employee Benefits or to State employees?

RESPONSE: The State's vendor will conduct 3-5 open enrollment meetings annually in the community for the early retirees. Additionally, the vendor and the State employee benefits office will conduct monthly meetings for early retirees at the Dept of Administration.

126. Section VIII: Legal/Contractual Q 2-4 requests for the effective date to be 1-1-2014 with the first contract anniversary being 7-1-2015. It then asks for a 7-1 to 7-1 contract year. Page 5 of Part 1 – Questionnaire/Terms and Conditions asks for a 1-1-2014 effective date for an initial 36-month period, that would bring the fee change to 1-1-2016. It then requests two sequential 18-month terms. Confirm what is being requested and what contract anniversary date is being requested?

RESPONSE: The current contract and plan year is on a 7-1 basis. Due to the timing of the RFP, the contract effective date will be 1-1-2014 however the plan year will still be on a 7-1 basis. The end of the initial 36-month period would be 12/31/2016. The contract anniversary date would be 1/1/2017.

127. Pharmacy Questionnaire - Section II. Bidding requirements: Q11: You use the "maintenance medication indicator" provided in a nationally recognized drug information source (e.g., First DataBank) to identify/define "maintenance medications" for purposes of a mandatory mail program (or a program that charges a penalty for refills obtained at retail pharmacies instead of mail). Question for the State: Would it be acceptable to use a nationally recognized drug information source to identify/define "maintenance medications", but adapted to exclude certain medications that may not be suitable for mandatory mail, such as warfarin products?

RESPONSE: This is acceptable.

128. Performance Guarantees – Confirm if the State is requesting both 30% of fees at risk and \$20 per household.

RESPONSE: We have requested \$20 per household at risk for performance guarantees. We have also requested that that the State is allowed to allocate 30% of the total dollars at risk to any one performance guarantee.

129. Would the State be open to Retail and/or Mail EDS – 90 Day supply as part of our overall response?

RESPONSE: The core bid requested pricing for 30 day retail pricing and 90 day mail order pricing. If you would like to provide an alternative offering for a retail 90 program, please submit a separate document outlining retail 90 discount guarantees for brand and generics, dispensing fees and rebates. Please outline any pharmacies (chain or independents) that are excluded from your standard retail 30 network. Retail 90 discounts and dispensing fees should be consistent with mail rates. Your retail 90 quoted discounts, dispensing fees and rebates should not impact the quote for the retail 30 and mail pricing provided as part of this bid.

130. Solicitation Information - Please clarify the RFP components that should comprise the “Technical” Proposal and those that should comprise the “Cost” Proposal. Do the Medical Questionnaire and Pharmacy Questionnaire worksheets represent the “Technical” component and the companion worksheets represent the “Cost” component. Which proposal should contain the W-9, Bidder Certification, and those documents listed in Part 3 of the Medical and Part 2 of the Pharmacy proposal formats?

RESPONSE: Per the Proposal Submission section of the RFP, the Technical proposal comprises of the Medical and Pharmacy Questionnaire, Minimum Qualifications, Performance Guarantees, Plan Design Deviations, Proposed Plan Changes, GeoAccess Match, Provider Disruption, Formulary Disruption and Retail Network Disruption. The Cost proposal comprises of the Administrative Fees, the Contract, the Discount Guarantee, Pharmacy Financials and Specialty Drugs. Please include the W-9, Bidder Certification and other required documents along with the Technical proposal.

131. Section 12.0 GOVERNING CONDITIONS references the “Special Terms and Conditions” and indicates that the award will not be considered official until the vendor complies with these terms and conditions. While the terms are included in the SORI Worksheets document along with the fee, plan design and PG sections, there does not appear to be space to provide comments. If we would like to comment on any of these terms, where should we do so in the RFP response?

RESPONSE: The vendor can provide comments on the Special Terms and Conditions. The comments should be provided as an attachment along with the Technical proposal.

132. PBM Questionnaire - In Section IV., Eligibility, #5, please confirm that the "X digit" referenced in this question would be coming on all subscribers always and that it is not more than 12 digits.

RESPONSE: The State currently utilizes a 9 digit non-SSN ID # generated by the medical plan and includes all subscribers.

133. In Section IV, Client Service, #62, please provide clarification on this question. Ability to approve requested overrides of what?

RESPONSE: The State would require eligibility override capability only.

134. Performance Guarantees - In the Behavioral Health Performance Guarantee, is it possible for the State of Rhode Island to supply the respective readmission rates for 2010, 2011, and 2012 in order for Tufts Health Plan to understand the current state of mental health and substance abuse readmission patterns?

RESPONSE: Information is not readily available. The State will negotiate the performance guarantee with the successful vendor.

135. With regard to the Clinical Performance/Depression Screening and ROI Guarantees, please define “CAT”.

RESPONSE: CAT is defined as Care Advocate Team.

RFP # 7464385 Medical and Pharmacy Plans for State of RI  
 Non-mandatory Pre-bid Conference 17-May-13

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DATE: 4/23/13

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