THE TEXAS A&M UNIVERSITY SYSTEM
Office of HUB & Procurement Programs

REQUEST FOR PROPOSAL
RFP NUMBER: RFP01 SBA-20-069
Self-Insured Employee Group Health Plan Administration

PROPOSAL MUST BE RECEIVED BEFORE:
2:00 P.M. Central Time (CST), January 28, 2020

EMAIL RFP RESPONSES TO:
SOPROCUREMENT@TAMUS.EDU
SUBJECT LINE: RFP01 SBA-20-069
Attn: Jeff Zimmermann

NOTE: PROPOSAL must be time stamped at **The Texas A&M University System Office** of Procurement and HUB Programs before the hour and date specified for receipt of proposal.

Sealed proposals will be received until the date and time established for receipt. After the due date and time, only the names of Respondents will be made public.

REFER INQUIRIES TO:

Jeff Zimmermann, Director
The Texas A&M University System
Procurement & HUB Programs
email: soprocurement@tamus.edu

All proposals shall become the property of the State of Texas upon receipt. Proposals may be subject to public review after contracts have been executed. Refer to Section 4.15 for more information regarding public information.

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SECTION 1 – INTRODUCTION

1.1 Introduction

The Texas A&M University System ("A&M System") is soliciting proposals from qualified vendors licensed to operate in the state of Texas to provide claims and network administration services for employees, graduate student employees, retirees, and their dependents enrolled in the A&M Care plan, a self-insured Preferred Provider Organization (PPO) employee group health plan beginning September 1, 2020. The A&M System desires proposals that represent the best combination of quality and cost.

Proposals shall be in accordance with the terms, conditions, and requirements set forth in this Request for Proposal (RFP).

1.2 Background

The A&M System is one of the largest systems of higher education in the nation, with a budget of $4.7 billion. Through a statewide network of 11 universities and 8 state agencies, the A&M System educates more than 153,000 students and makes more than 22 million additional educational contacts through service and outreach programs each year. System-wide, research and development expenditures exceeded $996 million in FY 2017 and helped drive the state's economy. More information about the A&M System and all of its members can be found at http://www.tamus.edu/about/.

1.3 Plan Background

The A&M System intends to continue to self-insure the plan, maintaining a PPO managed care approach. The prescription drug plan is a carve-out program, providing prescription drug benefits to those enrolled in the A&M Care plan and is not included in this RFP. A separate RFP for prescription drug plan administration will be issued next year.

The A&M System currently contracts with Blue Cross and Blue Shield of Texas for administration of the self-insured health plan and Express Scripts for administration of the self-insured prescription drug plan. The A&M System is required by law to rebid these contracts at least every six years. The current contract will expire on August 31, 2020.

In addition to the A&M Care self-insured PPO health plan, a fully-insured PPO health and prescription drug plan is available as an option to graduate student employees and their dependents. Most graduate student employees elect to enroll in the Graduate Student Health Plan rather than the A&M Care plan because of its lower premiums.

Proposers may link to the System Benefits Administration website at https://www.tamus.edu/business/benefits-administration/health/ to review details of the current health plans offered by the A&M System.

1.4 Enrollment

The A&M System currently has 41,633 benefit-eligible employees and retirees of which just over 17,831 are located in the Bryan/College Station area.

Current enrollment in the self-insured A&M Care PPO plan is 30,723, with approximately 14,054

in the Bryan/College Station area. Of the 30,723 enrolled in the A&M Care plan, 8,734 are retirees and another 449 are working retirees. There are 55,479 covered lives, including employees, retirees, survivors, COBRA participants and dependents in the A&M Care plan.

You should have downloaded a supplemental file listed in Exhibit E named Demographics. If you failed to download this file, you can do so by returning to the ESBD. The file contains two worksheets. The first worksheet provides demographic information for all those who are benefit eligible, i.e. A&M Care Plan, Graduate Student Plan, those certifying that they have medical coverage other than through the A&M System and are allowed to use up to half of the employee-only employer contribution to pay for optional benefit plan coverage, and those who are eligible, but opt not to take A&M System health coverage. The second worksheet provides demographic information only for those enrolled in the A&M Care Plan

1.5 Purpose

This RFP provides detailed information about the A&M System and its benefit needs and provides the required format for the vendor's response. Proposals containing deviations are strongly discouraged. If included, deviations must be identified and described in detail in order to be considered. While a proposal with minor deviations from the RFP will not be disqualified, preference will be given to prospective vendors whose proposals contain the fewest and least significant deviations from the requirements presented herein.

The intent of this RFP is to allow all interested / prospective firms to provide a sufficient amount of data that will enable the A&M System to assess the proposal and qualifications of the Respondent. To this end, each Respondent shall furnish, as a part of the proposal, a complete general description of experience in their respective fields.

By submitting responses, each Respondent certifies that it understands this RFP and has full knowledge of the scope and nature of the opportunity described herein. Each Respondent also certifies that it understands that all costs relating to preparing and responding to this RFP will be the sole responsibility of the Respondent.

Respondent is to independently investigate and verify, at its own discretion, all information acquired from the A&M System or from any other source which is relied on by Respondent in the preparation of its proposal.

1.6 Benefit Philosophy

The A&M System's benefit programs are viewed as an important part of the total compensation package. It is expected that the benefits offered will attract new employees, promote the retention of career employees and reward retired employees for their service. Therefore, superior quality and responsiveness to participants' needs are essential.

The A&M System is committed to providing eligible employees, retired employees and their dependents access to group benefit plans of the highest quality at the lowest possible cost to the A&M System and to its employees. The manner in which the programs are funded demands strict containment of costs in order to maximize benefits for the participants.

The self-insured A&M Care health plan for which an RFP is being solicited is available to all benefit-eligible employees at all System members and includes graduate student employees. Rather than

each System Member soliciting RFP responses for the various benefit plans, the authority to plan, implement and control the A&M System's benefit programs has been assigned to the Director of Benefits Administration (the Director). The Director and Assistant Director have responsibility for the design and development of System-wide health plans, and for the operation and administration of other employee benefit plans.

The System Office of Benefits Administration (SBA) staff monitors plan experience, negotiates contracts, maintains official records, and ensures quality, efficiency, and statutory compliance in the benefit plans. SBA also maintains, reports, and analyzes claims and financial data related to the plans. It is the responsibility of each System Member to inform employees and retirees of their insurance eligibility, advise them about options and perform enrollment and counseling functions. These activities are usually performed in the Human Resource and/or Payroll departments of each System Member.

The plan for which proposals are being sought is not an ERISA plan. However, for the most part, we do comply with ERISA.

One tool to provide the A&M System administration with a continuous evaluation of benefit plans is the System Employee Benefits Advisory Committee (SEBAC). SEBAC consists of representatives from each System Member, retired employee representatives, and ex-officio members. Meetings are held several times per plan year between September and May to update participants on new developments and provide a forum for public comment. The conclusions of the committee are forwarded as recommendations to the Director for consideration or action.

1.7 RFP Calendar Of Events

Issue RFP ..... December 20, 2019
Deadline to Submit Questions .....January 3, 2020
Release of Addendum (if applicable) .....by January 8, 2020
Deadline for Receiving Proposals.....January 28, 2020 by 2:00 PM CST
Finalist notifications.....February 18, 2020
Interview Top Proposal Teams (A&M System's Option) .....February 27, 2020
Anticipated Award Date.....March 5, 2020

The A&M System will make every effort to adhere to the above schedule. The schedule, however, is subject to change. This may be in the event that further clarification of responses or terms of contract are in the best interest of the A&M System and/or in the event the A&M System requires more time to assure that the selection of the Respondent is in accordance with its policies, rules and regulations, as well as actual timing needs.

1.8 Schedule of Implementation

Within 3 weeks from notice of award	Selected Proposer will provide first draft of the Service Agreement, HIPAA Business Associate Agreement, and any other required legal documentation.
June 15, 2020	Enrollment information materials finalized and mailed
July 1 – July 31, 2020	Open Enrollment period for all A&M System employees and retirees

	for September 1, 2020 effective date
July 2020	Summary Plan Description (SPD) written and edited by System Benefits Administration and submitted to vendor for comments
August 3, 2020	All documents necessary for claim processing available to System Benefits Administration
August 5, 2020	Initial Annual Enrollment file provided to carrier
August 14, 2020	Administrative Services Agreement, HIPAA Business Associate Agreement, and any other required legal documentation completed and signed by both parties
No later than August 25, 2020	Member ID cards mailed by carrier
September 1, 2020	Effective date of plan

1.9 Priorities/Expectations

Respondents should note the following priorities/expectations with regard to the possibility of the A&M System establishing a contractual relationship with any Respondent:

(a) *Ensuring a* High *Quality of Service*. This priority encompasses the quality of service that can be provided to the A&M System in a timely, cost effective manner. The A&M System is seeking a Respondent that will ensure the provision of such quality in its delivery of service through proven techniques and established metrics.

(b) *Past Experience and Expertise*. Respondent must demonstrate its capabilities in providing the utmost level of experience and expertise to ensure a successful project as determined by the A&M System.

(c) *Delivery Efficiency and Total Costs*. Respondent must demonstrate its ability to deliver the required services in a cost-effective and timely manner while not sacrificing the quality required by a Tier I research System.

(d) *Financial Stability*. Respondent must demonstrate its financial stability and capabilities in providing the required services.

1.10 Period of Performance

An initial three-year period of performance under a contract pursuant to this RFP will commence on September 1, 2020. Fees, expense schedules, charges, and management arrangements must be guaranteed for the three-year period through August 31, 2023. Assuming satisfactory performance and terms and fees are mutually agreed upon in writing prior to the expiration of the agreement, an affirmative renewal for up to three years may be allowed. In the event of successive affirmative renewal(s), the maximum period of performance pursuant to this RFP ends August 31, 2026. Any renewal must be agreed to in writing by both parties.

SECTION 2 - INSTRUCTION FOR RESPONDENTS

2.1 General Information

This RFP outlines the services and proposal requirements in Section 3. Proposals are to be in accordance with the outline and specifications contained herein, are to remain in effect a minimum of 180 days from the date of submission, and may be subject to further extensions as negotiated. A statement to this effect should be contained in the Respondent's cover letter.

Each proposal shall be prepared simply and economically, providing a straightforward and concise description of the Proposer's ability to meet the requirements of this RFP. Emphasis shall be on completeness, clarity of content and responsiveness to the offer requirements.

This RFP contains specific requests for information. Respondents are encouraged to examine all sections of this RFP carefully, in that the degree of interrelationship between sections is critical. In responding to this RFP, Respondents are encouraged to provide any additional information they believe relevant.

Clause headings appearing in this RFP have been inserted for convenience and ready reference. They do not purport to define, limit or extend the scope or intent of the respective clauses. Whenever the terms "must", "shall", "will", "is required", or "are required" are used in the RFP, the subject being referred to is to be a required feature of this RFP and critical to the resulting submittal.

In those cases where mandatory requirements are stated, material failure to meet those requirements could result in disqualification of the Respondent's response. Any deviation or exception from RFP specifications must be clearly identified by the Respondent in its submittal.

Expenses for developing and presenting proposals shall be the entire responsibility of the Respondent and shall not be chargeable to the A&M System. All supporting documentation submitted with this submittal will become the property of the A&M System unless otherwise requested by the Respondent, in writing, at the time of submission, and agreed to, in writing, by the A&M System.

By submitting a proposal, Respondent agrees that Respondent and Respondent's employees and agents are independent vendors and have no employer-employee relationship with the A&M System. The A&M System shall not be responsible for the Federal Insurance Contribution Act payments, federal or state unemployment taxes, income tax withholding, Workers' Compensation Insurance payments, or any other insurance payments, nor will the A&M System furnish any medical or retirement benefits or any paid vacation or sick leave.

The A&M System reserves the right to alter the specifications of its benefit programs and subsequently negotiate with the selected Proposer as needed to comply with any required changes.

In the event the selected organization fails to perform any of its duties or obligations as provided by the contract which will include the RFP and the Proposer's response to the RFP, the A&M System 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 selected organization

understands and acknowledges that, notwithstanding any termination of the contract, certain obligations shall survive the termination of the contract.

In addition to and without restricting or waiving any other legal, contractual or equitable remedies otherwise available to the A&M System, the A&M System may terminate the contract without cause by giving the selected organization ninety (90) days written notice.

In the event of a change in condition which may affect the group health plan administrative services for which proposals are solicited, the A&M System will expect a good-faith effort from any Proposer selected, to absorb additional liabilities during the term of the contract without requiring rate increases until the next following renewal date. Such changes in condition include, but are not limited to, the following:

- Rules of the Texas Department of Insurance.
- Opinions of the Attorney General of the state of Texas.
- Federal and State statutes, court decisions and regulations from agencies and departments that may affect employment and benefit programs.

No reimbursement will be made by the A&M System for any expenses incurred in the preparation or presentation of proposals.

2.2 Examination of the Request for Proposal

Before submitting, each Respondent will be held to have examined the A&M System requirements outlined in this RFP, and satisfied itself as to the existing conditions under which it will be obligated to perform in accordance with specifications of this RFP.

No claim for additional compensation will be allowed due to unfamiliarity with the specifications and/or existing conditions. It shall be understood that the Respondent has full knowledge of all the existing and/or revised conditions and accepts them "as is."

2.3 Proposal Submission Instructions

All proposals must be received by the A&M System, no later than **2:00 p.m. CST, January 28, 2020** electronically via email to soprocurement@tamus.edu with the subject line of "**RFP01 SBA-20-069 – Self-Insured Employee Group Health Plan Administration**". The sent time indicated within the A&M System email server shall be used for the receipt and acceptance of the response. Late proposals will not be considered under any circumstances.

The following documents are to be returned as part of your proposal response. **Failure to include these documents will be basis for response disqualification.**

- ✓ Proposal (Section 3.15)
- ✓ Signed Execution of Offer (Exhibit A)
- ✓ Non-Collusion Affidavit (Exhibit B) signed and notarized
- ✓ HUB Subcontracting Plan (Section 3.16)

NOTE: The signature in the Execution of Offer within the electronic copy shall serve as the official signature of record.

Submittal Format: The submittal, except for Section 3.15k, shall be saved as two separate files in Adobe Portable Document Format (PDF). The first file shall contain the Proposal (Section 3.15) and named "***company name* – Proposal SBA-20-069**". The second file shall contain the Execution of Offer, Non-Collusion Affidavit, and the HUB Subcontracting Plan and name "***company name* – Forms SBA-20-069**". All files provided in response to Section 3.15k should be provided in the specified format (excel, text file, etc.). Deviations from the specified formats in this section are not permitted.

- The Proposal must include all items listed within Section 3.15(*a.* through *m.*) and labeled as such with a divider page to include the underlined titles in *a*. through *m*., i.e. "a. Contact Information".
- Information or exhibits you wish to provide that are not specifically requested in *Items a.* through *Section m.* should be included at the end of the proposal behind a divider page entitled "n. Supplemental Information".

Respondents are instructed to respond using the Proposal format included in this RFP in order to expedite analysis and comparison of proposals received. Failure to use the stated format or failure to provide complete responses, may, at the A&M System's option, disqualify the Respondent.

2.4 Inquiries and Interpretations

All technical questions concerning this RFP are to be directed, in writing, to Jeff Zimmermann at soprocurement@tamus.edu. Respondent may not contact other individuals at the A&M System to discuss any aspect of this RFP, unless expressly authorized by the A&M System Procurement & HUB Program office to do so. Questions regarding the RFP, including questions for more data or information beyond that included in this RFP and attachment, shall also be presented in writing as stated above. **Deadline for submission of questions is January 3, 2020.** The A&M System will publish all questions with responses according to the schedule in Section 1.7.

Responses to inquiries which directly affect an interpretation or change to this RFP will be issued in writing by addendum/amendment and posted to the Electronic State Business Daily (ESBD) at the following site.

http://www.txsmartbuy.com/sp (Input Agency Number "710" and select "Posted" for the Status)

All such addenda/amendments issued by the A&M System prior to the time that proposals are received shall be considered part of the RFP, and the Respondent shall consider and acknowledge receipt of such in their proposal. Only those inquiries replied to by formal written amendment/addendum shall be binding. Oral and other interpretations or clarification will be without legal effect. It is the responsibility of the interested vendors to regularly check the ESBD for any possible amendment/addendum to this RFP.

In the event an amendment/addendum is posted to the ESBD, Respondents are requested to acknowledge receipt of such amendment/addendum in the Addenda Acknowledgment section of the Execution of Offer (*Exhibit A).*

2.5 Selection Process

Proposals submitted in response to this RFP shall be evaluated on the basis of the criteria listed below with the selection being the proposal that the A&M System deems to represent the **best**

value to the A&M System. The list of criteria is not exhaustive and is not listed in order of importance. While the criteria shall provide the basis for an objective evaluation of each proposal, the experience and judgment of the SBA staff and the evaluation committee shall also be important in the selection process.

- Compliance with the requirements listed in the RFP
- Vendor License
- Provider Network Adequacy and Accessibility
- Provider Network Quality
- Financial Strength and Stability
- Administrative Capability
- Healthcare Management Incentive
- Past experience
- Customer/Member services
- Costs
- Organizational flexibility
- References
- Finalist presentations
- Site visits

The A&M System is not required to select the lowest priced proposal, but will take into consideration other factors such as those enumerated above.

The RFP provides the information necessary to prepare and submit proposals for consideration by the A&M System. All properly submitted proposals will be reviewed, evaluated, scored and/or ranked by the A&M System. The A&M System may compile a final ranking of the Respondents in the order that they provide the overall "best value" to the A&M System based on an evaluation of the responses to the RFP. The A&M System may interview one or more of the top ranked Respondents as part of the evaluation process.

After proposal tabulation and such investigation of Respondents as the A&M System deems appropriate, an award may be made to the Respondent whose proposal it judges to represent the best value to the A&M System. Final determination for award of the contract will be made on the overall best value to the A&M System. The A&M System reserves the right to reject any or all proposals.

The selection of the successful proposal may be made by the A&M System on the basis of the proposals initially submitted, without discussion, clarification, or modification. In the alternative, selection of the successful proposal may be made by the A&M System on the basis of negotiation with any of the Respondents. The A&M System shall not disclose any information derived from the proposals submitted by competing Respondents in conducting such discussions.

All proposals must be complete and convey all of the information requested to be considered responsive. If a proposal fails to conform to the essential requirements of the RFP, the A&M System alone will determine whether the variance is significant enough to consider the proposal susceptible to being made acceptable, and therefore a candidate for further consideration, or not susceptible and therefore not considered for award.

A&M System may perform reference checks and seek further information, as needed from all

Respondents whose proposals A&M System, at its discretion, considers viable, based on the initial evaluation and scoring. The Respondent's response to this requirement officially authorizes A&M System to contact these organizations to discuss the services and other considerations which the Respondent has provided to such organizations and authorizes the organizations to provide such information to A&M System and Respondent shall and hereby does release and hold harmless A&M System, the state of Texas, and the organization of any and all liability whatsoever, in connection with providing and receiving all such information. Any negative responses received from reference checks may be grounds for disqualification of the proposal.

The A&M System may cancel this RFP or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous. The selection of the successful proposal may be made by the A&M System on the basis of the proposals initially submitted, without discussion, clarification, or modification. In the alternative, selection of the successful proposal may be made by the A&M System on the basis of negotiation with any of the Proposers. The A&M System shall not disclose any information derived from the proposals submitted by competing Proposers in conducting such discussions.

By submitting its proposal in response to this RFP, Respondent accepts the evaluation process and acknowledges and accepts that determination of the "best value" firm will require subjective judgments by the A&M System.

SECTION 3 – REQUIREMENTS & PROPOSAL

3.1 Required Services

Notwithstanding other sections of this RFP which describe administrative interactions, Proposers are advised of the administrative requirements listed in this section of the RFP. The selected Proposer will become responsible for these items and services to the A&M System upon the award of any contract. **Any cost associated with these items and services must be included in your proposal.**

a. Benefit contracts, affirmed by the A&M System as to form and content and approved by the State Board of Insurance in accordance with state and federal statutes, and technical and legal assistance in the administration thereof.

b. Management agreements, in addition to any benefit contracts, which formalize the A&M System's relationship with any carrier.

c. Communication materials necessary for the proper administration of the plans (including but not limited to claim forms, identification cards, Explanation of Benefits forms) subject to editing of format, content and final approval by the A&M System.

d. Claim management and processing.

e. Monthly, quarterly, and annual management reports, including but not limited to, enrollment, claims, utilization, patient satisfaction, and case management information as agreed to by the A&M System and the Proposer.

f. Ad hoc claim/utilization reports or analyses as requested by the A&M System which do not represent extraordinary data processing effort by the claim administrator.

g. Process eligibility information on a weekly basis via secure FTP. Provide SBA with a discrepancy report for each file.

h. COBRA premiums will be set at 102% of the normal premium. In addition, premiums for disability COBRA extension participants are 150% of the normal premium.

   Currently there are 230 terminated employees, dependents, participants reaching the age maximum, and participants due to divorce enrolled in COBRA coverage.

3.2 Current Funding

The A&M Care Health Plan is a self-funded plan. The contract to be executed shall involve no insurance or reinsurance.

The contract shall be for administrative services, claims processing, network management and credentialing, utilization review, and disease management services as described within this RFP. The cost to meet the requirements described in this RFP shall be recovered by the vendor only by making provision for such expense in the vendor's Price Proposal Worksheet included in *Section I*. Funding for all health plans is derived from the statutory contribution from the State of Texas and personal payments by participants (payroll deduction or billing/bank draft for retirees). The

A&M System's plan year corresponds to the State and A&M System fiscal years, which begin on September 1st and end on August 31st.

3.3 Administrative Fee

The Proposer shall propose an administrative fee which will be guaranteed for three years. The administrative fee proposed should be adequate to cover costs incurred for the performance of all services described within this RFP, both prior to and during the period of the contract as well as during any runoff period following termination of the Contract.

3.4 Payment Methodology for Administrative Fees and Claims

For each month, the A&M System shall pay the Proposer per employee (employee/retiree) per month administrative fees which may become due under the contract.

The Proposer shall process and pay all claims submitted under the A&M Care Health Plan as described herein. The Proposer shall pay claims from the Proposer's account prior to seeking reimbursement from the A&M System. The Proposer shall be responsible for maintaining its own funds which are sufficient to provide for the costs incurred under the A&M Care Health Plan.

The Proposer shall be reimbursed only for actual claim payments (i.e., it is not acceptable for the proposer to seek reimbursement from the A&M System in an amount that is different than the amount the Proposer paid to the provider, facility, or participant). The Proposer shall be reimbursed only for paid claims, and shall not be reimbursed for claims that have been processed but not yet paid.

If the Proposer's contracts with providers include payment on a capitation basis, such capitation shall be submitted and reimbursed as any other claim as described above. Reimbursement of capitation amounts shall be subject to adequate documentation presented by the Proposer. Such documentation shall include the provider's name, the number of A&M Care participants included in each capitation arrangement, and the amount of the capitation.

3.5 Annual Experience Accounting

Within 90 days after the end of each Contract Year, the Proposer shall provide the A&M System with a complete accounting of the financial experience under the Contract. The accounting shall include detail regarding monthly enrollment, paid claims and administrative fees.

In addition, the Proposer shall provide the A&M System with any other experience data and accounting information that the System may reasonably require.

3.6 Actuarial Reporting

The Proposer shall submit to the A&M System and their consulting actuary, at a minimum, on a monthly basis a detailed file including all claims processed during the previous calendar month. This data will be used to analyze claims experience and reconcile invoices. The files and all information contained in the files will be the property of the A&M System. The A&M System and their consulting actuary will agree not to disclose confidential provider discount information to any other party. The vendor shall not require an indemnification provision. The detailed claim file will include but will not be limited to paid date, date of service, provider of service, service

provided, line charge, allowable amount, plan payment and patient share. This file will be due no later than the 15th of the month for the previous month's claim payments.

3.7 Claims Run-Off

Following termination of the contract for any reason, the Proposer must continue to be responsible for processing and paying claims which were incurred during the term of the contract. The cost of such run-off administration should be accounted for in the proposed administrative fee. The A&M System will not incur additional administrative fees during the run-off period. The current contracting vendor is responsible for processing and payment of all claims incurred prior to September 1, 2020.

3.8 Healthcare Management Performance Incentive

Under the contract, the Proposer will have an incentive for the efficient and cost-effective management of health care provided to participants. The Proposer will be charged a penalty if Actual Claims are more than 105% of Target Claims. This incentive is not an insurance or reinsurance arrangement. The contract will not include either specific or aggregate stop loss coverage.

A Proposer's ability to provide a cost-effective network is best evaluated on the basis of the Target Claims level to which the Proposer is willing to commit. Accordingly, the proposed Target Claims Cost will be an important factor in the evaluation process.

3.8.1 Incentive

1) The Proposal must include a Target Claim Cost (TCC). The TCC will include both network and non-network claims expected to be incurred during the fiscal year. Retirees over age 65 for whom Medicare is primary will not be included in the determination of the health care management incentive. Costs associated with the A&M Care Prescription Drug Plan (PDP) are not a part of the TCC determination.
2) The TCC will be expressed as an amount per Employee/Retiree per month as specified in the Price Proposal Worksheet.
3) The TCC for FY2021 (September 1, 2020 – August 31, 2021) will be calculated and finalized on or before February 1, 2021, based on a specified, guaranteed formula submitted in the Proposal and accepted by the A&M System along with the actual claims experience for FY2020 as determined using data available through November 30, 2020. A provision accounting for incurred, but unpaid FY2020 claims as of November 30, 2020, will be established through good faith negotiations.
4) The formula referenced in (3) must be specified in the Price Proposal Worksheet, although it may take into account the actual FY2020 claims experience, FY2021 enrollment data available through November 30, 2020, and the anticipated impact of benefit design or eligibility changes implemented for FY2021, if any. Enrollment variables may recognize the following changes in composition: (a) relative proportion of the enrollment in the various employee/dependent categories, (b) age distribution, (c) gender distribution, and (d) geographic distribution. The manner in which the variability in these factors will be recognized must be clearly specified. The anticipated impact of any benefit design or eligibility changes will be determined through good faith negotiations.
5) All locations will be combined for the purpose of determination of the TCC and the ultimate calculation of the gain or loss.
6) The Target Claims for FY2021 will be equal to the sum of the products obtained by multiplying each month's actual enrollment by the TCC determined above. As noted in 1) above, retirees

over age 65 for whom Medicare is primary will not be included.

7) The A&M System recognizes that a certain degree of variability in claims experience is inevitable and beyond the influence of the vendor. Accordingly, the A&M System provides that should Actual Claims fall within 105% of Target Claims no penalty will be assessed under the Health Care Management Incentive.
8) The Actual Claims for FY2021 will be determined based on claims incurred through August 31, 2021, using actual claims paid through February 28, 2022. A provision accounting for incurred, but unpaid FY2021 claims as of February 28, 2022, will be determined through good-faith negotiation.
9) The loss for the year will be determined through comparison of Target Claims and Actual Claims calculated as described herein.
10) Should Actual Claims exceed 105% of Target Claims, the vendor will be assessed a penalty determined as follows, with a maximum penalty of 1.5% of Target Claims:
    - When Actual Claims are more than 5% but less than 10% above Target Claims, the vendor will pay a penalty equal to 10% of the difference between Actual Claims and 105% of Target Claims.
    - When Actual Claims are more than 10% but less than 15% above Target Claims, the vendor will pay a penalty equal to 0.5% of Target Claims plus 20% of the difference between Actual Claims and 110% of Target Claims.
    - When Actual Claims are more than 15% above Target Claims, the vendor will pay a penalty equal to 1.5% of Target Claims.

Independent determinations will be made for each year of the Contract following similar procedures as described herein.

The table in *Section 3.8.3* below presents a tabular display of the requested health care management incentive structure.

3.8.2 Renewal Year Target Claim Cost

In addition to submission of a formula with guaranteed factors for FY2021, the Proposer must also submit a formula for determination of the TCC for the second and third years of the Contract in the Price Proposal Worksheet. While such a formula may take into consideration actual claims, actual enrollment, and the anticipated impact of any benefit design or eligibility changes that may be implemented in the second and/or third years, it must guarantee the maximum trend factors that will be utilized in developing second and third year TCC.

The actual trend factors used for renewal year TCC will be determined through good faith negotiation subject to the guaranteed maximum. The anticipated impact of any benefit design or eligibility changes effective for the second and third years of the contract will be determined through good faith negotiation. Any benefit design or eligibility changes occurring after the TCC has been established for a given year will result in a revision to the TCC as determined through good faith negotiation.

3.8.3 Table and Examples

The table on the following below represents the health care management incentive arrangement. Several example calculations of the incentive amount are included following the table.

Health Care Management Incentive Arrangement

Actual Claims Range	Relative Share of Loss[1] In the Actual Claims Range		Maximum Penalty to Vendor
	A&M System	Proposer	
100%-105% of Target Claims	100%	0%	0
105%-110% of Target Claims	90	10	.5% of Target Claims
110%-115% of Target Claims	80	20	1.5% of Target Claims
more than 115% of Target Claims	100	0	1.5% of Target Claims

[1]Loss = Actual Claims – Target Claims

Example Calculations of Health Care Management Incentive

Each of the following examples is based on these assumptions:

- Target Claims = $150 million
- Maximum penalty = $2.25 million

Example 1:

Actual Claims = $156 million
Penalty to Proposer = $0

Actual Claims are less than 105% of Target Claims

Example 2:

Actual Claims = $162 million
Penalty to Proposer = $450,000

Actual Claims exceed Target Claims by 8%; i.e., they fall in the range of more than 105% but less than 110% of the target claims. Therefore, the Proposer incurs a penalty of 10% of $4.5 million.

Example 3:

Actual Claims = $168 million
Penalty to Proposer = $1.35 million

Actual Claims are 12% greater than Target Claims; i.e., they fall in the range of more than 110% but less than 115% of the Target Claims. Therefore, the Proposer incurs a penalty of (a) 10% of $7.5 million, plus (b) 20% of $3 million.

3.9 Contract Documents

Within three weeks from award of the contract, the proposer will provide a first draft of the Administrative Services Agreement, HIPAA Business Associate Agreement, and any other required legal documentation to System Benefits Administration in electronic format (preferably MS WORD) for review and edits. **Completion of these documents is not required as part of the RFP response.** Final documents must be completed and signed no later than August 14, 2020.

Administrative Services Agreement - In addition to standard terms and conditions, the Administrative Services Agreement between the A&M System and the selected Proposer must include the following items:

- Mandatory Dispute Resolution – This exact language.

A) To the extent Chapter 2260, Texas Government Code, as it may be amended from time to time ("Chapter 2260") is applicable to this Agreement, and is not preempted by other applicable law, the dispute resolution process provided for in Chapter 2260 of the Government Code shall be used, as further described herein, by the A&M System and CONTRACTOR in attempts to resolve any claim for breach of contract made by CONTRACTOR:

1) A CONTRACTOR'S claim for breach of this Agreement that the parties cannot resolve pursuant to other provisions of this Agreement or in the ordinary course of business shall be submitted to the negotiation process provided in subchapter B of Chapter 2260. To initiate the process, CONTRACTOR must submit written notice as required by subchapter B of Chapter 2260, in accordance with the notice provisions in this Agreement. CONTRACTOR'S notice shall specifically state that the provisions of subchapter B of Chapter 2260 are being invoked, the date and nature of the event giving rise to the claim, the specific contract provision that the A&M System allegedly breached, the amount of damages CONTRACTOR seeks, and the method used to calculate the damages. Compliance by CONTRACTOR with subchapter B of Chapter 2260 is a required prerequisite to CONTRACTOR'S filing of a contested case proceeding under subchapter C of Chapter 2260. The Deputy Chancellor and Chief Financial Officer, or such other officer of the A&M System as may be designated from time to time by the A&M System by written notice thereof to CONTRACTOR in accordance with the notice provisions in this Agreement, shall examine CONTRACTOR'S claim and any counterclaim and negotiate with CONTRACTOR in an effort to resolve such claims.

2) If the parties are unable to resolve their disputes under subparagraph (1) of this Section, the contested case process provided in subchapter C of Chapter 2260 is CONTRACTOR's sole and exclusive process for seeking a remedy for any and all of CONTRACTOR's claims for breach of this Agreement by the A&M System.

B) Compliance with the contested case process provided in subchapter C of Chapter 2260 is a required prerequisite to seeking consent to sue from the Legislature under Chapter 107 of the Civil Practices and Remedies Code. The parties specifically agree (i) neither the execution of this Agreement by the A&M System nor any other conduct, action or inaction or any representative of the A&M System relating to this Agreement constitutes or is

intended to constitute a waiver of the A&M System's or the State of Texas' sovereign immunity to suit, and (ii) the A&M System has not waived its right to seek redress in the courts.

C) The submission, processing and resolution of CONTRACTOR's claim is governed by the published rules adopted by the Texas Attorney General pursuant to Chapter 2260, as currently effective, hereafter enacted or subsequently amended.

D) Neither the occurrence of an event giving rise to a breach of contract claim nor the pendency of a claim constitutes grounds for the suspension of performance by CONTRACTOR in whole or in part. The A&M System and CONTRACTOR agree that any period set forth in this Agreement for notice and cure of defaults are not waived.

E) The designated individual responsible on behalf of the A&M System for examining any claim or counterclaim and conducting any negotiations related thereto as required under §2260.052 shall be the Deputy Chancellor and Chief Financial Officer.

- General Release and Indemnification – Language should be included that will release, hold harmless, and unconditionally indemnify the A&M System, each and all of its System Members, its officers and employees, and the State of Texas from:
  - Any liability that might result from discriminatory organizational practices; and
  - Any liability that arises from the acts or omissions of any officer, employee, agent, or representative of the contractor or individual or organization under contract to the contractor for specific services related to the administration of the A&M System's benefit plans.

- Ability to Audit – Language should be included that will allow for audits to be performed by either the A&M System internal audit staff or a third party auditor contracted with the A&M System.

HIPAA Business Associate Agreement – In the interest of safeguarding our employees' and retirees' protected health information, the A&M System will require the execution of a HIPAA Business Associate Agreement documenting the selected Proposer's compliance with both the privacy and security rules as set forth by the Health Insurance Portability and Accountability Act. The HIPAA Business Associate Agreement is attached as *Exhibit F* for your review.

3.10 Eligibility

Newly eligible employees have a 45-day enrollment period. Depending upon the date the employee enrolls online or submits an enrollment form, coverage may begin as early as the date of hire, or as late as the first of the month following the 60th day after the hire date.

The A&M System will, in all cases, determine eligibility for coverage and effective dates of coverage in accordance with its rules and procedures. If these rules and procedures differ from those normally utilized by the Proposer, it is understood that the A&M System's determination will prevail.

Currently, an employee and his/her dependents are eligible for benefits if he/she is one of the

following:

a. eligible to participate in the Teacher Retirement System of Texas (TRS) or Optional Retirement Program (ORP), and the employee is either: (1) expected to work at least 20 hours per week and to continue in the employment for a term of at least 4-1/2 months; or (2) appointed for at least 50 percent of a standard full-time appointment.

   OR, the employee is employed at least 20 hours a week; and is not permitted to be a member of the Teacher Retirement System of Texas because the individual is solely employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate-level courses.

b. a retired employee who has met the eligibility requirements for retirement under TRS, whether or not he/she was a member of TRS.

Dependents eligible for coverage include:

a. the employee's spouse

b. the employee's children younger than age 26, regardless of where they live or whether they are enrolled in school; or disabled dependent children over the age of 26

c. grandchildren claimed on the employee's/retiree's income tax

Other categories of individuals eligible for coverage include COBRA participants, survivors, and postdoctoral fellows as described in Chapter 1601 of the Texas Insurance Code.

3.11 Communications and Enrollment

The A&M System will conduct an annual enrollment period for its eligible employees and retirees during the month of July, for the plan year beginning the following September 1. Between twenty and twenty-five voluntary annual enrollment meetings are held across the state and the selected Proposer will be required to have personnel available to make presentations at all meetings. SBA will produce a booklet summarizing the benefit plans, and employees will make benefit selections using the A&M System's enrollment process. Over 80% of annual enrollment benefit selections are done online by employees and retirees.

The A&M System will require the selected Proposer to distribute identification cards and additional new member information to employees' and retirees' homes. Costs associated with this process must be included in your proposal. All employee communication materials must be reviewed by SBA prior to release.

On a weekly basis throughout the year, the A&M System will report new employees who have enrolled in the plan. Identification cards and new member information should be mailed to home addresses as soon as enrollment information is received.

The A&M System will make personnel available during normal business hours to respond to inquiries regarding the status or eligibility of a participant.

3.12 Qualifications of Respondents

The Proposer must have a net worth of at least $250 million, as demonstrated by an audited

financial statement as of the close of the Proposer's most recent fiscal year. To affirm financial capability, the Proposer must submit all documentation as requested in the Company Profile to be included in the RFP response (*see Section 3.15d)*.

All entities responding to this RFP must certify (*see Section 3.15i*.) that they are licensed to do business in the state of Texas and permitted to contract with the State or any of its subdivisions. The organization must also certify in *Section i.* that it is in good standing with the Texas Department of Insurance (TDI) and disclose any actions that are pending or in process with TDI.

3.13 Plan Design

The A&M Care Plan is composed of three plans.

The A&M Care Plan has a $400 deductible with an 80% / 20% coinsurance split and an annual out-of-pocket maximum of $5,000 plus the $400 deductible. All benefit eligible employees (except those on a J-1 or J-2 visa) and retirees have the option to enroll in the A&M Care Plan regardless of where they live or work. There are currently 23,459 employees/retirees enrolled in the A&M Care Plan.

The A&M Care 65 Plus Plan has a $400 deductible with an 80% / 20% coinsurance split and an annual out-of-pocket maximum of $1,000 plus the $400 deductible. Retirees are enrolled in the 65 Plus Plan if the retiree and covered spouse (if applicable) are disabled or 65 or older, enrolled in Medicare Parts A and B and not a "working retiree" that would normally meet the requirements for active coverage. A "carve out" approach to coordination of benefits for all primary plans, including Medicare, is used. There are currently 7,265 retirees enrolled in the A&M Care 65 Plus Plan.

The A&M Care J Plan has a $400 deductible with a 80% / 20% coinsurance split and an annual out-of-pocket maximum of $5,000 plus the $400 deductible. This plan meets the visa requirements and only employees on a J-1 or J-2 visa may, but are not required, enroll in the A&M Care J Plan.

The A&M Care Plan DOES NOT require the designation of a primary care physician as a gatekeeper. Family Practice, General Practice, Internal Medicine, OB-GYN, and Pediatric physicians are considered to be primary care physicians.

The current definition of network includes all of Texas and the remaining 49 states. The successful vendor will also be required to offer national PPO coverage. Except in certain circumstances, such as emergency care and in cases where a network specialist is not located within a certain distance, a participant who lives in a BlueChoice or BlueCard network area and chooses to use a doctor or hospital that is not a member of the network will receive out-of-network benefits that result in higher out-of-pocket costs. Medicare primary participants are not required to use network providers and are not eligible to use the copayment structure with the exception of MDLive, the virtual provider.

The A&M System began a preferred provider network referred to as the Brazos Valley Network (BVN) in June 2018. Providers under this network have a lower copay structure with a 90% / 10% coinsurance split. The deductible and the out-of-pocket maximum remain the same as the rest of the A&M Care Plan.

The A&M Care Plan SPD can be found at:
http://www.tamus.edu/assets/files/benefits/pdf/spdhealth.pdf.

YOUR QUOTE SHALL BE BASED ON THE SAME BENEFIT DESIGN THAT IS CURRENTLY IN PLACE.

3.14 Historical Claims Experience

All Respondents shall have downloaded a supplemental file named "Experience A&M.xlsx" from the RFP posting on the ESBD (site provided in Section 2.4). This file contains A&M Care plan-specific medical claims experience paid through September 30, 2019. The file contains 10 worksheets which provide various summary statistics regarding A&M Care Plan medical utilization and cost. A description of each of the worksheets is provided below.

Attachment A – Claim lag report separated by inpatient, outpatient, and professional/OME.

Attachment B – Patient plan paid amount distribution report. This report identifies the large claim experience. The A&M System does not carry individual or aggregate stop-loss coverage.

Attachment C – Claims experience by 3-digit zip codes.

Attachment D – Hospital claims experience by Major Diagnostic Category Code.

Attachment E – Claims experience by ICD-10 Diagnostic Category Code.

Attachment F – Utilization report separated by inpatient, outpatient, and professional/OME.

Attachment G – Claims experience by billing NPI.

Attachment H – Premium and claims report.

Attachment I – Top 100 hospital admission types by ICD-10 Diagnostic Category Code.

Attachment J – Claims experience by provider type and specialty.

3.15 Proposal

Respondents are instructed to respond using the proposal format included in this RFP in order to expedite analysis and comparison of proposals received. Failure to use the stated format or failure to provide complete responses, may, at the A&M System's option, disqualify the proposer.

A complete proposal shall consist of the following items:

a. Cover Letter – This letter shall summarize interest and ability to provide the scope of this RFP, include a statement to the validity of the proposal, and provide a contact name for this RFP response, including title, address, telephone number, facsimile, and email address.

b. Execution of Offer – The Execution of Offer provided in Exhibit A must be signed by Proposer's company official duly authorized and having the authority to legally bind and commit the proposing organization.

c. Non-Collusion Affidavit - The Non-Collusion Affidavit provided in Exhibit B must be signed and notarized.

d. Company Profile – Complete the Company Profile as provided in Exhibit C.

e. Organizational Chart – Provide an organizational chart identifying the chain of authority through the company's CEO for this account. Include names, addresses, titles, email addresses and telephone numbers for each individual.

f. Staffing – Describe the staff involved in the management of this group account. Include names, titles, addresses, email addresses, phone numbers and brief biographies of the following individuals or their organizational equivalents who will be assigned to the A&M System account:
   - National/Governmental Accounts, Director
   - Account Manager
   - Account Representative
   - Customer Service/Claims Processing Manager
   - Account underwriter
   - Reporting/Analytics Representative
   - Wellness Programs Manager
   - Eligibility File Coordinator

g. Installation Team Staffing - Describe the installation team and provide the names, titles addresses, email addresses, and brief biographies of any individuals who are not included in *Section f*. above.

h. References
   - Provide the name, address, email address, and telephone number of the primary contact at two public entities or corporations and two major universities of similar size and with decentralized administration that are current clients of your company.
   - Provide two references, including the name, address, email address, and telephone number for the individual who will have primary responsibility for the A&M System account.
   - Provide the name, address, email address, and telephone number of the primary contact at two large accounts that have cancelled their coverage with your organization within the past year.

   The A&M System may perform reference checks and seek further information, as needed from all Respondents whose proposals the System, at its discretion, considers viable, based on the initial evaluation and scoring. The Proposer's response to this requirement officially authorizes the A&M System to contact these organizations to discuss the services and other considerations which the Proposer has provided to such organizations and authorizes the organizations to provide such information to the A&M System and Proposer shall and hereby does release and hold harmless the A&M System, the state of Texas, and the organization of any and all liability whatsoever, in connection with providing and receiving all such information. Any negative responses received from reference checks may be grounds for disqualification of the proposal.

i. Certification

- Certify that the proposing organization is licensed to offer the group insurance contracts in the state of Texas for which it is submitting proposals and is legally able to contract with the State or any of its subdivisions.
- Certify that the organization has a current license from the Texas Department of Insurance (TDI) to serve in Texas as a TPA, if applicable, is in good standing with the TDI and disclose any actions that are pending or in process with TDI.
- Certify that no commissions, broker or finders fees are included in the quoted fees/premiums or will be paid to any individual, agency or company, if your company is selected to provide coverage for the A&M System.
- Certify that enrollment of any employee of the A&M System will not be limited or discouraged by "quota" or other restriction.
- Certify against discriminatory selection or segregation of the total group of eligible employees of the A&M System by excluding, or seeking to exclude, or otherwise discriminating against any of the following classes:
    - Women: Title VII of the Civil Rights Act of 1964, as amended; Executive Order 11246 of 1965, as amended
    - Pregnant Women: Pregnancy Discrimination Act of 1978, PL95-555
    - Racial Minorities: Title VII of the Civil Rights Act of 1964, as amended
    - Aged and Retired: Age Discrimination in Employment Act of 1967, as amended; Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA); Deficit Reduction Act of 1984 (DEFRA); Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)
    - Disabled Individuals and those with catastrophic and terminal diseases: Sections 503 and 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990

j. Questionnaire – This section should include the completed Questionnaire found in *Exhibit D*.

k. Data Files - When you downloaded the RFP, you should have also downloaded the supplemental files listed in *Exhibit E* which will be used for you to provide the data files requested below. If you failed to download these files, you can do so by returning to the ESBD. All data files requested below should be provided on CD in *Section k.* of your response.

- Price Proposal Worksheet - You should have downloaded a supplemental file named *Price Proposal Worksheet.* The file should be completed in the requested format. No deviations from the requested pricing terms will be accepted at this time.

- Network – You should have downloaded a supplemental file named *Network.* The proposer must complete this file for each of the following proposed state of Texas networks: hospital, primary care providers and specialty providers. Please provide the network as of January 1st, 2020. If the Proposer has contractual arrangements with non-network providers, please include this information in the worksheets labeled "Non-network contracted." Failure to provide complete data or to properly identify the data may result in a delay in the review of the Proposer's response. Please note that the documentation required is more detailed than what is generally listed in the provider directory. The required format may not be altered. No other format will be accepted. All required data fields must be included for all records or the proposal will be considered incomplete. Blank records, abbreviated names and extra fields are not

acceptable. Only those specialty codes provided by the A&M System, as listed below, are valid.

- Hospital – the following fields must be included for each record.

Item No.	Field Name	Format	Field Description
1	NPI	Numeric	National Provider Identifier
2	Name	Character	Hospital Name
3	Address 1	Character	Hospital Street Name
4	Address 2	Character	Additional Street Information
5	City	Character	Hospital City Location
6	Zip	Numeric	Hospital STREET Address Zip Code

- Primary Care Providers – the following fields must be included for each record.

Item No.	Field Name	Format	Field Description
1	NPI	Numeric	National Provider Identifier
2	Last Name	Character	Physician's Last Name
3	First Name	Character	Physician's First Name
4	MI	Character	Physician's Middle Initial
5	Address 1	Character	Primary Street Address of Physician's Office (No P.O. Boxes)
6	Address 2	Character	Additional Address Information (Suite #, Floor, etc.)
7	City	Character	Physician's City Location
8	Zip	Numeric	Physician's STREET Address Zip Code
9	Spec	Character	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	Character	O=Open practice C=Closed practice
11	AFF	Character	Affiliated with a group: Y=yes or N=No
12	Group	Character	Name of group practice

- Specialty Care Providers (including Ancillary Providers) – the following fields must be included for each record.

Item No.	Field Name	Format	Field Description
1	NPI	Numeric	National Provider Identifier
2	Last Name	Character	Physician's Last Name

3	First Name	Character	Physician's First Name
4	MI	Character	Physician's Middle Initial
5	Address 1	Character	Primary Street Address of Physician's Office (No P.O. Boxes)
6	Address 2	Character	Additional Address Information (Suite #, Floor, etc.)
7	City	Character	Physician's City Location
8	Zip	Numeric	Physician's STREET Address Zip Code
9	Spec	Character	See Specialty Values Table below
10	AFF	Character	Affiliated with a group: Y=yes or N=No
11	Group	Character	Name of group practice

Only the following Specialty Values are valid to identify specialties for the specialty care provider network file.

Two-Digit Code	Specialty
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 Urology
OTH	All Other Specialties
ANCIL	Ancillary Provider

- Provider Reimbursement Response - You should have downloaded a supplemental file named *Provider Reimbursement.* This file includes 5 forms requesting information regarding the proposer's provider network and network reimbursement. All forms must be completed in the format requested. **The same**

network should be used in completing all information. It is not appropriate to use a broader network for one response and a narrower network for another response.

Forms 1 through 4 require information by city. For purposes of completing these forms the cities are defined as follows:

City	County
Bryan/College Station	Brazos
Corpus Christi	Nueces
Kingsville	Kleberg
Amarillo	Randall & Potter
Canyon	Randall & Potter
Houston	Harris
Stephenville	Erath
Prairie View	Waller
Dallas/Fort Worth	Colin, Dallas & Tarrant
Galveston	Galveston
Laredo	Webb
Killeen	Bell
San Antonio	Bexar
Commerce	Hunt
Texarkana	Bowie
Lufkin	Angelina
Tyler	Smith
Palestine	Anderson
Overton	Rusk
Marshall	Harrison
Brownsville	Cameron
Harlingen	Cameron
McAllen	Hidalgo

- *Form 1* - Requests information regarding the number of network providers for selected provider types for certain areas of Texas as of January 1st, 2020.

- *Form 2* - Requests information regarding the type(s) of reimbursement arrangements used by the proposer in selected areas as of January 1st, 2020. Indicate with an "x" which type(s) of reimbursement are utilized.

- *Form 3* - Contains selected professional physician procedure codes (CPT) for certain areas of Texas. For each procedure in each service area, provide the Proposer's average network allowable charge for the Proposer's network as of January 1, 2020. Provide a global, unmodified fee for all procedures other than lab and radiology. For lab and radiology procedures (other than chest x-ray), provide a modifier 26 (professional only) fee. For chest x-ray, provide a global, unmodified fee. If the Proposer utilizes multiple fee schedules in a particular area, provide the average fee weighted by the percentage of current

membership. If the proposer utilizes capitation in their professional reimbursement methodology for certain physicians, so indicate.

Note: The A&M System reserves the right to validate by audit the Proposer's submitted reimbursement amounts.

- *Form 4* - Requests information regarding the effective dates of the current physician fee schedules for selected areas of Texas.

- *Form 5* - Requires completion with the vendor's allowable charge for each of the claims included in the file *Detail Claims*, a zipped archive containing twelve (12) claims data text files and an Excel document with file description details. These files include A&M Care self-insured PPO health plan experience for the incurred period July 1, 2018 through June 30, 2019 and paid through September 30, 2019 and only include claims for which Medicare is not primary. Instructions regarding the required format for the response, including the provider network status and allowed amount as of January 1st, 2020, are included on the form. For each claim, Proposer is to provide (a) the claim number, (b) claim line, (c) provider contracting status as of January 1, 2020, and (d) the charge amount that Proposer would have allowed under its reimbursement arrangement with that provider as of January 1, 2020. Provider contracting status should indicate whether the provider is (1) a contracted network provider, (2) a non-network provider with some alternative contracting status, either directly or indirectly with Proposer, which allows for discounted reimbursement and / or relief from balance billing to Participants (referred to herein as a contracted non-network provider). or (3) a provider with no contracting status with Proposer.

  The information provided in the claims file should be adequate to determine the allowable charge. The Proposer is not to provide payment amounts, only allowable charges. A detailed description of the methodology used to re-price these sample claims must be provided along with a detailed example of repricing an individual claim. If the Proposer utilizes capitation in their reimbursement methodology for certain facilities, so indicate.

  The Proposer should provide the requested information for each monthly file provided in the exact same order as the information included in the original claim files. Proposer should review the worksheet "control report" included in the file description to ensure the record count from this worksheet matches the record count from the Proposer's response.

  Note: The A&M System reserves the right to validate by audit the proposer's submitted allowable charge amounts for these claims.

l. Confidential and Proprietary Information – In order to protect and prevent inadvertent access to confidential information submitted in the response, the Respondent is to provide a schedule of all pages that the Respondent in good faith, and with legally sufficient due diligence, considers to contain any confidential and/or proprietary information.

Information in any tangible form which is submitted by Respondents will be treated as

confidential until such time as a contract is executed. After that time, the A&M System is required to provide access to certain records in accordance with the provisions of Chapter 552, Tex. Government Code, now known as the Texas Public Information Act (TPIA), formerly known as the Open Records Act. By submitting a response, the Respondent acknowledges and agrees that the A&M System shall have no liability to the Respondent or to any other person or entity for disclosing information in accordance with the TPIA. The A&M System shall not have any obligation or duty to advocate the confidentiality of the Respondent's material to the Texas Attorney General or to any other person or entity. The Respondent further understands and agrees that upon the A&M System's receipt of a TPIA request for a copy of the Respondent contract, including the response and any exhibits to the contract and response, the only documents that the A&M System shall treat as the Respondent's confidential and proprietary information shall be the documents the Respondent identifies as required above. It is the Respondent's sole obligation to advocate in good faith the confidential or proprietary nature of any information it provides in its response, and the Respondent understands that the Texas Attorney General may nonetheless determine that all or part of the claimed confidential or proprietary information shall be publicly disclosed.

m. Deviations – In an effort to compare "apples to apples", deviations to the RFP and the current plan design are strongly discouraged. The Proposer shall enumerate and provide a detailed description of any deviations to provisions contained in the RFP. If your organization is unable to perform any of the required administrative services or unable to administer any portion of the current plan design please provide details.

n. Supplemental Information – Information or exhibits provided that are not specifically requested in *Sections a. through m.* above should be included at the end of the proposal behind a divider page entitled "n. Supplemental Information".

3.16 HUB Subcontracting Plan

It is the policy of the state of Texas and the A&M System to encourage the use of Historically Underutilized Businesses (HUBs) in our prime contracts, subcontractors, and purchasing transactions. The goal of the HUB program is to promote equal access and equal opportunity in A&M System contracting and purchasing.

Based on the scope of this RFP, Respondents must determine if they can perform the entire scope with their own resources or if it will be necessary to subcontract any portion of the scope. Subcontracting opportunities are defined as those opportunities contracted with a vendor to provide services, supply commodities, or contribute toward completing work for a governmental entity.

Subcontracting opportunities are possible for this RFP and therefore a HUB Subcontracting Plan (HSP) is **required**. Failure to submit a comprehensive, acceptable HSP will be considered a material failure to comply with the requirements of the RFP and will result in rejection of the submittal. The HUB Subcontracting Plan shall be submitted **with** the RFP response by the date and time specified. The applicable **HUB goal** to utilize for this RFP is **10%** for "all other services".

Respondents shall complete the HSP form attached or as found on the following site; https://www.tamus.edu/business/hub-procurement/hub-programs-3/system-offices-hub-program/ and submit it with the RFP response. If there are pre-existing agreements in

place with companies who will be hired as subcontractors, the Respondent will show those vendors as subcontractors on the HSP and provide an explanation as to why solicitations were not done, e.g. contractual requirements. If no pre-existing agreements with companies who will be hired as subcontractors exist, then the Respondent will be expected to make a good faith effort according to the HSP instructions. Don't forget to include any backup documentation and sign the HSP form.

If the Respondent is completing as **self-performing,** a statement, which attests that the respondent shall perform the subcontracting opportunities identified by the agency, with its own employees and resources, is required. The sections in the HSP form to be completed for self-performing are Section 1, 2a (check No), 3 with your statement included in the open text field, and 4**.**

For information regarding the HUB Subcontracting Plan requirements, please contact Keith Williams from the A&M System's HUB Program at (979) 458-3265 or kwilliams@tamus.edu for assistance in determining available HUB subcontractors and proper completion of the HSP. Respondents have the opportunity to submit a draft of the HSP prior to submittal of their response to the RFP for review by Mr. Williams.

SECTION 4 - GENERAL TERMS AND CONDITIONS

4.1 TERMS AND CONDITIONS

The A&M System reserves the right to accept, reject, modify, and/or negotiate any and all proposals received in conjunction with this RFP. It reserves the right to waive any defect or informality in the proposals on the basis of what it considers to be in its best interests. Any submittal which the A&M System determines to be incomplete, conditional, obscure, or which has irregularities of any kind, may be rejected. The A&M System reserves the right to award to the firm, or firms, which in our sole judgment, will best serve our long-term interest.

This RFP in no manner obligates the A&M System to the eventual purchase of any products or services described, implied, or which may be proposed, until confirmed by written agreement, and may be terminated by the A&M System without penalty or obligation at any time prior to the signing of an agreement.

4.2 GOVERNING LAW

The validity of any resultant agreement and all matters pertaining to any resultant agreement, including but not limited to, matters of performance, non-performance, breach, remedies, procedures, rights, duties, and interpretation or construction, shall be governed and determined by the Constitution and the laws of the State of Texas.

4.3 NON-DISCRIMINATION

The parties agree that in the performance of any resultant agreement they shall not discriminate in any manner on the basis of race, color, national origin, age, religion, sex, genetic information, veteran status, sexual orientation, gender identity, or disability protected by law. Such action shall include, but is not limited to the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation. By submitting a submittal, Respondents certify that they will conform to the provisions of the federal Civil Rights Act of 1964, as amended.

4.4 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By submitting a proposal, the Respondent certifies it does not and will not, during the performance of any resultant agreement act, employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986, as amended.

4.5 DEBARMENT STATUS

By submitting a statement of qualification, Respondent certifies it is not currently debarred from submitting proposals on contracts nor is it an agent of any person or entity that is currently debarred from submitting bids on contracts.

4.6 INDEMNIFICATION AND HOLD HARMLESS

The Respondent shall defend, indemnify and hold harmless the A&M System, its officers, employees and agents, against any and all liability of whatever nature which may arise directly or indirectly by reason of the Respondent’s performance under the resultant agreement.

4.7 RESPONDENT LIABILITY

The Respondent will be liable for any associated costs of repairs for damage to buildings or other A&M System property caused by the negligence of the Respondent's employees.

4.8 CIVIL RIGHTS REQUIREMENTS

All Respondents must comply with applicable civil rights laws.

4.9 ENTIRE AGREEMENT

The resultant agreement, when fully executed, shall supersede any and all prior and existing agreements, either oral or in writing, and will contain all the covenants and agreements between the parties with respect to the subject matter of the agreement. Any amendment or modification to the agreement must be in writing and signed by the parties hereto.

4.10 TERMINATION

In the event the successful Respondent fails to perform any of its duties or obligations as provided by any resultant agreement, which will include the RFP and the Respondent's response to the RFP, the A&M System without limiting any other rights or remedies it may have by law, equity or under contract, shall have the right to terminate the resultant agreement immediately. The Respondent understands and acknowledges that, notwithstanding any termination of the resultant agreement, certain obligations shall survive the termination of the resultant agreement.

In addition to and without restricting or waiving any other legal, contractual or equitable remedies otherwise available to the A&M System, the A&M System may terminate the resultant agreement without cause by giving the Respondent ninety (90) days written notice.

In the event of a change in condition which may affect the Employee Assistance Program services for which proposals are solicited, the A&M System will expect a good-faith effort from any Respondent selected to absorb additional liabilities during the term of the resultant agreement without requiring rate increases until the next following renewal date. Such changes in condition include, but are not limited to, the following:

- Rules of the Texas Department of Insurance.
- Opinions of the Attorney General of the State of Texas.
- Federal and State statutes, court decisions and regulations from agencies and departments that may affect employment and benefit programs.

4.11 SEVERABILITY

It is understood and agreed that if any part, term, or provision of the resultant agreement is by the courts held to be illegal or in conflict with any law of the State of Texas, the validity of the remaining portions or provisions shall be construed and enforced as if the agreement did not contain the particular part, term, or provision held to be invalid.

4.12 PUBLICITY

Respondents must refrain from giving any reference to this project, whether in the form of press releases, brochures, photographic coverage, or verbal announcements, without specific written approval from the A&M System.

Information provided to Respondent by the A&M System, including but not limited to information from the members, officers, agents, or employees of the A&M System or any of its members, and information provided to Respondent by members of the public or any other third party shall belong to the A&M System.

4.13 INDEPENDENT CONTRACTOR

The successful Respondent agrees that in all respects its relationship with the A&M System will be that of an independent contractor, and that it will not act or represent that it is acting as an agent of the A&M System or incur any obligation on the part of the A&M System without written authority of the A&M System. As an independent contractor, Respondent will be solely responsible for determining the means and methods for performing the services described. Respondent shall observe and abide by all applicable laws and regulations, policies and procedures, including but not limited to, those of the A&M System relative to conduct on its premises.

4.14 AGENT OF RECORD

The A&M System will not designate an Agent of Record or any other such commissioned representative. All requests for the A&M System to provide such a designation will be rejected. The A&M System will communicate and negotiate only with principals of the Proposer. The A&M System will not pay commissions in the event that the Proposer chooses to name an agent of record and such an agent will not be recognized by the A&M System. In addition, no commission, broker or finders fees may be paid by the A&M System. You must certify in *Section i.* that you will abide by these stipulations.

4.15 PUBLIC INFORMATION ACT

(a) Respondent acknowledges that A&M System is obligated to strictly comply with the Public Information Act, Chapter 552, Texas Government Code, in responding to any request for public information pertaining to this Agreement, as well as any other disclosure of information required by applicable Texas law.
(b) Upon A&M System's written request, Respondent will promptly provide specified contracting information exchanged or created under this Agreement for or on behalf of A&M System.
(c) Respondent acknowledges that A&M System may be required to post a copy of the fully executed Agreement on its Internet website in compliance with Section 2261.253(a)(1), Texas Government Code.
(d) The requirements of Subchapter J, Chapter 552, Texas Government Code, may apply to this agreement and the Respondent agrees that the agreement can be terminated if the Respondent knowingly or intentionally fails to comply with a requirement of that subchapter.

4.16 OWNERSHIP OF DOCUMENTS

Upon completion or termination of any resultant agreement, all documents prepared by the Respondent for the benefit of the A&M System shall become the property of the A&M System. At the A&M System' option, such documents will be delivered to the System Procurement Office. The A&M System acknowledges that the documents are prepared only for the contracted services specified. Prior to completion of the contracted services, the A&M System shall have a recognized proprietary interest in the work product of the Respondent.

4.17 SOLICITING

Information provided to the Respondent, including lists of covered employees or other employee data may not be used to solicit any other insurance coverage, annuity product, or any other product, unless specifically approved in advance by the A&M System.

4.18 INSURANCE

The Respondent shall obtain and maintain, for the duration of the resultant agreement or longer, the minimum insurance coverage set forth below. With the exception of Professional Liability (E&O), all coverage shall be written on an occurrence basis. All coverage shall be underwritten by companies authorized to do business in the State of Texas or eligible surplus lines insurers operating in accordance with the Texas Insurance Code and have a financial strength rating of A- or better and a financial strength rating of VII or better as measured by A.M. Best Company or otherwise acceptable to the A&M System. By requiring such minimum insurance, the A&M System shall not be deemed or construed to have assessed the risk that may be applicable to the Respondent. Respondent shall assess its own risks and if it deems appropriate and/or prudent, maintain higher limits and/or broader coverage. Respondent is not relieved of any liability or other obligations assumed pursuant to the agreement by reason of its failure to obtain or maintain insurance in sufficient amounts, duration, or types. No policy will be canceled without unconditional written notice to the A&M System at least ten days before the effective date of the cancellation.

Coverage	**Limit**
A. **Worker's Compensation**	
Statutory Benefits (Coverage A)	Statutory
Employers Liability (Coverage B)	$1,000,000 Each Accident
	$1,000,000 Disease/Employee
	$1,000,000 Disease/Policy Limit

Workers' Compensation policy must include under Item 3.A. on the information page of the workers' compensation policy the state in which work is to be performed for the A&M System. Workers' compensation insurance is required, and no "alternative" forms of insurance will be permitted

B. **Automobile Liability**

Business Auto Liability Insurance covering all owned, non-owned or hired automobiles, with limits of not less than $1,000,000 Single Limit of liability per accident for Bodily Injury and Property Damage;

C. **Commercial General Liability**

Each Occurrence Limit	$1,000,000
General Aggregate Limit	$2,000,000
Products / Completed Operations	$1,000,000
Personal / Advertising Injury	$1,000,000
Damage to rented Premises	$300,000
Medical Payments	$5,000

The required commercial general liability policy will be issued on a form that insures Respondent or its subcontractors' liability for bodily injury (including death), property damage, personal and advertising injury assumed under the terms of the agreement.

D. Respondent will deliver to the A&M System: Evidence of insurance on a Texas Department of Insurance approved certificate form verifying the existence and actual limits of all insurance after the execution and delivery of the agreement and prior to the performance of any services by Respondent under this Agreement. Additional evidence of insurance will be provided on a Texas Department of Insurance approved certificate form verifying the continued existence of all required insurance no later than thirty (30) days after each annual insurance policy renewal.

All insurance policies, with the exception of worker's compensation, employer's liability and professional liability will be endorsed and name The Board of Regents for and on behalf of The Texas A&M University System and The Texas A&M University System as Additional Insureds up to the actual liability limits of the policies maintained by Respondent. Commercial General Liability and Business Auto Liability will be endorsed to provide primary and non-contributory coverage. The Commercial General Liability Additional Insured endorsement will include on-going and completed operations and will be submitted with the Certificates of Insurance.

All insurance policies will be endorsed to provide a waiver of subrogation in favor of The Board of Regents of The Texas A&M University System and The Texas A&M University System. No policy will be canceled without unconditional written notice to the A&M System at least ten days before the effective date of the cancellation. ***All insurance policies*** will be endorsed to require the insurance carrier providing coverage to send notice to the A&M System ten (10) days prior to the effective date of cancellation, material change, or non-renewal relating to any insurance policy required in this Section.

Any deductible or self-insured retention must be declared to and approved by the A&M System prior to the performance of any services by Respondent under the agreement. Respondent is responsible to pay any deductible or self-insured retention for any loss. All deductibles and self-insured retentions will be shown on the Certificates of Insurance.

Certificates of Insurance and Additional Insured Endorsements as required by the agreement will be mailed, faxed, or emailed to the following the A&M System contact:

The Texas A&M University System
Attn: Jeff Zimmermann
301 Tarrow Street, Rm 361
College Station, TX 77840
Facsimile Number: (979) 458-6101
Email Address: jzimmermann@tamus.edu

The insurance coverage required by this Agreement will be kept in force until all services have been fully performed and accepted by the A&M System in writing.

4.19 PREMIUM TAXES

The A&M System is exempt from the payment of premium taxes under Chapter 1601, *Texas Insurance Code.* No provision for the payment of premium taxes will be included in the calculation of premium rates.

4.20 DISPUTE RESOLUTION

The dispute resolution process provided in Chapter 2260, *Texas Government Code*, and the related rules adopted by the Texas Attorney General pursuant to Chapter 2260, shall be used by the A&M System and Respondent to attempt to resolve any claim for breach of contract made by Respondent that cannot be resolved in the ordinary course of business. Respondent shall submit written notice of a claim of breach of contract under this Chapter to the Deputy Chancellor and Chief Financial Officer for the A&M System, who shall examine Respondent's claim and any counterclaim and negotiate with Respondent in an effort to resolve the claim.

4.21 VENUE

Pursuant to Section 85.18, *Texas Education Code*, venue for any suit filed against the A&M System shall be in the county in which the primary office of the chief executive officer of the A&M System is located. At the date of this RFP, such county is Brazos County, Texas.

4.22 STATE AUDITOR'S OFFICE

Respondent understands that acceptance of funds under this Agreement constitutes acceptance of the authority of the Texas State Auditor's Office, or any successor agency (collectively, "Auditor"), to conduct an audit or investigation in connection with those funds pursuant to Section 51.9335(c), *Texas Education Code*. Respondent agrees to cooperate with the Auditor in the conduct of the audit or investigation, including without limitation, providing all records requested. Respondent will include this provision in all contracts with permitted subcontractors.

4.23 CONFLICT OF INTEREST

Respondent and each person signing on behalf of Respondent certifies, and in the case of a sole proprietorship, partnership or corporation, each party thereto certifies as to its own organization, that to the best of their knowledge and belief, no member of The A&M System or The A&M System Board of Regents, nor any employee, or person, whose salary is payable in whole or in part by The A&M System, has direct or indirect financial interest in the award of this Agreement, or in the services to which this Agreement relates, or in any of the profits, real or potential, thereof.

4.24 PROHIBITION ON CONTRACTS WITH COMPANIES BOYCOTTING ISRAEL

To the extent that Texas Government Code, Chapter 2271 applies to the resultant agreement, Respondent certifies that (a) it does not currently boycott Israel; and (b) it will not boycott Israel during the term of the resultant agreement. PROVIDER acknowledges the resultant agreement may be terminated and payment withheld if this certification is inaccurate

4.25 CERTIFICATION REGARDING BUSINESS WITH CERTAIN COUNTRIES AND ORGANIZATIONS

Pursuant to Subchapter F, Chapter 2252, Texas Government Code, Respondent certifies it is not engaged in business with Iran, Sudan, or a foreign terrorist organization. Respondent acknowledges this Purchase Order may be terminated if this certification is or becomes inaccurate.

4.26 PROHIBITION ON CONTRACTS RELATED TO PERSONS INVOLVED IN HUMAN TRAFFICKING

Under Section 2155.0061, Government Code, the vendor certifies that the individual or business entity named in this RFP is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

4.27 RECORDS RETENTION

Respondent will preserve all contracting information, as defined under Texas Government Code, Section 552.003 (7), related to the Agreement for the duration of the Agreement and for seven years after the conclusion of the Agreement.

4.28 Respondent shall neither assign its rights nor delegate its duties under the resultant agreement without the prior written consent of the A&M System.

EXHIBIT A

EXECUTION OF OFFER

RFP01 SBA-20-069
DATE:

In compliance with this RFP, and subject to all the conditions herein, the undersigned offers and agrees to furnish any or all commodities or services at the prices quoted.

A.1 Respondent Affirmation

NOTE TO RESPONDENTS: SUBMIT ENTIRE SECTION WITH RESPONSE.

This execution of offer must be completed, signed, and returned with the respondent's qualifications. Failure to complete, sign and return this execution of offer with the qualifications may result in rejection of the qualifications.

Signing a false statement may void the submitted qualifications or any agreements or other contractual arrangements, which may result from the submission of respondent's qualifications. A false certification shall be deemed a material breach of contract and, at the A&M System's option, may result in termination of any resulting contract or purchase order.

Addenda Acknowledgment

Receipt is hereby acknowledged of the following addenda to this RFP by entering yes or no in space provided and indicating date acquired. Enter "0" if none received.

No. 1 _____ Date _____ No. 3 _____ Date _____

No. 2 _____ Date _____ No. 4 _____ Date _____

A.2 Signature

By signing below, the Respondent hereby certifies as follows, and acknowledges that such certifications will be included in any resulting contract:

(i) the Response and all statements and information prepared and submitted in response to this RFP are current, complete, true and correct;

(ii) it has not given, nor intends to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount trip, favor or service to a public servant in connection with the submitted response or any subsequent proposal. Failure to sign below, or signing a false statement, may void the response or any resulting contracts at the A&M System' option, and the Respondent may be removed from all future proposal lists at this state agency;

(iii) the individual signing this document and the documents made part of the RFP is authorized to sign such documents on behalf of the Respondent and to bind the Respondent under any contract which may result from the submission of the Response;

(iv) no relationship, whether as a relative, business associate, by capital funding agreement or by any other such kinship exists between Respondent and an employee of the A&M System;

(v) Respondent has not been an employee of the A&M System within the immediate twelve (12) months prior to the RFP response;

(vi) no compensation has been received for participation in the preparation of this RFP (ref. Section 2155.004 Texas Government Code);

(vii) all services to be provided in response to this RFP will meet or exceed the safety standards established and promulgated under the Federal Occupational Safety and Health law (Public Law 91-596) and its regulations in effect as of the date of this solicitation;

(viii) Respondent complies with all federal laws and regulations pertaining to Equal Employment Opportunities and Affirmative Action;

(ix) to the best of its knowledge, no member of the Board of Regents of The Texas A&M University System, or the Executive Officers of the Texas A&M University System or its member institutions or agencies, has a financial interest, directly or indirectly, in the scope of this RFP;

(x) if the Respondent is subject to the Texas franchise tax, it is not currently delinquent in the payment of any franchise tax due under Chapter 171, Texas Tax Code, or is exempt from the payment of such taxes. A false certification may result in the Respondent's disqualification;

(xi) under Section 231.006, Family Code, the vendor or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate; and,

(xii) under Section 2155.004, Government Code, the vendor certifies that the individual or business entity named in this bid or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

(xiii) the requirements of Subchapter J, Chapter 552, Texas Government Code, may apply to this bid and resultant agreement and the Respondent agrees that the resultant agreement can be terminated if the PROVIDER knowingly or intentionally fails to comply with a requirement of that subchapter.

Respondent shall provide Federal EIN/Tax ID, full firm name, address and other information as requested in the spaces below. Failure to manually sign or with electronic signature (such as DocuSign or Adobe Sign) below will disqualify the proposal response. The person signing the submittal should show title or authority to bind his/her firm in contract.

Federal EIN/TAX ID: _____

Vendor/Company Name: _____

Authorized Signature (INK or electronic signature):_____

Name: _____

Title: _____

Street: _____

City/State/Zip: _____

Telephone No.: _____

Fax No.: _____

E-mail: _____

* By signing this RFP, Respondent certifies that if a Texas address is shown as the address of the respondent, respondent qualifies as a Texas Resident Bidder as defined in Texas Government Code, § 2252.001(4).

EXHIBIT B
NON-COLLUSION AFFIDAVIT

The undersigned, duly authorized to represent the persons, firms and corporations joining and participating in the submission of the foregoing Proposal (such persons, firms and corporations hereinafter being referred to as the "Respondent"), being duly sworn, on his or her oath, states that to the best of his or her belief and knowledge no person, firm or corporation, nor any person duly representing the same joining and participating in the submission of the foregoing Proposal, has directly or indirectly entered into any agreement or arrangement with any other Respondents, or with any official of the A&M System or any employee thereof, or any person, firm or corporation under contract with the A&M System whereby the Respondent, in order to induce acceptance of the foregoing Proposal by said the A&M System, has paid or is to pay to any other Respondent or to any of the aforementioned persons anything of value whatever, and that the Respondent has not, directly or indirectly entered into any arrangement or agreement with any other Respondent or Respondents which tends to or does lessen or destroy free competition in the letting of the contract sought for by the foregoing Proposal.

The Respondent hereby certifies that neither it, its officers, partners, owners, providers, representatives, employees and parties in interest, including the affiant, have in any way colluded, conspired, connived or agreed, directly or indirectly, with any other Respondent, potential Respondent, firm or person, in connection with this solicitation, to submit a collusive or sham bid, to refrain from bidding, to manipulate or ascertain the price(s) of other Respondents or potential Respondents, or to obtain through any unlawful act an advantage over other Respondents or the A&M System.

The prices submitted herein have been arrived at in an entirely independent and lawful manner by the Respondent without consultation with other Respondents or potential Respondents or foreknowledge of the prices to be submitted in response to this solicitation by other Respondents or potential Respondents on the part of the Respondent, its officers, partners, owners, providers, representatives, employees or parties in interest, including the affiant.

CONFLICT OF INTEREST

The undersigned Respondent and each person signing on behalf of the Respondent certifies, and in the case of a sole proprietorship, partnership or corporation, each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief, no member of the A&M System, nor any officer, employee, or person, whose salary is payable in whole or in part by the A&M System, has a direct or indirect financial interest in the award of this Proposal, or in the services to which this Proposal relates, or in any of the profits, real or potential, thereof, except as noted otherwise herein.

Signature _____

Company Name _____

Date _____

_____
Subscribed and sworn to before me this

_____ day of _____, 2020.

Notary Public in and for the County of _____, State of

_____. My commission expires: _____

THE EXECUTION OF OFFER AND NON-COLLUSION AFFIDAVIT MUST BE COMPLETED, SIGNED, AND RETURNED WITH RESPONDENT'S SUBMISSION. FAILURE TO SIGN AND RETURN THESE DOCUMENTS WILL RESULT IN THE REJECTION OF YOUR SUBMISSION.

EXHIBIT C – COMPANY PROFILE

a. Please provide the following:
- Legal Name
- DBA Name
- Number of Years in Business
- Type of Operation (i.e., Individual, Partnership, Corporation)
- Number of Employees
- Annual Revenues

b. Provide a general overview of the company, including where the company is headquartered, if it has a major base of operation in Texas, and if it has operated under other names.

c. Include a narrative history of the firm and its background in providing employee group benefits. Explain the added value or service that your organization provides that distinguishes it from all others.

d. **Financial Stability**. Respondent shall provide the following to verify financial stability:
- A copy of your company's audited financial statements for the past two (2) years; or
- A financial rating of your company and any documentation (such as a Dunn and Bradstreet Analysis) which indicates the financial stability of your company.

e. Describe your company's disaster recovery and contingency plans. Have you ever tested or actually implemented these plans?

f. Is your company currently for sale or involved in any transaction to expand or to become acquired by another business entity? If yes, please explain the impact both in organizational and directional terms.

g. Provide details of all past or pending litigation or claims filed against your company that would negatively impact your company's performance under an agreement with the A&M System.

h. Is your company currently in default on any loan agreement or financing agreement with any bank, financial institution, or other entity. If yes, specify date(s), details, circumstances, and prospects for resolution.

EXHIBIT D – QUESTIONNAIRE

Complete the attached questionnaire as instructed and include it in *Section k* of your RFP response.

General Instructions

A. When responding, please restate the question and provide your answer immediately thereafter.

B. Do not change the format of the Questionnaire. Do not change the numbering system within the Questionnaire. Do not leave any question blank. Do not change any questions. Do not provide an answer such as "it is in another exhibit" or "can be found under another question."

C. Provide all exhibits requested in the Questionnaire at the end of the Questionnaire.

D. The information given in response to the following questions should be based on an ASO arrangement.

E. Fees, expense schedules, charges, and management arrangements must be guaranteed for the initial three-year period through August 31, 2023.

F. Please base quantitative responses on the 12 months ending August 31, 2019, or the most recent 12-month period available, unless otherwise specified.

G. The A&M System operates on a fiscal year beginning September 1 and ending August 31.

Background Information

1. Where will the account representative be located? Will this individual have responsibility for other clients? If yes, how many?

2. Please provide the URL for your web site. How often is your online provider directory updated?

3. Would your employees use a secure e-mail system to communicate with us and, if so, what system do you use? Would you be able to establish a secure TLS channel between our organizations?

ASO Fees

4. Are there any start-up or "other" fees in addition to the ASO rate? If yes, identify and state the cost.

5. The A&M System expects any costs of the services below to be included in the ASO fee quoted in your proposal. Please confirm that is the case by completing the information below.

	Service	Included	Optional	Additional Cost
A	Identification cards (both initial & ongoing) printed & mailed to employee's homes			
B	Claim form printing			
C	Promotional material			
D	A&M Specific materials (i.e., emails, educational brochures, home mailings, videos, Brainsharks, fliers, one pager)			
E	Online access to eligibility and claims information by System Benefits Administration			
F	Hospital audits			
G	Bank reconciliation			
H	Monthly detailed claims file (via electronic media)			
I	Underwriting & actuarial support			
J	Electronically provide medical claims to prescription drug plan vendor			
K	Load prescription drug vendor claims into your system			
L	Management reports			
M	Representation at annual enrollment meetings			
N	Online access to claims by employees			
O	Collection of and sharing with the A&M System of SSNs as required by MMSEA Section 111			

Network

6. Comparing the *All Benefits Eligible* worksheet *(See Exhibit E - Demographics)* against your current network, provide a geo-access report based on driving distance answering the following questions:

    a. What number and percentage of employees/retirees are:
        1) In network – owned by you
        2) In network – rented by you, owned by another organization
        3) Non-network

    b. What number and percentage of employees/retirees have access to the following providers within a 10-mile radius?
        1) Two or more PCPs
        2) One or more Obstetricians
        3) One or more Mental Health Provider (MD)
        4) One or more Mental Health Provider (Ph.D.)
        5) One or more Mental Health Provider (MSW, LPC)

c. What number and percentage of employees/retirees have access to the following providers within a 25-mile radius?
   1) Two or more PCPs
   2) One or more Obstetricians
   3) One or more Mental Health Provider (MD)
   4) One or more Mental Health Provider (Ph.D.)
   5) One or more Mental Health Provider (MSW, LPC)

d. What number and percentage of employees/retirees have access to the following providers within a 25-mile radius?
   1) One or more Acute Care Hospitals
   2) One or more Mental Health Hospitals
   3) One or more Outpatient Surgical Centers (Include Acute Care Hospitals with OP Surgical services)

e. What number and percentage of employees/retirees have access to the following providers within a 50-mile radius?
   1) One or more Acute Care Hospitals
   2) One or more Mental Health Hospitals
   3) One or more Outpatient Surgical Centers (Include Acute Care Hospitals with OP Surgical services)

f. What number and percentage of employees/retirees have access to the following providers within a 25-mile radius?
   1) One or more Durable Medical Equipment companies
   2) One or more Home Health Agencies
   3) One or more Physical Therapy providers
   4) One or more Chiropractors
   5) One or more Freestanding Radiology Centers
   6) One or more Pathology Drawing Stations

g. What number and percentage of employees/retirees have access to the following providers within a 50-mile radius?
   1) One or more Durable Medical Equipment companies
   2) One or more Home Health Agencies
   3) One or more Physical Therapy providers
   4) One or more Chiropractors
   5) One or more Freestanding Radiology Centers
   6) One or more Pathology Drawing Stations

7. Comparing the *A&M Care Plan Enrollment* worksheet *(See Exhibit E - Demographics)* against your current network, provide a geo-access report based on driving distance answering the same questions noted in 6.a. through 6.g. above.

8. For those locations that the A&M System has a presence, but you do not have network coverage, how will you attempt to contract with hospitals and physicians?

9. Describe any significant network changes planned for implementation prior to or within six months after September 1, 2020.

10. Please provide information regarding services, available networks, and claim filing procedures outside the United States; particularly in Qatar, where we have employees (less than 250 benefit-eligible) at a satellite campus. The employees at the Qatar campus are provided the same plan benefits as those residing in the United States and are members of the A&M Care Plan.

11. Describe how the out-of-state and out-of-country networks are accessed.

12. Provide the number of participating physicians currently in your network by the following categories: Family/General Practice, Internal Medicine, Pediatric, OB/GYN, Mental Health, Other, Total. Please provide separate counts for Texas and nationally.

13. How long has your organization's PPO network been operational?

14. Please provide the number of clients and total lives enrolled in your network within the state of Texas and nationally for calendar year 2018, 2019 and currently.

15. Does your company own or lease its PPO networks? Provide details.

16. Please explain in detail how your program operates. Provide a detailed step-by-step description of how your network is accessed and operates.

17. Do you contract individually with physicians or on a group IPA basis? How are these physicians or groups represented in the directory? Please give a detailed explanation.

18. Explain the provisions and obligations of your organization and physicians within your network regarding cancellation of provider contracts.

19. What is your process for credentialing and re-credentialing hospitals and physicians? How often does the re-credentialing process occur? How long does the process take? Is there a mechanism that an employer or employee can use to recommend a provider for inclusion in the network?

20. What type of fee schedules are in place for your physician network, i.e., RBRVS, discount off billed charge, capitation, etc.? Please provide details.

21. Based on your response to number 20 above, what percentage of physician providers (separately for Texas & Book of Business (BOB)) are reimbursed using the various types of fee schedules?

Type of Schedule	% of Texas Providers	% of BOB
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Based on your response to number 20 above, what percentage of paid claims dollars (Texas & BOB) are made using the various types of fee schedules?

Type of Schedule	% of Paid Claims $ Texas	% Paid Claims $ BOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

23. Based on your response to number 20 above, what was your average percentage discount (Texas & BOB) from billed charge to paid amount (amount due from plan and employee) for the various types of fee schedules? Duplicate charges and non-approved charges should not be included in this calculation.

Type of Schedule	% Discount - Texas			% Discount - BOB		
	CY2017	CY2018	CY2019	CY2017	CY2018	CY2019
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____

24. What type of inpatient fee schedules are in place for your hospital network, i.e., DRG, per diem, discount off billed charge, etc.? Please provide details.

25. Based on your response to number 24 above, what percentage of hospital providers (Texas & BOB) are reimbursed using the various types of fee schedules?

Type of Schedule	% of Texas Providers	% of BOB
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

26. Based on your response to number 24 above, what percentage of paid claims dollars (Texas & BOB) are made using the various types of fee schedules?

Type of Schedule	% of Paid Claims $ Texas	% Paid Claims $ BOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. Based on your response to number 24 above, what was your average percentage discount (Texas & BOB) from billed charge to paid amount (amount due from plan and employee) for the various types of fee schedules? Duplicate charges and non-approved charges should not be included in this calculation.

Type of Schedule	% Discount - Texas			% Discount - BOB		
	CY2017	CY2018	CY2019	CY2017	CY2018	CY2019
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____

28. What type of outpatient fee schedules are in place for your hospital network, i.e. ASC rates, discount off billed charge, etc.? Please provide details.

29. Based on your response to number 28 above, what percentage of outpatient providers (Texas & BOB) are reimbursed using the various types of fee schedules?

Type of Schedule	% of Texas Providers	% of BOB Providers

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

30. Based on your response to number 28 above, what percentage of paid claims dollars (Texas & BOB) are made using the various types of fee schedules?

Type of Schedule	% of Paid Claims $ Texas	% Paid Claims $ BOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

31. Based on your response to number 28 above, what was your average percentage discount (Texas & BOB) from billed charge to paid amount (amount due from plan and employee) for the various types of fee schedules? Duplicate charges and non-approved charges should not be included in this calculation.

Type of Schedule	% Discount - Texas			% Discount - BOB		
	CY2017	CY2018	CY2019	CY2017	CY2018	CY2019
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____

32. Have your provider network discounts been evaluated and compared against those of other vendors by an independent third party? If so, provide a copy of the applicable documentation. A summary prepared by the proposer will not be considered adequate.

33. For your broadest PPO network, provide the provider discounts for 2019, 2018, and 2017, including all claims except Medicare.

34. Do you currently have contractual arrangements with non-network providers? If so, provide the following information concerning those contracts:
    a) Summarize the key provisions of those contracts related to participant access.
    b) Describe the reimbursement arrangements applicable to contracted non-network providers. Quantify the difference in reimbursement between (i) the level provided under these arrangements and (ii) network reimbursement for similar specialties in the same geographic region.
    c) Are contracted non-network providers allowed to balance bill for services?
    d) Complete the requested information on the Network file as instructed in *Section 3.15k* for contracted non-network providers.

35. Based on the Detail Claim file provided *(See Exhibit E)* what percentage of A&M Care claims for services provided by hospital-based physicians (radiologists, pathologists, anesthesiologists and ER) do you expect to be provided by network providers?

36. Based on the Detail Claim file provided *(See Exhibit E)* what percentage of in-network claims are expected to be paid under a subcontracted, rental or wrap network?

37. Describe initiatives to increase the number of network hospital-based providers as well as behavioral health providers.

38. What percentage of savings are retained by the Proposer and/or the subcontracted, rental or wrap network for in-network claims incurred through the subcontracted, rental or wrap network?

39. Are subcontracted rental or wrap networks included in your discount analysis? If so, what are the provider discounts specific to these subcontracted, rental or wrap networks?

40. When determining network discount and utilization, what factors are used in this calculation?

41. Does your network discount calculation included in response to 33 above exclude any claims? Please identify any of the following that are excluded and include any applicable dollar thresholds:
    a) Medicare claims
    b) Out-of-Network claims
    c) Catastrophic claims
    d) Claims where the paid amount equals the billed charges
    e) Mental Health and substance abuse claims
    f) Durable Medical Equipment and anesthesia
    g) Subcontracted, rental or wrap network claims

h) Claims from contracting providers where the billed amount equals the allowed

i) Claims from non-contracting providers where the billed amount equals the allowed

j) Large claims

k) Stop loss claims

l) Specialty facilities

m) Pathology

n) Radiology

o) Neonatology

42. List any additional exclusions not identified in the previous item. What percentage of total claims do the excluded claims represent in your book of business?

43. Is network utilization based on how a claim was paid or submitted?

44. Is the requested provider network information you provided in *Section k.* of your response (See *Section 3.15k. Network* of the RFP) identical to those utilized in the discount information provided above and in response to the Detailed Claims Repricing *(See Section 3.15k. Provider Reimbursement Report Form 5)?*

45. Do you utilize capitated networks (ex. behavioral health)? If yes, do you retain a percentage of the savings? If yes, what percentage?

46. Do you negotiate large balance bills on behalf of participants? If yes, do you retain a percentage of the savings? If yes, what percentage? How are the savings and withhold tracked and reported?

47. In what situations may a participant be balance billed for costs exceeding the allowed amount?

48. Do you retain a percent of savings related to duplicate claim denials?

49. Are you willing to provide a quote without any shared savings?

50. Do your facility contracts in which reimbursement is based on a percentage of charges have stop-loss provisions? Please describe, including any limits to the stop-loss provision.

51. What was the turnover rate of physicians, hospitals, and ancillary providers in your network in CYs 2017, 2018, and 2019? Please differentiate between voluntary and involuntary turnover.

52. Provide information concerning the most common out-of-network reimbursement bases used by the Proposer in Texas.

a) The information should be provided separately for facilities and professional providers.

b) Among professional providers, the information should be provided separately for hospital-based and non-hospital based providers.

c) Reimbursement should be expressed relative to Medicare reimbursement levels

d) Reimbursement should be compared to that of similar network providers.

53. Describe the options available to the A&M System to reimburse out-of-network providers. Can the vendor vary out-of-network reimbursement by region and/or specialty?

54. Discuss the Proposer's ability to administer unique financial reimbursement arrangements with providers, including, but not limited to, hospitals and physician hospital organizations, that have different discounts from the Proposer's current agreement.

55. Describe any new or creative network design Proposer offers which drives member engagement in the plan.

56. Does Proposer have high performing providers in its network and if so, how does Proposer promote these high performing providers to participants? How does the Proposer define "high performing"?

Utilization Review

57. Describe your organization's utilization review and pre-certification process as it relates to pre-admission review, concurrent review, discharge planning, large case management, and any other services provided. (See SPD at http://www.tamus.edu/assets/files/benefits/pdf/spdhealth.pdf for current policy)

58. If utilization review services are subcontracted, provide the name and location that is proposed to provide these services.

59. Describe the measures your organization has in place to discourage inappropriate utilization of low value, high cost treatments or services?

60. Describe the frequency with which your organization reviews utilization for new cost and trend drivers and what measures are in place to address emerging issues.

61. Discuss how your organization coordinates cost containment efforts with an unaffiliated Pharmacy Benefit Manager (PBM).

Administration

62. Please provide the location of the office where the following functions are performed and note how long the office has been in operation.
    a. Account Manager/Account Representative
    b. Claims processing
    c. Eligibility processing
    d. Utilization review
    e. Customer service
    f. Mental health/substance abuse management
    g. Web site management
    h. ID card mailing

63. During the month of July, the A&M System holds between twenty and twenty-five enrollment meetings throughout the state of Texas. These meetings are voluntary for employees and retirees, however should you be awarded this contract, a representative from your organization will be required to be in attendance at each meeting. When you downloaded the RFP, you should have also downloaded a supplemental file listed in *Exhibit E* named *Sample Annual Enrollment Calendar* which contains a copy of the 2019 annual enrollment meeting calendar for your reference. If you failed to download the file, you can do so by returning to the ESBD. Please indicate your willingness to meet this requirement.

Claims Processing

64. Would your organization establish a dedicated or designated claims processing unit for the A&M System?

65. For the office that would process A&M System claims, please provide:
    a. the number of clients for whom you process claims
    b. the number of covered employees for whom you process claims
    c. the number of claims processors

66. What additional responsibilities do claim processors have (e.g., telephone inquiries, correspondence, filing, opening mail, etc.)?

67. How long is an individual claimant's payment history maintained online? Can System Benefits Administration staff view the information online as well?

68. Are you able to coordinate benefits for employees/retirees covered under multiple plans? Please describe the coordination process in detail.

69. Describe in detail how out-of-state and out-of-country claims are processed. The A&M System has some (less than 500) individuals who work outside of the United States. The international employees are not identifiable from the supplemental demographic files you downloaded. They are included in the demographic files with their "work" zip code rather than a foreign address code. We will be able to flag those individuals for the carrier who is awarded the bid.

70. What is your organization's goal for claims turnaround time? What have the actual results been in the past twelve months in the office that will process A&M System claims?

71. Please describe in detail the recoupment process for an ASO group when a provider overpayment is identified. Include in your description, what reports, such as an accounts receivable aging report, would be available for the A&M System to monitor recovery of overpayments.

72. Describe claim accuracy performance standards. Provide the 2018 and 2019 actual accuracy performance for the claim office that will process A&M System claims.

73. Please confirm your organizations ability to coordinate reviews by an Independent Review Organization in connection with the appeal process for adverse benefit determinations. Describe the process your organization has in place to provide such services and any additional costs associated with providing this service.

74. In a claim appeal situation, can you confirm that you can provide a specialist in the applicable medical field of study for peer-to-peer review? If so, explain the process and any additional cost.

75. What percentage of payments is made electronically for the following providers? a) Hospitals, b) Other Facilities, c) Physicians

76. In the most recent 12-month period for your book of business, what percentage of claims were processed systematically without any manual intervention?

Customer Service

77. How would you monitor and control the level of service provided to A&M System employees? How are patterns of customer service inquiries monitored and used to improve claims processing activities?

78. Do you provide any automated customer service via voice response for routine questions?

79. Please identify the number of bilingual customer service personnel that will be assigned to the A&M System account. Identify languages spoken.

80. Do you have an app that members can use? If so, would you be able to provide test access?

81. Does your organization conduct member and/or provider satisfaction surveys? Please provide a copy of the survey questionnaire and the results of the most recent surveys.

82. Can employees access specific claim information via your web site to determine the status of claims and make inquiries?

83. Would you be willing to provide a dedicated on-site representative to assist with claims issues and member questions at no additional cost?

Eligibility

84. The System Office currently provides a single eligibility file including information for all System Members (System Member identification is not required) on a weekly basis in the most current HIPAA 834 format via secure FTP from our server to the carrier's server. You will have a central point of contact in SBA and a technical contact. We expect the selected Proposer to email a discrepancy report to the SBA eligibility contact for review and assistance in resolving outstanding issues within a few days of your receipt of an eligibility file. Please confirm your ability to do this.

85. Who has the ability to alter eligibility information in your organizational structure?

86. Does your system accept future start and termination dates for participants?

87. What is the turnaround time goal for loading eligibility information received from the employer? What has your actual performance been for the last six months?

88. Does a retroactively terminated employee/retiree pose any system problems for your organization? Is there a time limit beyond which you cannot process retroactive actions?

89. What is the length of the street address field in your system?

90. Are you able to provide an ID card with the dependent spouse's name in order to accommodate dependent spouses who have a different last name than the member?

91. The A&M System will require the selected vendor to use the A&M System generated unique identifying number (UIN) rather than a social security number for all participants on all documents, including ID cards. Please confirm your acceptance of this requirement.

    The A&M System has assigned each employee, retiree, and dependent an internally unique identifier (a 9-digit number with the 4th and 5th digits equal to 0.) The A&M System has the capability to pass both the SSN and the unique identifier on the eligibility file. Verify your willingness to use the A&M System unique identifier as the primary identification for individuals, including ID cards, claims processing, customer service, and provider calls. In addition to our UIN, will you be able to also store social security numbers in the event an individual/provider does not have the UIN available?

System Capabilities

92. What claim payment software do you use for medical claims processing?

93. How long have you been using this software? When was the last substantial upgrade?

94. Are you aware of plans for software conversions prior to September 1, 2020 or within the next five years?

95. Which of the following features are inherent to your current claims payment software?

	Feature	Yes or No
a.	"Hard coded" plan design	
b.	Direct eligibility interface	
c.	Deductible applied and calculated	
d.	Out-of-pocket applied and calculated	
e.	Combining medical & Rx claims for out-of-pocket maximum	
f.	Annual and lifetime accumulators by Type of Service	
g.	Duplicate payment edit	
h.	Interface to pre-certification data	
i.	Identifies potential COB	
j.	Dependent eligibility information (name, DOB, relationship)	

96. Please indicate if the following require system or manual intervention?

		System Intervention or Manual Intervention

a.	"Hard coded" plan design	
b.	Per diem reimbursement	
c.	DRG reimbursement	
d.	Employee copayment per occurrence	
e.	Physician fee schedule	
f.	Risk or capitation basis	

97. Please provide the details of any portion of the current plan design that your system is unable to administer.

98. The A&M System has implemented **Workday** as its Human Capital Management System. Benefits were included in this implementation. Does your organization currently have a relationship with Workday? Do you have an existing Cloud Connect for Benefits (CCB) integration with Workday? Do you use weekly full files for your eligibility transfers?

99. Please describe the system (purchased, internally customized, proprietary, built in partnership with another vendor) and the information the customer service and clinical care management teams have access to. Are the customer service and care management systems integrated so that the team will see similar information?

100. Please describe how the system setup helps the customer service team member or clinical team member address member issues holistically. Are there alerts or notifications that direct the team members to discuss any programs or benefits that may be applicable to the member?

Performance Guarantees

101. Are you willing to put some amount of fees at risk and how much for:
- Claim processing accuracy,
- Claim financial accuracy,
- Claim payment turnaround time,
- On-time ID card distribution (each year),
- Member service response time and accuracy,
- Maintaining appropriate network access standards,
- Customer Service standards,
- COB and Subrogation management,
- Interstate claims processing turnaround and accuracy,
- Timeliness of recouping overpayments,
- Timely completion of Administrative Agreement, HIPAA Business Associate Agreement, and any other required legal documentation
- Other

What methodology and standards would you propose for calculating and reporting this information?

Healthcare Innovation

102. The A&M System is interested in learning about Proposers capabilities for network development, provider reimbursement, administration and wellness programs that are intended to be innovative, unique solutions to healthcare quality and cost in both the short and long term. With that in mind, please describe any innovative or unique product offerings the Proposer has recently developed and implemented during the past two years or is in the process of developing. Such innovations may include but are not limited to narrow, high performance networks, incentivized plan designs, shared savings reimbursement models, etc.

103. For any innovations that have been implemented please describe any Return on Investment (ROI) that has been calculated.

Management Reporting

104. Please describe your data analysis and reporting capabilities. Do you have customized reporting capabilities? Is there an additional cost involved with customized reporting?

105. Please provide a list and a brief explanation of your standard reports including frequency of production and availability following the close of the reporting period. Are reports available electronically? (The A&M System expects the standard report package to be provided at no additional cost.)

106. What additional ad hoc reports are available and at what cost?

107. Does your organization offer online access for SBA management to run management or utilization reports, eliminating the need for paper reports and allowing immediate access? Please describe what is available online and if there is an additional cost for such services.

108. What additional data assessment services are available? Do you have a statistician than can assist with data analysis? If so, is there an additional cost?

109. Discuss your reporting capabilities, including but not limited to participation, sustained engagement, health outcomes, savings, etc. at a plan and institution level, in the context of supporting ongoing wellness and condition management efforts. Provide sample reports that demonstrate the Proposer's reporting capabilities in relation to wellness and other care management.

Quality Assurance

110. Do you have a formalized claims auditing (accuracy) program?

111. How is the claims auditing program administered?

112. What percent of claims are subject to internal claim office audit?

113. What is the name of the senior executive who is responsible for the Quality Assurance program?

114. Does your Quality Assurance program include both the quality of clinical care as well as the quality of service?

115. Describe how your PPO/Network evaluates the continuity and coordination of care members receive.

116. How does your PPO/Network detect under-utilization as well as over-utilization? Explain what mechanisms are used in this process.

Implementation

117. How much lead-time would you need to implement the program from the time you are selected? Please provide a detailed timetable for implementation based on a September 1, 2020 start date.

118. Describe the services you will furnish with respect to installation of the plan, and for maintenance.

119. Provide a sample work plan illustrating the transition of a client to you from the previous carrier (include data requirements, dates, etc.).

Samples

120. Please provide samples of the following:
    a. Explanation of Benefit
    b. Standard Claims Processing communications (including subrogation letters, denial letters)
    c. Standard (no additional cost) management reports
    d. Optional (additional cost) management reports

Banking Arrangements

121. Describe your proposed banking arrangement/payment transfer and reconciliation procedures. Include if you plan to require the A&M Care plans to reimburse you as you issue checks to providers and members or at the time checks clear the bank.

Subcontracting

122. Are any activities subcontracted, i.e. Mental Health Services, Utilization Review Services, Claim Audit Services? If so, please provide the subcontractors name, services performed and detailed information describing under what circumstances subcontractors are used? Make certain you comply with *Section 3.15i.* of this RFP.

Wellness and Disease Management Programs

The A&M System is interested in offering disease management programs that improve member's health and help reduce medical costs.

The following are highlights of the disease management and wellness initiatives in the A&M Care Plan:

- Wellness Incentive – A premium differential of $30 per month is added to the premium for each active employee and covered spouse (not applicable to retirees/spouses or those covered under the J Plan) who does not complete an annual wellness exam and health assessment. 78% of the applicable population completed exams for the plan year beginning September 1, 2019. For the current fiscal year, The A&M System will incorporate a personal checklist (PCL) with five options from which the employee and covered spouse can choose two to complete for the wellness exam incentive. The PCL will include five of the following options preventive exams, recommended cancer screenings, self-management programs, weight loss programs, and registration with our telemedicine provider.
- Tobacco Use Premium – An additional premium differential of $30 per month is added to the premium for each employee, retiree, or spouse who self-reports as a tobacco user.
- Tobacco Cessation products are covered under the prescription drug benefit administered by Express Scripts.
- Wellness Grants – SBA is in the seventh year of making wellness grants available to individual System Members based on an application process. The A&M System Chancellor has made limited funds available to each System Member for improving wellness through healthy living programs. Each System Member has designed a wellness program to meet the needs of their respective workforce and submits an application for funds to SBA for approval.
- 100% coverage for preventive care, as provided for by the ACA requirements. This includes, but is not limited to routine annual exams, children's immunizations, preventive colonoscopies, screenings for diabetes, cholesterol, blood pressure, HIV, depression, STDs, breast & prostate cancer,
- Participation in Blue Cross and Blue Shield of Texas' Well Being Management program which integrates medical, prescription drug, lab, and HRA data, concentrating on those identified as moderate and high risk and intervening by telephone and letter with physicians and members. Also included are fitness programs, health and wellness communication campaigns, health counseling with nurse-line and personal health manager online tools for weight management and tobacco cessation including coaches,
- Participation in Express Scripts' Rational Med program which integrates medical claims, and lab data with prescription drug claims and provides outreach to physicians and pharmacists with health and safety risk information and opportunities for improvement in quality of care.

123. Provide a list with a detailed description of the disease management programs currently offered, whether or not you would recommend the program for the A&M Care population, and the cost associated with each, if any.

124. BCBSTX, the current medical TPA provides ESI, the current prescription drug administrator, with a weekly file of individuals that BCBSTX case managers or chronic condition managers have been unsuccessful in contacting. If a member calls ESI and is on the list, ESI customer service will perform a warm transfer to BCBSTX after completing the call. Is your organization able and willing to send such a file to ESI? Are you currently providing this service for any of your clients?

125. Are you willing to provide a monthly detailed claims data set to ESI, the current prescription drug administrator? Do you currently provide monthly detailed claims data sets to ESI or other PBMs for your clients?

126. Are you willing to receive and load a monthly detailed claims data set from ESI, the current prescription drug administrator, to enhance your disease management efforts? Do you currently have this process in place with ESI or other PBMs?

127. What is the staffing ratio of active cases to case managers?

128. How do you document the return on investment for disease management programs?

129. Provide samples of your disease management reports.

130. Does your website have a location available to disease management enrollees to search for and read information about their disease, post questions, and report vital statistics, such as their daily weight or medication use? Provide your URL and a user name/password where we may review what is available.

131. Do you carry professional liability insurance for the clinicians in your disease management unit?

Wellness and Preventive Programs

132. Provide a list with a detailed description of your wellness programs currently offered, whether or not you would recommend the program for the A&M Care population, and the cost associated with each, if any. Are these programs offered in-house or outsourced?

133. What are some examples of how you have partnered with employers to create wellness programs tailored to their needs?

134. Do you currently work with any of your employer groups to provide local biometric screenings and/or participate in local health fairs? What is the cost associated with these activities?

135. Do you have the ability and will you agree to provide a weekly file to the A&M System or a third party administrator for the wellness incentive program with a list of employees and their spouses who have completed a wellness exam as well as any other requested preventive exams and the date performed?

136. Do you have a location on your employee health portal (website) where an employee could see the wellness "credit" had been completed for this year? Next year?

137. Would you be willing to provide a dedicated on-site wellness coordinator who could travel to our different locations and assist with their individual programs at no additional cost?

Value Added Benefits

138. What type of value added benefits are available to A&M System employees?

139. Do you offer value added discount services for fitness facilities or alternative medicine such as acupuncture, herbal medicine, etc.?

140. What other benefit or wellness vendors do you partner with that could provide addition services to our employees on your platform? (Examples: Sleepio, Happify, Emindful, Evive, Castlight, Grand Rounds, 2ndMD, Catapult, Ovia, MD Live, etc.)

141. Please describe your level of integration with potential vendors. Describe any current integration in place including any file feeds or processes that might be leveraged for the A&M System.

Communications/Promotion

142. What communications materials are included in your standard offering (i.e., posters, emails, postcards, etc.)? Will the A&M System be able to customize these materials without incurring additional fees? Please provide details and samples. What communications materials may be provided as a buy-up?

143. The A&M System will be looking for its vendor partner to design and execute a communication and promotion plan. Outline how your organization would work with us to design the communications strategy for launch and ongoing campaigns to promote your programs and other our initiatives based on your standard level of marketing support.

Medical Evacuation and Repatriation

144. Please discuss what you can provide in the area of travel assistance for those living or spending extended periods abroad, as well as foreign nationals living in the United States, with medical emergencies giving particular emphasis on medical evacuation and repatriation coverage for both United States citizens and foreign nationals.

145. Describe how your firm will coordinate and pay for the traveler to return to their point of origin or home country following an emergency medical evacuation and stabilization.

146. Please describe in detail how assistance and emergency cases will be handled, addressing at a minimum the following in your response:

- Is there a centralized case management team? How are the services delivered?
- Are assistance services provided in-house or through a third party? What is the case review process?

147. Describe the specific triggers, including any waiting periods, used to determine whether a member is eligible for medical evacuation.

148. Do you outsource medical evacuation services? Do you contract directly with a preferred provider for a given service (air ambulance, evacuation assistance) or in a given area of the world?

149. Please describe in detail your role and that of the member when access to medical care is required in a medical emergency situation.

150. During emergencies, how do you communicate status updates on insured individuals to administrators?

151. During emergencies, how do you coordinate with the Medical Carrier?

152. Do you have on-staff crisis management personnel serving as direct liaison during any medical or legal emergency with participants, including mental health?

153. Please describe how your firm would coordinate and pay for dependent children to be returned home if a traveler is hospitalized.

154. Please describe how services are provided (i.e., dispatch or physician or specialist or by transport to nearest hospital). Please describe how hospitals and emergency transportation are vetted. Please describe consultation and follow-up services for individuals receiving treatment and communication with University representatives.

155. How do you handle coverage in countries such as Cuba, and countries currently embargoed by the U.S. such as Iran, North Korea, Sudan (North) and Syria?

EXHIBIT E – SUPPLEMENTAL FILES TO RFP INSTRUCTIONS

You should have downloaded the following files along with the RFP instructions. If you failed to download these files, you can do so by returning to the Electronic State Business Daily where you downloaded the RFP.

- **Price Proposal Worksheet –** *See Section 3.15k.*
- **Network -** *See Section 3.15k.*
- **Provider Reimbursement -** *See Section 3.15k.*
- **Detail Claims –** *See Section 3.15k. and Exhibit D, Questions 35 and 36*
- **A&M System Claims Experience** – *See Section 3.14*
- **Demographics** – *See Section 1.4 and Exhibit D, Questions 6 and 7*
  The file contains two worksheets, with both providing demographic information based on the zip code and the employee/retiree age. The worksheets represent a snapshot of enrollment as of October 2019. The same explanation of valid values applies to both worksheets noted below. These two worksheets will be used to run geo-access reports requested in questions 6 and 7 in the Questionnaire, *Exhibit D* of the RFP, to be included in *Section k*. of your response.

Field	Valid Values
Zip Code	Participant's Zip Code
Age	Participant's Age
Employee Status	A – Active, C – COBRA (employees), I – Incapacitated (disability retiree), K – COBRA (dependents), L – Leave of Absence, R – Retired, S – Survivor, W – Working Retiree
Type of Coverage	E – Employee Only, S – Employee & Spouse, C – Employee & Children, F – Employee & Family
Full-Time/Part-Time	FT – Full-time, PT – Part-time, blank – not working
Enrollment Status	PPO – A&M Care Plan, GS – Graduate Student Plan, blank - none
PPO Plan Code	1 – A&M Care Plan, 3 – A&M Care 65 Plus Plan, 4 – A&M Care J Plan
Male Participants	Numerical Count
Female Participants	Numerical Count
Male Spouses	Numerical Count
Female Spouses	Numerical Count
Male Child	Numerical Count
Female Child	Numerical Count

Worksheet # 1 – All Benefits Eligible

The first worksheet provides demographic information for all those who are benefit eligible, i.e. A&M Care Plan, Graduate Student Plan, those certifying that they have medical coverage other than through the A&M System and are allowed to use up to half of the employee-only employer contribution to pay for optional benefit plan coverage, and those who are eligible, but opt not to take A&M System health coverage. Dependent information is provided only for those who are currently enrolled in a health plan with dependent coverage. **In order to arrive at the appropriate number of participants (employees and retirees), you will need to sum the "Male Participants" and "Female Participants" columns and add them together. In order to arrive at the appropriate number of dependents, you will need to sum the "Male Spouses," "Female Spouses," "Male Children," and "Female Children" columns and add them together. You CANNOT just count the number of lines in the file since many lines include multiple individuals.**

Worksheet # 2 – A&M Care Plan Enrollment

The second worksheet provides demographic information only for those enrolled in the A&M Care plans. Dependent information is provided only for those who are currently enrolled in the A&M Care Plan with dependent coverage. **In order to arrive at the appropriate number of participants (employees and retirees), you will need to sum the "Male Participants" and "Female Participants" columns and add them together. In order to arrive at the appropriate number of dependents, you will need to sum the "Male Spouses," "Female Spouses," "Male Children," and "Female Children" columns and add them together. You CANNOT just count the number of lines in the file since many lines include multiple individuals.**

- **Sample Annual Enrollment Calendar:**

The PDF file is a copy of the annual enrollment meeting calendar from July 2019 and is provided to give you an idea of the number and location of meetings that you would be required to attend. See question 60 in *Exhibit E*.

EXHIBIT F – HIPAA BUSINESS ASSOCIATE AGREEMENT – (DRAFT, DO NOT EXECUTE)

THIS BUSINESS ASSOCIATE AGREEMENT (this "Agreement") between The Texas A&M University System ("A&M System"), an agency of the State of Texas, on behalf of the A&M Care Plan **("Covered Entity")** and **("Business Associate")**, shall be effective **(the "Effective Date")**. All terms used in this Agreement and not defined herein which are defined under Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), including *45 C.F.R. Parts 160* and *164* ("Privacy Rule"), shall have the meanings set forth in the applicable definition under HIPAA.

Covered Entity and Business Associate have entered into, are entering into, or may subsequently enter into, agreements or other documented arrangements (collectively, the "Business Arrangements") pursuant to which Business Associate may provide products and/or services for Covered Entity that require Business Associate to access, create, maintain, and use health information that is protected by state and/or federal law.

Pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the U.S. Department of Health & Human Services ("HHS") promulgated the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), at 45 C.F.R. Parts 160 and 164, requiring certain individuals and entities subject to the Privacy Standards (each a "Covered Entity", or collectively, "Covered Entities") to protect the privacy of certain individually identifiable health information ("Protected Health Information" or "PHI").

Pursuant to HIPAA, HHS issued the Security Standards (the "Security Standards"), at 45 C.F.R. Parts 160, 162 and 164, for the protection of electronic protected health information ("EPHI").

In order to protect the privacy and security of PHI, including EPHI, created or maintained by or on behalf of the Covered Entity, the Privacy Standards and Security Standards require a Covered Entity to enter into a "business associate agreement" with certain individuals and entities providing services for or on behalf of the Covered Entity if such services require the use or disclosure of PHI or EPHI.

On February 17, 2009, the federal Health Information Technology for Economic and Clinical Health Act was signed into law (the "HITECH Act"), and the HITECH Act imposes certain privacy and security obligations on Covered Entities in addition to the obligations created by the Privacy Standards and Security Standards.

The HITECH Act revises many of the requirements of the Privacy Standards and Security Standards concerning the confidentiality of PHI and EPHI, including extending certain HIPAA and HITECH Act requirements directly to Business Associates.

The HITECH Act requires that certain of its provisions be included in business associate agreements, and that certain requirements of the Privacy Standards be imposed contractually upon Covered Entities as well as Business Associates.

The Texas Legislature has adopted certain privacy and security requirements that are more restrictive than those required by HIPAA and HITECH, and such requirements are applicable to Business Associates as "Covered Entities" as defined by Texas law; and because Business Associate and Covered Entity desire to enter into this Business Associate Agreement, in consideration of the mutual promises set forth in this Agreement and the applicable Business Arrangements, and other good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, the parties agree as follows:

I. Definitions

a. Except as otherwise defined in this Agreement, all capitalized terms used in this Agreement shall have the meanings set forth in HIPAA.

b. "**Business Associate**" shall have the same meaning to the term "Associate" under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

c. "**Breach**" shall mean the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted by the HIPAA Privacy Rule that compromises the security or privacy of the Protected Health Information as defined, and subject to the exceptions set forth, in 45 CFR § 164.402.

d. "**Covered Entity**" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

e. "**Data Aggregation Services**" shall mean the combining of PHI or EPHI by Business Associate with the PHI or EPHI received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of, payment to, and treatment of patients by the respective covered entities.

f. "**Electronic Protected Health Information**" shall mean Protected Health Information that is transmitted or maintained in Electronic Media.

g. "**HIPAA**" shall mean the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended and supplemented by the HITECH Act and its implementing regulations, as each is amended from time to time.

h. "**HIPAA Breach Notification Rule**" shall mean the federal breach notification regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Part 164 (Subpart D).

i. "**HIPAA Privacy Rule**" shall mean the federal privacy regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Parts 160 and 164 (Subparts A & E).

j. "**HIPAA Security Rule**" shall mean the federal security regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Parts 160 and 164 (Subparts A & C).

k. "**HITECH Act**" shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and all its implementing regulations, when and as each is effective and compliance is required.

l. "**Protected Health Information of PHI**" shall mean Protected Health Information, as defined in 45 CFR § 160.103, and is limited to the Protected Health Information received, maintained, created or transmitted on behalf of, Covered Entity by Business Associate in performance of the Underlying Services.

m. "**Underlying Services**" shall mean, to the extent and only to the extent they involve the creation, maintenance, use, disclosure or transmission of Protected Health Information, the services performed by Business Associate for Covered Entity pursuant to the Underlying Services Agreement.

n. "**Underlying Services Agreement**" shall mean the written agreement(s) (other than this Agreement) by and between the parties as amended as set forth in the attached schedule by and between the parties pursuant to which Business Associate access to, receives, maintains, creates or transmits PHI for or on behalf of Covered Entity in connection with the provision of the services described in that agreement(s) by Business Associate to Covered Entity or in performance of Business Associate's obligations under such agreement(s).

II. Business Associate Obligations.

Business Associate may receive from Covered Entity, or create or receive or maintain on behalf of Covered Entity, health information that is protected under applicable state and/or federal law, including without limitation, PHI and EPHI. All references to PHI herein shall be construed to include EPHI. Business Associate agrees not to use or disclose (or permit the use or disclosure of) PHI in a manner that would violate the Privacy Standards, Security Standards the HITECH Act, or Texas law, including without limitation the provisions of Texas Health and Safety Code Chapters 181 and 182 as amended by HB 300 (82nd Legislature), effective September 1, 2012, in each case including any implementing regulations as applicable (collectively referred to hereinafter as the "Confidentiality Requirements") if the PHI were used or disclosed by Covered Entity in the same manner.

III. Use of Protected Health Information

Except as otherwise required by law, Business Associate shall use PHI in compliance with 45 C.F.R. § 164.504(e). Furthermore, Business Associate shall use PHI (i) solely for Covered Entity's benefit and only for the purpose of performing services for Covered Entity as such services are defined in Business Arrangements, (ii) for Data Aggregation Services (as herein defined), and (iii) as necessary for the proper management and administration of the Business Associate or to carry out its legal responsibilities, provided that such uses are permitted under federal and state law. For avoidance of doubt, under no circumstances may Business Associate sell PHI in such a way as to violate Texas Health and Safety Code, Chapter 181.153, as amended by HB 300 (82nd Legislature), effective September 1, 2012, nor shall Business Associate use PHI for marketing purposes in such as manner as to violate Texas Health and Safety Code Section 181.152, or attempt to re-identify any information in violation of Texas Health and Safety Code Section 181.151, regardless of whether such action is on behalf of or permitted by the Covered Entity. To the extent not otherwise prohibited in the Business Arrangements or by applicable law, use, creation and disclosure of de-identified health information, as that term is defined in 45 CFR § 164.514, by Business Associate is permitted.

IV. Disclosure of Protected Health Information

Subject to any limitations in this Agreement, Business Associate may disclose PHI to any third party persons or entities as necessary to perform its obligations under the Business Arrangement and as permitted or required by applicable federal or state law. Business Associate recognizes that under the HIPAA/HITECH Omnibus Final Rule, Business Associates may not disclose PHI in a way that would be prohibited if Covered Entity made such a disclosure. Any disclosures made by Business Associate will comply with minimum necessary requirements under the Privacy Rule and related regulations.

Business Associate shall not, and shall provide that its directors, officers, employees, subcontractors, and agents, do not disclose PHI to any other person (other than members of their respective workforce), unless disclosure is required by law or authorized by the person whose PHI is to be disclosed. Any such disclosure other than as specifically permitted in the immediately preceding sentences shall be made only if such disclosee has previously signed a written agreement that:

a.) Binds the disclosee to the provisions of this Agreement pertaining to PHI, for the express benefit of Covered Entity, Business Associate and, if disclosee is other than Business Associate, the disclosee;

b.) Contains reasonable assurances from disclosee that the PHI will be held confidential as provided in this Agreement, and only disclosed as required by law for the purposes for which it was disclosed to disclosee; and,

c.) Obligates disclosee to immediately notify Business Associate of any breaches of the confidentiality of the PHI, to the extent disclosee has obtained knowledge of such breach.

Business Associate shall not disclose PHI to any member of its workforce and shall provide that its subcontractors and agents do not disclose PHI to any member of their respective workforces, unless Business Associate or such subcontractor or agent has advised such person of Business Associate's obligations under this Agreement, and of the consequences for such person and for Business Associate or such subcontractor or agent of violating them as memorialized in a business associate agreement pursuant to the HIPAA/HITECH Omnibus Final Rule. Business Associate shall take and shall provide that each of its subcontractors and agents take appropriate disciplinary action against any member of its respective workforce who uses or discloses PHI in contravention of this Agreement

In addition to Business Associate's obligations under Section IX, Business Associate agrees to mitigate, to the extent commercially practical, harmful effects that are known to Business Associate and is the result of a use or disclosure of PHI by Business Associate or Recipients in violation of this Agreement.

V. Access to and Amendment of Protected Health Information

Business Associate shall (i) provide access to, and permit inspection and copying of, PHI by Covered Entity; and (ii) amend PHI maintained by Business Associate as requested by Covered Entity. Any such amendments shall be made in such a way as to record the time and date of the change, if feasible, and in accordance with any subsequent requirements promulgated by the Texas Medical Board with respect to amendment of electronic medical records by HIEs. Business Associate shall respond to any request from Covered Entity for access by an individual within seven (7) days of such request and shall make any amendment requested by Covered Entity within twenty (20) days of the later of (a) such request by Covered Entity or (b) the date as of which Covered Entity has provided Business Associate with all information necessary to make such amendment. Business Associate may charge a reasonable fee based upon the Business Associate's labor costs in responding to a request for electronic information (or the fee approved by the Texas Medical Board for the production of non-electronic media copies). Business Associate shall notify Covered Entity within five (5) days of receipt of any request for access or amendment by an individual. Covered Entity shall determine whether to grant or deny any access or amendment requested by the individual. Business Associate shall have a process in place for requests for amendments and for appending such requests and statements in response to denials of such requests to the Designated Record Set, as requested by Covered Entity.

VI. Accounting of Disclosures

Business Associate shall make available to Covered Entity in response to a request from an individual, information required for an accounting of disclosures of PHI with respect to the individual in accordance with 45 CFR § 164.528, as amended by Section 13405(c) of the HITECH Act and any related regulations or guidance issued by HHS in accordance with such provision.

VII. Records and Audits

Business Associate shall make available to the United States Department of Health and Human Services or its agents, its internal practices, books, and records relating to the use and disclosure of PHI received from, created, or received by Business Associate on behalf of Covered Entity for the purpose of determining Covered Entity's compliance with the Confidentiality Requirements or the requirements of any other health oversight agency, in a time and manner designated by the Secretary.

VIII. Implementation of Security Standards; Notice of Security Incidents

Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as expressly permitted under this Agreement. Business Associate will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate acknowledges that the HITECH Act requires Business Associate to comply with 45 C.F.R. §§164.308, 164.310, 164.312 and 164.316 as if Business Associate were a Covered Entity, and Business Associate agrees to comply with these provisions of the Security Standards and all additional security provisions of the HITECH Act.

Furthermore, to the extent feasible, Business Associate will use commercially reasonable efforts to secure PHI

through technology safeguards that render such PHI unusable, unreadable and indecipherable to individuals unauthorized to acquire or otherwise have access to such PHI in accordance with HHS Guidance published at 74 Federal Register 19006 (April 17, 2009), or such later regulations or guidance promulgated by HHS or issued by the National Institute for Standards and Technology ("NIST") concerning the protection of identifiable data such as PHI. Lastly, Business Associate will promptly report to Covered Entity any successful Security Incident of which it becomes aware. At the request of Covered Entity, Business Associate shall identify: the date of the Security Incident, the scope of the Security Incident, the Business Associate's response to the Security Incident and the identification of the party responsible for causing the Security Incident, if known.

IX. Data Breach Notification and Mitigation

HIPAA Data Breach Notification and Mitigation. Business Associate agrees to implement reasonable systems for the discovery and prompt reporting to Covered Entity of any "breach" of "unsecured PHI" as those terms are defined by 45 C.F.R. §164.402. Specifically, a breach is an unauthorized acquisition, access, use or disclosure of unsecured PHI, including ePHI, which compromises the security or privacy of the PHI/ePHI. A breach is presumed to have occurred unless there is a low probability that the PHI has been compromised based on a risk assessment of at least the factors listed in 45 C.F.R. § 164.402(2)(i)-(iv) (hereinafter a "HIPAA Breach"). The parties acknowledge and agree that 45 C.F.R. § 164.404 governs the determination of the date of discovery of a HIPAA Breach. In addition to the foregoing and notwithstanding anything to the contrary herein, Business Associate will also comply with applicable state law, including without limitation, Section 521 Texas Business and Commerce Code, as amended by HB 300 (82nd Legislature), or such other laws or regulations as may later be amended or adopted. In the event of any conflict between this section, the Confidentiality Requirements, Section 521 of the Texas Business and Commerce Code, and any other later amended or adopted laws or regulations, the most stringent requirements shall govern.

Discovery of Breach. Business Associate will, following the discovery of a HIPAA Breach, notify Covered Entity without unreasonable delay and in no event later than the earlier of the maximum of time allowable under applicable law or three (3) business days after Business Associate discovers such HIPAA Breach, unless Business Associate is prevented from doing so by 45 C.F.R. §164.412 concerning law enforcement investigations. For purposes of reporting a HIPAA Breach to Covered Entity, the discovery of a HIPAA Breach shall occur as of the first day on which such HIPAA Breach is known to the Business Associate or, by exercising reasonable diligence, would have been known to the Business Associate. Business Associate will be considered to have had knowledge of a HIPAA Breach if the HIPAA Breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the HIPAA Breach) who is an employee, officer or other agent of the Business Associate.

Reporting a Breach. Without unreasonable delay and no later than the earlier of the maximum of time allowable under applicable law or five (5) business days following a HIPAA Breach, Business Associate shall provide Covered Entity with sufficient information to permit Covered Entity to comply with the HIPAA Breach notification requirements set forth at 45 C.F.R. § 164.400 et seq. Specifically, if the following information is known to (or can be reasonably obtained by) the Business Associate, Business Associate will provide Covered Entity with:

a.) contact information for individuals who were or who may have been impacted by the HIPAA Breach (e.g., first and last name, mailing address, street address, phone number, email address);

b.) a brief description of the circumstances of the HIPAA Breach, including the date of the HIPAA Breach and date of discovery;

c.) a description of the types of unsecured PHI involved in the HIPAA Breach (e.g., names, social security number, date of birth, addressees, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information);

d.) a brief description of what the Business Associate has done or is doing to investigate the HIPAA Breach, mitigate harm to the individual impacted by the HIPAA Breach, and protect against future HIPAA Breaches; and,

e.) appoint a liaison and provide contact information for same so that Covered Entity may ask questions or learn additional information concerning the HIPAA Breach.

Following a HIPAA Breach, Business Associate will have a continuing duty to inform Covered Entity of new information learned by Business Associate regarding the HIPAA Breach, including but not limited to the information described above.

X. Termination

This Agreement shall commence on the Effective Date.

Upon the termination of the applicable Business Arrangement, either Party may terminate this Agreement by providing written notice to the other Party.

Upon termination of this Agreement for any reason, Business Associate agrees:

a.) to return to Covered Entity or to destroy all PHI received from Covered Entity or otherwise through the performance of services for Covered Entity, that is in the possession or control of Business Associate or its agents. Business Associate agrees that all paper, film, or other hard copy media shall be shredded or destroyed such that it may not be reconstructed, and EPHI shall be purged or destroyed concurrent with NIST Guidelines for media sanitization at http://www.csrc.nist.gov/; or,

b.) in the case of PHI which is not feasible to "return or destroy," to extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate further agrees to comply with other applicable state or federal law, which may require a specific period of retention, redaction, or other treatment of such PHI.

XI. Miscellaneous

Notice. All notices, requests, demands and other communications required or permitted to be given or made under this Agreement shall be in writing, shall be effective upon receipt or attempted delivery, and shall be sent by (i) personal delivery; (ii) certified or registered United States mail, return receipt requested; (iii) overnight delivery service with proof of delivery; or (iv) facsimile with return facsimile acknowledging receipt. Notices shall be sent to the addresses below. Neither party shall refuse delivery of any notice hereunder.

Covered Entity:	Business Associate:
Ms. Ellen Gerescher	Name
Employee Benefits Manager	Title
Moore/Connally Building	Address Line 1
301 Tarrow, 5th Floor	Address Line 2
College Station, TX 77840	Address Line 3

Waiver. No provision of this Agreement or any breach thereof shall be deemed waived unless such waiver is in writing and signed by the Party claimed to have waived such provision or breach. No waiver of a breach shall constitute a waiver of or excuse any different or subsequent breach.

Assignment. Neither Party may assign (whether by operation or law or otherwise) any of its rights or delegate or subcontract any of its obligations under this Agreement without the prior written consent of the other Party. Notwithstanding the foregoing, Covered Entity shall have the right to assign its rights and obligations hereunder to any entity that is an affiliate or successor of Covered Entity, without the prior approval of Business Associate.

Severability. Any provision of this Agreement that is determined to be invalid or unenforceable will be ineffective to the extent of such determination without invalidating the remaining provisions of this Agreement or affecting the validity or enforceability of such remaining provisions.

Entire Agreement. This Agreement constitutes the complete agreement between Business Associate and Covered Entity relating to the matters specified in this Agreement, and supersedes all prior representations or agreements,

whether oral or written, with respect to such matters. In the event of any conflict between the terms of this Agreement and the terms of the Business Arrangements or any such later agreement(s), the terms of this Agreement shall control unless the terms of such Business Arrangements are more strict with respect to PHI and comply with the Confidentiality Requirements, or the parties specifically otherwise agree in writing. No oral modification or waiver of any of the provisions of this Agreement shall be binding on either Party; provided, however, that upon the enactment of any law, regulation, court decision or relevant government publication and/or interpretive guidance or policy that the Covered Entity believes in good faith will adversely impact the use or disclosure of PHI under this Agreement, Covered Entity may amend the Agreement to comply with such law, regulation, court decision or government publication, guidance or policy by delivering a written amendment to Business Associate which shall be effective thirty (30) days after receipt. No obligation on either Party to enter into any transaction is to be implied from the execution or delivery of this Agreement. This Agreement is for the benefit of, and shall be binding upon the parties, their affiliates and respective successors and assigns. No third party shall be considered a third-party beneficiary under this Agreement, nor shall any third party have any rights as a result of this Agreement.

Governing Law. This Agreement shall be governed by and interpreted in accordance with the laws of the state of Texas. Venue for any dispute relating to this Agreement shall be in Brazos County, Texas.

Nature of Agreement; Independent Contractor. Nothing in this Agreement shall be construed to create (i) a partnership, joint venture or other joint business relationship between the parties or any of their affiliates, or (ii) a relationship of employer and employee between the parties. Business Associate is an independent contractor, and not an agent of Covered Entity. This Agreement does not express or imply any commitment to purchase or sell goods or services.

Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same document. In making proof of this Agreement, it shall not be necessary to produce or account for more than one such counterpart executed by the party against whom enforcement of this Agreement is sought. Signatures to this Agreement transmitted by facsimile transmission, by electronic mail in portable document format (".pdf") form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same force and effect as physical execution and delivery of the paper document bearing the original signature.

[Signature page follows.]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

COVERED ENTITY: **BUSINESS ASSOCIATE:**