ADDENDUM #2

November 29, 2018

Reference Request for Proposals #3000011460 soliciting Proposals from any qualified proposers to provide a capitated primary care network in return for a monthly capitation payment.

Addendum #2 provides clarification to the RFP and includes responses to written inquiries received by the deadline stated in the Request for Proposals.

THIS ADDENDUM IS HEREBY OFFICIALLY MADE A PART OF THE REFERENCED REQUEST FOR PROPOSALS.

INQUIRIES AND RESPONSES

No	Inquiry	Response
1	(Attachment IV – Page 70) Please define the number of plan participants to be included in the following format (by region): Employees Spouses Children Active employees _____ _____ _____ Retirees _____ _____ _____	See revised Attachment IV.
2	(Section 1.5, Page 6, and Attachment III, page 67) Please clarify whether or not "Primary Plan Participant" means the Employee and/or retiree.	The Primary Plan Participant is the person with the relationship to OGB. In most cases, it is the employee or the retiree.
3	We assume this program will include COBRA participants. Please confirm whether or not this is accurate.	This is accurate. Payment will be based on the Primary COBRA Plan Participant.
4	Page 4, Section 1.1 says "Plan participants that ***choose to participate*** in the capitated primary care network". What is the definition of "choose"? Is participation denoted by a plan election or by seeking treatment at the clinic?	Participation is denoted by seeking treatment at the capitated network provider's facility.
5	(Page 5, Section 1.5) Will you accept another type of measurement for costs savings? (The Value Report)	No.
6	Page 6 states "Primary Care services does not include Pediatrics." Are children not allowed to use the clinics even if the clinics would accept them?	The capitated network provider will be responsible for treating all eligible dependents for which they customarily provide services, unless pediatric specialty services are medically indicated.
7	With respect to cost proposal, page 15 and 33 required disclosures seem to contradict each other. What will be confidential/proprietary and what will be public record?	There is no contradiction. Essentially, the RFP process and the resulting contract are public records. Any

No	Inquiry	Response
		information protected by state or federal law and designated as proprietary or trade secret by the proposer will not be produced voluntarily by OGB, provided the requirements of Section 1.14 of the RFP are followed.
8	Page 5, Section 1.4 reflects the term of contract starts in February. Page 42 reflects a March start date. What is the desired start date of this capitated program?	March 1, 2019
9	On page 14, Section 1.10 (number of copies) states One (1) Original (clearly marked "Original") and **six (8)** numbered copies. Do you need six or eight copies?	OGB requests the number of Proposal copies specified below be submitted to the OGB RFP Coordinator/Blackout Period Contact. One (1) Original (clearly marked "Original") and six **(6)** numbered copies of the Technical Proposal. **All should be clearly marked "Technical Proposal".**
10	Page 42, Monitoring Plan: reflects the Contract Supervisor will be the OGB Medical and Pharmacy Group Benefits Administrator. Who are these entities?	The Medical and Pharmacy Group Benefits Administrator is an employee of OGB.
11	On pages 46-47, section 3.4 (Payment), is this total based on 3 or 5 years?	The total is based on 3 years.
12	Since all models will be unique, shouldn't there be oral presentations?	Oral presentations are not anticipated at this time. OGB reserves the right to invite proposers reasonably susceptible of being selected for award to provide oral presentations.
13	**2.2 Tasks and Services, Task (3): Primary Care Network Services, Third Bullet on Page 36** **Original Text:** Provide laboratory services and radiology services. Page 36 specifies that the primary care network services include laboratory and radiology services. What CPT codes will be included for those two services?	The capitated network provider will be required to provide those laboratory and radiology services customarily provided to its patients at the capitated network provider facility.
14	**1.5 Definitions Page 5** **Original Text: Cost Savings Report:** Denotes the report produced monthly by OGB comparing the monthly Value Report to OGB's Monthly Capitated Primary Plan participant fee. The Cost Savings report will be the base report used to calculate whether Contractor has met its	The monthly fee will be paid per Primary Plan Participant as defined in the RFP, for each applicable region awarded to the vendor.

No	Inquiry	Response
	guaranteed Return on Investment. OGB will calculate the value of Capitated Services as follows: Value of Capitated Services = Fee for Service Amount X 40% (representing customary 60% discount for Louisiana in-network providers) minus the monthly Capitated Primary Plan Participant fee. Does the monthly fee apply to the subscriber level or enrollee level?	
15	**2.2 Tasks and Services, Task (3): First Bullet on Page 33** **Original Text:** Assist OGB in preparation of any return or report pertaining to the capitated primary care network as required by any federal government agency, and furnish OGB an annual report of information available to Contractor which may be needed by OGB to satisfy ERISA or any other applicable state or federal requirements. Contractor shall not be responsible for determining when or whether government filings are required or completing or filing any report or return. What is the timeline for submitting reports to OGB as referenced in that section? What will need to be included in the report?	The referenced reports will be required within a reasonable period of time upon being requested by OGB. The contents of the reports will be mutually agreed upon by the parties.
16	**2.2 Tasks and Services, Task (3): First Bullet on Page 33** **Original Text:** On or before August 1 prior to each Plan year, Contractor shall prepare a document containing a description of the covered benefits provided by the capitated primary care network to be used by OGB to prepare a plan document. OGB shall review and approve the description of covered benefits prior to dissemination to the Primary Plan Participant(s) covered under the capitated primary care network. If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days. Can OGB please explain why August 1 was chosen?	The timing of this document will give OGB sufficient time to prepare for annual enrollment, which occurs from October 1 to November 15 each year.
17	**2.2 Tasks and Services, Task (3): Fourth Bullet on Page 33** **Original Text:** From time to time, health plans are certified as class Plan Participants in class actions that involve payments made by the plans for health care	For purposes of this obligation, the "OGB claims" will be the proof of claim required by the class action litigation to document OGB's ultimate claim in the litigation.

No	Inquiry	Response
	services, medications or medical devices. Contractor must notify OGB within five (5) business days of receipt that it has received any class action notice and/or notice of other lawsuits in which Contractor determines OGB could have an interest. Contractor will file any OGB claims on behalf of OGB upon request of OGB. Contractor will provide data and reporting to use in filing for refunds and judgments at no additional cost. Can OGB explain what is meant by "Contractor will file any OGB claims?"	
18	**2.2 Tasks and Services, Task (3) Page 35** **Original Text:** Newly-enrolled network providers must make availability to undergo an initial on-site visit from OGB representative(s) to ensure that quality measures are met. Can OGB please define the quality measures expected in this section?	The purpose of the visit is to ensure that the services described in Section 2, Task 3 can be performed by capitated network provider.
19	**1.10 Number of Copies of Proposals** **Original Text:** One (1) Original (clearly marked "Original") and six (8) numbered copies of the Technical Proposal. **All should be clearly marked "Technical Proposal".** Does OGB require 6 or 8 copies?	OGB requests the number of Proposal copies specified below be submitted to the OGB RFP Coordinator/Blackout Period Contact. One (1) Original (clearly marked "Original") and six **(6)** numbered copies of the Technical Proposal. **All should be clearly marked "Technical Proposal".**
20	Can you please provide more information about the members for whom OGB will pay the monthly fee? Is it all primary plan participants, employees listed by region on page 71 or only employees who choose to participate in the capitated network?	The capitated network will be paid a monthly fee for each OGB Primary Plan Participant in each region awarded to the network, regardless of whether the plan participant chooses to utilize the capitated network.
21	Will the successful bidder be paid monthly capitated care payments for employees, retirees and each dependent?	No. See Response to Inquiry 20.
22	Considering the variation in charge patterns, will billed charges be used as the baseline to calculate the cost savings ROI?	Yes
23	How will provider's varying levels of charges factor into the ROI calculation?	OGB will require that the billed charges be the capitated network provider's customary billed charges for that particular visit.
24	Without claims, how will OGB validate the quality of the care provided?	OGB will monitor our existing performance guarantees.

No	Inquiry	Response
25	What will be the procedure when a member visits a provider outside of their home region?	The capitated provider will be required to treat the member, regardless of home region.
26	Will any CPT codes be considered all-inclusive in the capitation? If so, can you please provide a list?	No. See Section 2.2, Task 3 for the delineation of primary care services
27	Can the participating provider be reimbursed for services billed outside of the specified scope of capitated services? If yes, would those items be considered a referral?	No. All services provided during the primary care visit are covered by the capitated rate. If necessary, a specialist referral can be made to a separate provider, in accordance with Section 2.2
28	If employees must elect to take part in the capitated network, can those employees still use non-capitated providers for PCP services?	There is no "election" to take part, other than visiting a capitated network provider. Yes, plan participants may still use non-capitated providers pursuant to the applicable OGB Plan Document and Schedule of Benefits.
29	Are the ROI performance measures based on provider performance or overall network performance?	The ROI is based on the Contractor's overall network performance within a region.
30	How will OGB provide the list of members participating in the program?	OGB will send each successful network contractor, per region, an eligibility file for the Plan Participants in that region.
31	If a provider in the existing carrier's network today becomes part of the network under this RFP, will OGB's direction be to deny all claims for services that are covered under the scope of this RFP? If so, would it be regardless of diagnosis since diagnosis is not an element used to adjudicate professional services?	All services rendered for primary care to the eligible Plan Participant during a visit will be covered under the monthly capitated payment to the capitated network, regardless of diagnosis.
32	How many visits can a subscriber or enrollee have per contract year?	There are no limits on number of visits per contract year.
33	What happens if funding is not approved by the Legislature for the year?	See Section 1.36.2 of the RFP
34	How will ROI be calculated for the savings report?	See the definitions of Cost Savings Report and Value Report in Section 1.5 of the RFP.
35	Can OGB provide detailed requirements/required elements for the value report?	See Definition of "Value Report", RFP Section 1.5.
36	Can OGB define requirements/elements for eligibility file data?	Reference Attachment XI below for file layout.
37	Please give us more details as to how OGB defines "primary plan participants."	Please see response to Inquiry No. 2.

No	Inquiry	Response
38	Please clarify when OGB will begin tracking the carrier's performance and when the carrier will be required to implement the network.	On the effective date of the respective contract.
39	Can OGB provide us with more information on why this network requires an SBC if it's not an election of a benefit?	OGB must comply with the Patient Protection and Affordable Care Act (PPACA). The capitated network concept is a subplan within a plan, and the standard SBC OGB utilizes for its current Plan and network is broader than the capitated services provided through this RFP. OGB also wants its Plan Participants to understand the benefits provided or not provided through the capitated arrangement.
40	Can OGB please explain what information the SBC should include?	OGB will now prepare the SBC. See Revised Text below, Section 2.2 Tasks and Services and Section 2.3 Deliverables.
41	Who will be the OGB inspector reviewing onsite services, and what services will be reviewed?	The OGB inspector will be an OGB employee or one of OGB's contractors.
42	Regarding the Appeals section on page 35, please give us more information on why there is an appeal process for stand-alone clinics used only for walk-in primary care services.	OGB must comply with PPACA, Department of Labor, and CMS requirements.
43	Regarding OGB's requirement of receiving appeals information within 5 business days, please let us know whether or not holidays and clinic closure days are included in the timeframe.	Louisiana State holidays are not included in the 5-day timeframe. If the provider facility closure day is not a Louisiana State holiday, it will be included in the 5-day timeframe.
44	Can OGB explain what an EOB for this network would include?	The EOB to be provided would be the standard EOB with $0 pricing
45	Is it possible to get the NIC in a Word format?	No.
46	Is there an expectation that the contractor tracks referrals from the capitated provider to another provider when services are outside of their scope?	Yes. See RFP Section 2.3 Deliverables.
47	Regarding the Value Report listed on Page 2, is the fee-for-service amount the allowed amount or the billed charge amount? Are we correct in assuming it's the allowed amount?	The amount to be included on the Value Report is the billed amount.
48	Are out-of-state members excluded from this offering?	No.
49	Is the ROI calculation limited to the members who go to a participating clinic? Or does it include all members who	The ROI calculation is limited to the Plan Participants who receive primary care

No	Inquiry	Response
	select this supplemental offering but choose to see their PCP for same type of services?	services through the participating capitated network.
50	Chronic disease burden accounts for 75% of this country's annual health care costs (article reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1183496/), yet the minimum requirements in this RFP are focused on acute care versus chronic care management. Was that intentional?	Yes.
51	Can care visits be performed via telehealth if appropriate for the patient?	No.
52	Will members have to enroll in the program?	No.
53	Will member/employees have to pay/contribute to access benefits under this program?	No.
54	Will members be required to choose a specific primary care provider? Network?	No.
55	It appears that you will select a network at the regional level. Will that network then be capitated for all members living in that service area. If you choose two networks in the service area, how will each network know what members in that service area they are responsible for.	The capitated network awarded for the region will be available to all eligible Plan Participants. Only one capitated network will be awarded per region.
56	If members can use primary care providers other than those in the capitated network, how will those providers get paid for their services?	Providers other than those in the primary care capitated network would be subject to the respective OGB Schedule of Benefits and any provider contract with BCBSLA in effect at the time of service.
57	Does OGB plan to change the design of their PPO plans to work in coordination with this capitated primary care network program?	No.
58	If a provider is currently in the PPO network with Blue Cross, and is also a participant in the network awarded the contract, what will prevent both plans from paying that provider for services rendered to an OGB member?	The participating capitated network provider shall not bill BCBSLA for primary care services rendered to eligible OGB Plan Participants.
59	The capitation payment from OGB is 'Per Primary Plan Participant Per Month". We assume that is per covered life, which would include a pmpm for dependents as well as employees? The enrollment information seems to be the number of OGB employees under the benefit plans. Or, do these counts include dependents?	See response to Inquiry No. 2 regarding the definition of Primary Plan Participant. This capitation payment is not per covered life; it is per Primary Plan Participant. See also the revised census data included in revised Attachment IV to this Addendum, which

No	Inquiry	Response
		includes counts of both Primary Plan Participants per region and Plan Participants per region.
60	If a primary care physician/physician extender is currently in the Blue Cross PPO network, and also joins a contractor's network, which plan will be primary? (the capitated plan, or the Blue Cross plan?) Do they coordinate?	There will be no coordination of benefits The Plan Participant will decide whether to visit the capitated provider or the BCBSLA network provider.
61	Can the award go to providers who do not participate in all four plans (Pelican HRA, Magnolia Local, Magnolia Local Plus, Magnolia Open Access)? If so, what happens when the non-network provider who is in the capitated network performs services that are not covered under the cap? Will the member be responsible for out of network cost share?	Yes. All services provided in the primary care clinic are covered by the capitated rate. Otherwise, there shall be a specialist referral. The member shall not be responsible for any cost share from a capitated provider.
62	If the PCP network removes some physicians for clinical performance reasons, and notifies State in accordance with contract, what will State do, if anything?	OGB will monitor networks to ensure adequacy.
63	In the "Fixed Monthly Fee" calculation and scoring section, how will the differences in the scope of services to be covered under the fee by each bidder be taken into account? Do you want more services covered at a higher cap rate versus the minimum services at the lowest rate?	The differences in the scope of services to be provided by each proposer will be evaluated in Phase I, Technical Approach for Region or Statewide Network, which includes approach and methodology and experience and staff qualifications. The fixed monthly fee will be scored separately under Phase 2, Cost Proposal for Region or Statewide Network. See Section 3.1, Evaluation and Review of the RFP.
64	Under the Deliverable section, what is the difference between "description of covered service" and "Summary of Benefits and Coverage (SBC)"	You can assume that the terms are interchangeable.
65	How will "provider visit wait times" be determined and monitored by OGB?	The provider will report this information to OGB periodically, as stated in Section 2.3.
66	The RFP states that providers must provide lab and radiology services. If a provider cannot/does not provide these services in their office, can they send the patient to providers such as Labcorp, Quest, or a Freestanding radiology center to get these necessary services? If so, will those services get billed under the patient's insurance plan (Blue Cross, Vantage, etc) and subject to their cost sharing under those plans?	Basic lab and radiology services must be provided under the capitated rate. Advanced lab and radiology services will be paid under the Schedule of Benefits for the applicable OGB Plan. See also, response to Inquiry No. 67.

No	Inquiry	Response
67	If a provider uses a Professional Radiology services vendor "reads", how are those services paid. Are they covered under the PPO plans?	The capitated network provider will be required to provide those radiology services customarily provided to its patients at its facility. If the reading requires expertise beyond the capability of the capitated clinic, and a referral is needed to a non-capitated provider, then claims for these services would be processed under the Schedule of Benefits for the applicable OGB Plan.
68	Are there any specific requirements of the "tailored personal health report" required to be provided each patient on page 36. Is telehealth an acceptable service to be included in the offering?	Catapult provides wellness and preventive services to OGB Plan Participants. Rather than visiting one of the Catapult clinics, eligible Plan Participants may take the form for the personal health report to the capitated network provider for completion. Telehealth is not a substitute for a capitated network provider visit.
69	How will a claim for capitated services performed by a capitated provider be processed by Blue Cross if submitted along with non-capitated services? Can Blue Cross distinguish which services to process and which services to reject?	No claims shall be submitted to BCBSLA for primary care services rendered in the capitated network provider facility.
70	Are providers in the network expected to treat patients for chronic disease such as hypertension, diabetes, asthma, CKD, etc.	Yes, if such conditions are normally treated as primary care in the capitated network facility.
71	It's our understanding that a provider in the capitated network will be removed from the Blue Cross network. Is that the case? If not, what is the impact of a physician currently in the Blue Cross network also being in the capitated network?	OGB has not been informed that participation in a capitated network will result in removal from the BCBSLA provider network. These types of questions should be directed to BCBSLA and the particular provider's contract with BCBSLA.
72	If practitioners have different scope of practices (some practitioners do annual Gyn exam for women, others refer that service to ob-gyn physicians) are the capitation rates from the State tiered for broad or narrow scope of practice?	No. The capitation rates are not tiered. The rates proposed should take into account the scope of all primary care services rendered at a particular capitated primary care facility.
73	Under what conditions can a practice terminate a patient? Repeated no shows? Documented verbal abuse of staff at the practice? Failure to follow clinical direction?	Since no appointments are necessary, repeated no shows would not be a ground for termination. Otherwise, the capitated provider should follow its normal practices for termination of patients.

No	Inquiry	Response
74	Can the capitation rate be split into 6 age/sex demographic cells to recognize differences in underlying patient complexity and utilization?	No.
75	For the Cost Savings Report, is the "Fee for Service Amount" the provider's billed charge? If so, how will you account for the fact that our networks standard discount on billed charge may not be as high as 60%? Are providers allowed to change/raise their billed charges during the contract period? The change levels may be inadvertently incentivized to be higher than normal given the way you have decided to determine ROI. If not, what are you going to do to prevent such gaming?	The fee-for-service billing should be the capitated network provider's customary billing for the particular service utilized to bill all fee-for-service clients. OGB will apply a 60 percent discount factor to the provider's billed charges in order to determine the ROI.
76	You seem to be assuming that savings from this program will come from OGB paying less for primary care services through the capitation program that you believe you would pay to those same providers at 40% of their charges? If that is the case, what's the incentive for a provider to participate in this program? Is appears the only strategy here is to buy primary care services for 40 cents on the dollar or force providers to use nurse practitioners or extenders.	Providers can choose whether or not to participate in a capitated network. OGB's objective is to solicit proposals from those capitated network providers who are interested in the care and health of our plan participants.
77	The RFP does not require any commitment to adequately treat chronic disease, the major driver of medical cost. Are you intending this network to treat chronic disease and if so, how do you plan to hold the network accountable for the appropriate treatment?	This RFP addresses chronic diseases if treated in a capitated primary care setting. If treatment is required beyond the capitated primary care clinic's capability, referrals to a specialty provider may be necessary.
78	Can the ROI calculation consider the savings from a reduction in potentially preventable ER visits?	No.
79	Can increased presenteeism be included in the ROI calculation?	No.
80	If a patient misses their appointment but comes in later that day, is that an appointed patient or a walk-in for purposes of measurement and reporting?	No appointment is necessary under the capitated primary care plan. The patient would be a walk-in.
81	What kind of patient-focused clinical quality measures are expected to assure adequate care is being provided inside the capitation? (high blood pressure monitoring, diabetes testing, mammography and cervical cancer screening?)	The capitated network provider will be required to provide all services customarily provided to its patients at its facility. The capitated network provider shall treat the patients who utilize the capitated network with the same quality of care being dispensed to all of its other patients. Proposers should include a listing and description of all services they

No	Inquiry	Response
		intend to provide within this capitated primary care plan.
82	What kind of down-stream measures of cost/quality/outcome measures is the state using to measure the total value of the PCP capitation program? Risk adjusted Total cost care? Adherence to clinical advice? Medication management? Use of ER? Admissions for minor illnesses? PCP Transitions of care visits after discharge? Immunization rates for flu and pneumonia?	OGB will be monitoring the performance guarantees in the respective contract. See RFP, Section 2.4.
83	Will State provide network with full claims data dump for all services, all providers, on all capitated members so that the PCPs can better manage care to efficient and clinically effective downstream clinical providers?	No.
84	If a provider is in the contractor's network and the Blue Cross network, will Blue Cross be given the encounter data from the visits to the Capitated Primary Care Network visits in order to incorporate that info in their quality measurement processes involved in the QBPC program? Their ACO programs?	It is expected that providers will continue to fulfill their contractual obligations to provide encounter and clinical data to BCBS of Louisiana, in accordance with applicable state and federal laws, including but not limited to HIPAA.
85	Will providers in this network be required to share clinical data with providers in the PPO network in order to prevent fragmentation of existing care being delivered to OGB members today?	No.
86	Is OGB concerned about the fragmentation in care this could cause? Are you concerned about the increased cost and erosion of your reserve fund that could cause?	It is not anticipated that the implementation of a capitated network will cause "fragmentation in care" or an erosion of the fund balance.
87	Under the Deliverable section, what is the difference between "description of covered service" and "Summary of Benefits and Coverage (SBC)"	See response to Inquiry No. 64.
88	How is a provider to produce a "Plan Document" if they are not the insurer or TPA?	See Revised Deliverables, Section 2.3 below. The requirement that the successful Contractor prepare a plan document has been removed.
89	Is the ID card that the contractor must produce just for the PCP services? Would this be a duplication of what the current TPA provides?	An ID card shall be produced for only PCP capitated services. The provider network contact information must be displayed on the membership card.
90	How is Contractor to know when Primary Care Participants make changes to their coverage in order to produce a new ID card?	Contractors will receive a monthly eligibility file.

No	Inquiry	Response
91	Can the ROI guarantee simply be met by setting high billed charges relative to the capitation payment?	No.
92	For the Veteran owned clinic we have 3 locations with separate tax id's and different ownership. Do we have to submit three RFP's or just one with the different ownership? We only have one clinic that qualifies for the Veteran ownership. We will waive the Veteran advantage if we can simplify the process by submitting one application.	Proposers should submit one proposal for each region regardless of the number of networks which will be utilized. For information on the Veteran advantage, see RFP Section G. Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Participation.
93	Do we need to be in network with other payers to participate like BCBS and Medicare etc?	No.
94	Do we have to have EMR and ERX in order to participate?	The participating capitated providers must have EMR and EMX in order to participate.
95	How would we remit the claims if we get the contract?	Providers will submit electronic documentation of services and costs of services provided to OGB, rather than claims.
96	Is OGB the same as a third party?	The question is not understood.
97	Do we get paid monthly per patient if they sign on as a PCP?	See response to Inquiry No. 14.
98	Do we get paid a monthly fee if the patient is seen as walk-in?	See response to Inquiry No. 14.
99	Are employees, retirees and dependents of each eligible to participate in this program?	All employees, retirees and dependents participating in one of OGB's self-funded plans (except the Pelican HSA) will be eligible to participate.

Section Reference RFP 1.10 Number of Copies of Proposals

ORIGINAL TEXT:

1.1 Number of Copies of Proposals

OGB requests the number of Proposal copies specified below be submitted to the OGB RFP Coordinator/Blackout Period Contact.

- One (1) Original (clearly marked "Original") and six (8) numbered copies of the Technical Proposal. **All should be clearly marked "Technical Proposal".**
- Two (2) CDs or portable drives of the entire Technical Proposal in both PDF and Word formats. **All should be clearly marked "Technical Proposal".**

- One (1) Original (clearly marked "Original") and two (2) numbered copies of the Cost Proposal. **All should be clearly marked "Cost Proposal".**
- Two (2) CDs or portable drives of the entire Cost Proposal in both Word and Excel formats. **All should be clearly marked "Cost Proposal".**
- If applicable (see Section 1.14), Proposer should also submit two (2) electronic redacted versions of the Proposal. **All should be clearly marked "Redacted".**

At least one (1) copy of the Proposal shall contain original signatures of those individuals, firm officials, or agents duly authorized to sign Proposals or contracts on behalf of the individual/firm. A certified copy of a board resolution granting such authority should be submitted if Proposer is a corporation. The copy of the Proposal with original signatures will be retained for incorporation in any Contract resulting from this RFP.

REVISED TEXT:

1.1 Number of Copies of Proposals

OGB requests the number of Proposal copies specified below be submitted to the OGB RFP Coordinator/Blackout Period Contact.

- One (1) Original (clearly marked "Original") and six **(6)** numbered copies of the Technical Proposal. **All should be clearly marked "Technical Proposal".**
- Two (2) CDs or portable drives of the entire Technical Proposal in both PDF and Word formats. **All should be clearly marked "Technical Proposal".**
- One (1) Original (clearly marked "Original") and two (2) numbered copies of the Cost Proposal. **All should be clearly marked "Cost Proposal".**
- Two (2) CDs or portable drives of the entire Cost Proposal in both Word and Excel formats. **All should be clearly marked "Cost Proposal".**
- If applicable (see Section 1.14), Proposer should also submit two (2) electronic redacted versions of the Proposal. **All should be clearly marked "Redacted".**

At least one (1) copy of the Proposal shall contain original signatures of those individuals, firm officials, or agents duly authorized to sign Proposals or contracts on behalf of the individual/firm. A certified copy of a board resolution granting such authority should be submitted if Proposer is a corporation. The copy of the Proposal with original signatures will be retained for incorporation in any Contract resulting from this RFP.

<u>Section Reference RFP 1.4 Term of Contract</u>

ORIGINAL TEXT:

1.4 Term of Contract

The initial term of any Contract resulting from this RFP shall begin on or about February 1, 2019, and is anticipated to end on January 31, 2022. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial Contract term. Prior to the extension of the contract beyond the initial thirty-six (36)-month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) and/or other approval authorized by law shall be obtained. Written evidence of JLCB approval shall be submitted, along with the contract amendment, to the Office of State Procurement (OSP) to extend contract terms beyond the initial 3-year term. The total Contract

term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

REVISED TEXT:

1.4 Term of Contract

The initial term of any Contract resulting from this RFP shall begin on or about **March 1, 2019**, and is anticipated to end on **February 28, 2022**. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial Contract term. Prior to the extension of the contract beyond the initial thirty-six (36)-month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) and/or other approval authorized by law shall be obtained. Written evidence of JLCB approval shall be submitted, along with the contract amendment, to the Office of State Procurement (OSP) to extend contract terms beyond the initial 3-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

SECTION REFERENCE RFP 2.2 Tasks and Services

ORIGINAL TEXT:

Task (3): Primary Care Network Services

- Provide at least 45 days advance written notification to OGB of any change in capitated primary care provider network that will effect a 1% or greater change in the number of providers in the network.
- Submit standardized reports and/or data to OGB for the purpose of evaluating utilization, savings, financial experience, and other aspects of the Contractor's performance, as provided in Section 2.3 Deliverables. Format and layout must be approved by OGB.
- On or before August 1 prior to each Plan year, Contractor shall prepare a document containing a description of the covered benefits provided by the capitated primary care network to be used by OGB to prepare a plan document. OGB shall review and approve the description of covered benefits prior to dissemination to the Primary Plan Participant(s) covered under the capitated primary care network. If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days.
- On or before August 1 prior to each Plan year, Contractor shall prepare a Summary of Benefits and Coverage ("SBC") document to be used by OGB. Contractor will provide the SBC to OGB within ten (10) business days after it has received from OGB all of the benefits information Contractor needs to draft the document. OGB will review the draft prepared by Contractor. If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days. If no changes are required, OGB will approve the document in writing.

  The SBC will be prepared by Contractor in the English language. Contractor will not be responsible for any translations of the SBC or any other Plan documents into any other language.

- Contractor shall distribute the SBC to participating Primary Plan Participant(s) by October 1, 2019, and by each October 1st prior to each subsequent Plan year, and when changes made by OGB to the Plan would require the distribution of a new SBC to all participating Primary Plan Participant(s). Distribution of the SBCs shall be accomplished by Contractor mailing a copy to each participating Primary Plan Participant.

  Note: The Transitional Reinsurance Program fees and the Patient Certified Outcome Research Institute (PCORI) fees are the responsibility of OGB and are not included in the Monthly Fees.
- Provide assistance to OGB in complying with grievance and appeal procedures adopted by OGB and as outlined in the Plan Document, see Attachment X: Appeal Procedures.

  1) With respect to processes for internal Claims and appeals and external review, Contractor shall abide by the grievance and appeals procedures as stated in OGB's annual Plan Document for the self-insured Plans. Contractor shall:

     (i) For the first level of internal appeal, determine whether benefits are payable in accordance with the Plan Document as a result of an adverse benefit determination, within the timeframes required by applicable law. Contractor will also issue timely decision notices of benefit determination in the appropriate format. If the Contractor receives first level internal appeals requiring eligibility determinations, Contractor will immediately notify and forward the appeal to OGB within five (5) business days of receipt.

     (ii) At the conclusion of the first level of internal appeal for benefit determination, Contractor will notify the Plan Participant of Contractor's disposition of the appeal including instructions on how to initiate any additional levels of appeal that may be available to the Plan Participant. The determination will include instructions on how the Plan Participant may initiate a second level benefit determination appeal to the Contractor. For the second level internal appeal for benefit determination, Contractor will determine whether benefits are payable in accordance with the Benefit Plan as a result of an adverse benefit determination, within the timeframes required by law and issue timely decision notices in the appropriate format. Additionally, Contractor will notify the Plan Participant in writing of any external review rights that may be available.

     (iii) Unless otherwise requested by OGB in writing, Contractor will facilitate OGB's external review procedures by randomly assigning an external review request to one of Contractor's contracted independent review organizations ("IRO"). Contractor is responsible for complying with applicable laws regarding external review.

  Once the claimant exhausts the appeal rights to be provided through Contractor under the Plan Document, in the event Contractor receives any final appeal or grievance requests made by a denied claimant, Contractor shall immediately forward the request to OGB within five (5) business days of receipt.
- Prepare and distribute an explanation of benefits to the Plan Participant following each provision of service, as required by applicable law.

- Provide a network of capitated primary care providers (herein, referred to as "Providers"). Providers included in the capitated primary care network must meet or exceed the following criteria:
    - Board certified or board eligible in primary care, internal medicine, emergency medicine, or family medicine.
    - Graduates of accredited medical schools with a degree of MD or DO.
    - Licensed to practice medicine in the State of Louisiana.
    - Maintains medical professional liability insurance and/or medical malpractice insurance.
    - Able to work with diverse populations
    - In possession of a Drug Enforcement Administration (DEA) number.
    - Licensed Nurse Practitioners and/or Physician Assistants working under the supervision of a licensed physician that is a provider in the capitated primary care network (meeting the requirements listed above) are eligible to participate as Providers in the capitated primary care network.

The Providers participating in the capitated primary care network must provide, at a minimum, the following services:

- Maintain walk-in services: same day services with no appointment needed. Appointments may be made by Plan Participants in advance, but should not be required.
- Maintain laboratory and radiology accreditations.
- Newly-enrolled network providers must make availability to undergo an initial on-site visit from OGB representative(s) to ensure that quality measures are met.
- Provide direct patient care including but not limited to taking medical histories, providing treatment and education of Plan Participants, and ordering and interpreting laboratory and radiological tests.
- Provide medical evaluation and treatment for general health conditions, including but not limited to the following:
    - Cold, flus, seasonal allergies
    - Burns and other minor skin conditions
    - Sprains, joint injuries
    - Wound care
    - Gastrointestinal virus
    - Upper respiratory illnesses including, but not limited to, bronchitis, sinusitis, pneumonia, mononucleosis, and strep throat
    - Conjunctivitis and other eye infections
    - Immunizations and influenza vaccines
- Make referrals to other medical providers when treatment by a capitated primary care provider is not possible or appropriate. Referrals shall only be made to medical providers that are in the OGB self-funded plan network, currently administered by Blue Cross and Blue Shield of Louisiana. Specialist referrals should be made only when medically necessary. OGB reserves the right to monitor the specialty referral rate.
- Provide trained personnel in CPR/Automated External Defibrillator
- Provide laboratory services and radiology services
- Provide preventative screening laboratory services and provide a comprehensive and tailored personal health report for each Plan Participant to whom the Providers render such services.
- Provide services to Plan Participants within thirty (30) minutes of arrival at the capitated primary care network provider, whether the capitated network provider visit is on a walk-in or appointment basis.
- Advise patients on diet, exercise, hygiene, and general health to aid in the prevention of illnesses, diseases, and disorders.
- Provide the necessary personnel, equipment, supplies, and services to perform the Scope of Services.
- Maintain all licensures, insurance and permits to provide medical services in the State of Louisiana.

- Maintain and handle medical records and respond to subpoenas for medical records in compliance with all applicable laws.
- Give Plan Participants resources to help them better monitor their health, understand their risk factors and make educated choices as to their health.

REVISED TEXT:

Task (3): Primary Care Network Services

- Provide at least 45 days advance written notification to OGB of any change in capitated primary care provider network that will effect a 1% or greater change in the number of providers in the network.
- Submit standardized reports and/or data to OGB for the purpose of evaluating utilization, savings, financial experience, and other aspects of the Contractor's performance, as provided in Section 2.3 Deliverables. Format and layout must be approved by OGB.
- On or before August 1 prior to each Plan year, Contractor shall prepare a document containing a description of the covered benefits provided by the capitated primary care network to be used by OGB to prepare a plan document. OGB shall review and approve the description of covered benefits prior to dissemination to the Primary Plan Participant(s) covered under the capitated primary care network. If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days.
  Note: The Transitional Reinsurance Program fees and the Patient Certified Outcome Research Institute (PCORI) fees are the responsibility of OGB and are not included in the Monthly Fees.
- Provide assistance to OGB in complying with grievance and appeal procedures adopted by OGB and as outlined in the Plan Document, see Attachment X: Appeal Procedures.

2) With respect to processes for internal Claims and appeals and external review, Contractor shall abide by the grievance and appeals procedures as stated in OGB's annual Plan Document for the self-insured Plans. Contractor shall:

(iv) For the first level of internal appeal, determine whether benefits are payable in accordance with the Plan Document as a result of an adverse benefit determination, within the timeframes required by applicable law. Contractor will also issue timely decision notices of benefit determination in the appropriate format. If the Contractor receives first level internal appeals requiring eligibility determinations, Contractor will immediately notify and forward the appeal to OGB within five (5) business days of receipt.

(v) At the conclusion of the first level of internal appeal for benefit determination, Contractor will notify the Plan Participant of Contractor's disposition of the appeal including instructions on how to initiate any additional levels of appeal that may be available to the Plan Participant. The determination will include instructions on how the Plan Participant may initiate a second level benefit determination appeal to the Contractor. For the second level internal appeal for benefit determination, Contractor will determine whether benefits are payable in accordance with the Benefit Plan as a result of an adverse benefit determination, within the timeframes required by law and issue timely decision notices in the appropriate

format. Additionally, Contractor will notify the Plan Participant in writing of any external review rights that may be available.

(vi) Unless otherwise requested by OGB in writing, Contractor will facilitate OGB's external review procedures by randomly assigning an external review request to one of Contractor's contracted independent review organizations ("IRO"). Contractor is responsible for complying with applicable laws regarding external review.

Once the claimant exhausts the appeal rights to be provided through Contractor under the Plan Document, in the event Contractor receives any final appeal or grievance requests made by a denied claimant, Contractor shall immediately forward the request to OGB within five (5) business days of receipt.

- Prepare and distribute an explanation of benefits to the Plan Participant following each provision of service, as required by applicable law.
- Provide a network of capitated primary care providers (herein, referred to as "Providers"). Providers included in the capitated primary care network must meet or exceed the following criteria:
  - Board certified or board eligible in primary care, internal medicine, emergency medicine, or family medicine.
  - Graduates of accredited medical schools with a degree of MD or DO.
  - Licensed to practice medicine in the State of Louisiana.
  - Maintains medical professional liability insurance and/or medical malpractice insurance.
  - Able to work with diverse populations
  - In possession of a Drug Enforcement Administration (DEA) number.
  - Licensed Nurse Practitioners and/or Physician Assistants working under the supervision of a licensed physician that is a provider in the capitated primary care network (meeting the requirements listed above) are eligible to participate as Providers in the capitated primary care network.

The Providers participating in the capitated primary care network must provide, at a minimum, the following services:

- Maintain walk-in services: same day services with no appointment needed. Appointments may be made by Plan Participants in advance, but should not be required.
- Maintain laboratory and radiology accreditations.
- Newly-enrolled network providers must make availability to undergo an initial on-site visit from OGB representative(s) to ensure that quality measures are met.
- Provide direct patient care including but not limited to taking medical histories, providing treatment and education of Plan Participants, and ordering and interpreting laboratory and radiological tests.
- Provide medical evaluation and treatment for general health conditions, including but not limited to the following:
  - Cold, flus, seasonal allergies
  - Burns and other minor skin conditions
  - Sprains, joint injuries
  - Wound care
  - Gastrointestinal virus
  - Upper respiratory illnesses including, but not limited to, bronchitis, sinusitis, pneumonia, mononucleosis, and strep throat
  - Conjunctivitis and other eye infections
  - Immunizations and influenza vaccines
- Make referrals to other medical providers when treatment by a capitated primary care provider is not possible or appropriate. Referrals shall only be made to medical providers that are in the OGB

self-funded plan network, currently administered by Blue Cross and Blue Shield of Louisiana. Specialist referrals should be made only when medically necessary. OGB reserves the right to monitor the specialty referral rate.

- Provide trained personnel in CPR/Automated External Defibrillator
- Provide laboratory services and radiology services
- Provide preventative screening laboratory services and provide a comprehensive and tailored personal health report for each Plan Participant to whom the Providers render such services.
- Provide services to Plan Participants within thirty (30) minutes of arrival at the capitated primary care network provider, whether the capitated network provider visit is on a walk-in or appointment basis.
- Advise patients on diet, exercise, hygiene, and general health to aid in the prevention of illnesses, diseases, and disorders.
- Provide the necessary personnel, equipment, supplies, and services to perform the Scope of Services.
- Maintain all licensures, insurance and permits to provide medical services in the State of Louisiana.
- Maintain and handle medical records and respond to subpoenas for medical records in compliance with all applicable laws.
- Give Plan Participants resources to help them better monitor their health, understand their risk factors and make educated choices as to their health.

Section Reference RFP 2.3 Deliverables

ORIGINAL TEXT:

2.3 Deliverables

The Contractor shall provide the following deliverables:

- An electronic primary care network provider directory to include on the OGB website, updated monthly, in a format acceptable to OGB.
- Description of covered services offered through Contractor for the following Plan year, by August 1 prior to each Plan year.
- Summary of Benefits and Coverage ("SBC") by August 1 prior to each Plan year, to be disseminated on or before October 1 prior to the beginning of each Plan year.
- Copy of Providers' medical licenses, DEA certificate, and documentation demonstrating laboratory and radiology accreditations.
- Provider access mapping on an annual basis for each Contract Year.
- Monthly invoices.
- Monthly referral report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly referral report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual referral report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Monthly encounter data report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly encounter data report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual encounter data report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.

- Monthly Value Report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly Value Report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual Value Report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Monthly provider visit wait time report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly provider visit wait time report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual provider visit wait time report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Independent assurance reporting as provided in Attachment I: Sample Contract, Section 19, no later than September 30 of each Contract year.
- Providers in the Contractor's capitated primary care network will provide the provider's HIPAA privacy notice to Plan Participants who receive services at the provider's clinic.
- Prepare and distribute the following materials to each new Primary Plan Participant(s) within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application and Plan Participant:

    1. A Plan Document, which includes information on all covered services, including, but not limited to: benefits, limitations, exclusions, copayments, coinsurances and deductibles, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's membership may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in a contractual agreement with the Contractor.

    2. Contractor will supply identification cards to Primary Plan Participant(s) of the Plan upon the Plan Participant's joining the Plan. New cards will be issued to all Primary Plan Participant(s) of the Plan when OGB is serviced by Contractor for the first time. The identification cards must contain all elements required by all applicable laws, including but not limited to Louisiana Revised Statutes Title 22 and La. R.S. 40:2201, et seq. Thereafter, new cards will only be issued on an individual basis, when Primary Plan Participant(s) make changes to their coverage at annual or any other special enrollment that require the issuance of a new card, whenever OGB adds new Primary Plan Participant(s) to the Plan during a Plan year, or whenever a card duplicate is requested, at no additional charge to OGB or the Primary Plan Participant(s). Additional cards for family Plan Participants shall also be provided upon request and at no additional charge to OGB or the Plan Participant.

    3. Summary of Benefits and Coverage and Uniform Glossary, as required by the federal PPACA and/or state law and/or rules and regulations promulgated pursuant thereto. If requested by OGB, Contractor shall provide printed SBC documents to OGB for distribution to eligible employees who are not enrolled in a health plan.
- Provide OGB-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance of OGB's Plan Participants.
- During the term of the contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each, if applicable.

REVISED TEXT:

2.3 Deliverables

The Contractor shall provide the following deliverables:

- An electronic primary care network provider directory to include on the OGB website, updated monthly, in a format acceptable to OGB.
- Description of covered services offered through Contractor for the following Plan year, by August 1 prior to each Plan year.
- Copy of Providers' medical licenses, DEA certificate, and documentation demonstrating laboratory and radiology accreditations.
- Provider access mapping on an annual basis for each Contract Year.
- Monthly invoices.
- Monthly referral report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly referral report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual referral report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Monthly encounter data report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly encounter data report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual encounter data report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Monthly Value Report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly Value Report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual Value Report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Monthly provider visit wait time report in a format acceptable to OGB within fifteen (15) business days after the first day of each month.
- Quarterly provider visit wait time report in a format acceptable to OGB within forty-five (45) calendar days after the close of each quarter
- Annual provider visit wait time report in a format acceptable to OGB within ninety (90) business days after the end of each Contract year.
- Independent assurance reporting as provided in Attachment I: Sample Contract, Section 19, no later than September 30 of each Contract year.
- Providers in the Contractor's capitated primary care network will provide the provider's HIPAA privacy notice to Plan Participants who receive services at the provider's clinic.
- Prepare and distribute the following materials to each new Primary Plan Participant(s) within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application and Plan Participant:

    Contractor will supply identification cards to Primary Plan Participant(s) of the Plan upon the Plan Participant's joining the Plan. New cards will be issued to all Primary Plan Participant(s) of the Plan when OGB is serviced by Contractor for the first time. The identification cards must contain all elements required by all applicable laws, including but not limited to Louisiana Revised Statutes Title 22 and La. R.S. 40:2201, et seq. Thereafter,

new cards will only be issued on an individual basis, when Primary Plan Participant(s) make changes to their coverage at annual or any other special enrollment that require the issuance of a new card, whenever OGB adds new Primary Plan Participant(s) to the Plan during a Plan year, or whenever a card duplicate is requested, at no additional charge to OGB or the Primary Plan Participant(s). Additional cards for family Plan Participants shall also be provided upon request and at no additional charge to OGB or the Plan Participant.

- Provide OGB-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance of OGB's Plan Participants.
- During the term of the contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each, if applicable.

SECTION REFERENCE RFP 2.4 Performance Guarantees

ORIGINAL TEXT:

2.4 Performance Guarantees

The table below shows the return on investment ("ROI") performance guarantee that the Contractor's performance will be measured against, along with the performance guarantee related to provider visit wait time. Contactor will also be subject to per day fees for Independent Assurance Reporting performance guarantees.

Performance Guarantee	Fees at Risk	Measurement
Return on Investment guarantee	Meeting the guarantee as agreed upon by OGB and the Contractor	For each Contract Year, the ROI guarantee will be measured against the Contractor's performance. OGB will generate a Cost Savings Report by comparing the Value Report to OGB's Monthly Capitated Primary Plan participant fee. This will be used to determine if Contractor has met its guaranteed ROI. Any shortfall will be paid to OGB within 90 days of the end of the measurement period. Fifteen (15%) of the payment under the resulting contract for contract calendar year 3 and contract calendar year 5 will be withheld until the ROI guarantee is provided to OGB.
Provider visit wait time	5% of annual fees	Greater than one percent (1%) of Plan Participant visits were seen by the provider in greater than thirty (30) minutes from arrival time, whether the network provider visit is on a walk-in or appointment basis.
Independent Assurance Reporting	$1,000 per day	Submit annual independent assurance report as provided in Attachment I: Sample Contract, Section 19, no later than September 30 of each Contract year.

ROI and provider visit wait time performance guarantees must be reconciled on an annual basis for each Contract Year. ROI and provider visit wait time performance guarantee penalties owed to OGB shall be paid within ninety (90) days after the end of each Measurement Period.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Periods: The first period to be measured shall be February 1, 2019, through January 31, 2020. The second period will be for Contract year February 1, 2020 through January 31, 2021, and the third period will be for Contract year February 1, 2021 through January 31, 2022. The fourth and fifth periods, subject to the renewal option, will be for Contract years February 1, 2022 through January 31, 2023; and February 1, 2023 through January 31, 2024, respectively.

REVISED TEXT:

2.4 Performance Guarantees

The table below shows the return on investment ("ROI") performance guarantee that the Contractor's performance will be measured against, along with the performance guarantee related to provider visit wait time. Contactor will also be subject to per day fees for Independent Assurance Reporting performance guarantees.

Performance Guarantee	Fees at Risk	Measurement
Return on Investment guarantee	Meeting the guarantee as agreed upon by OGB and the Contractor	For each Contract Year, the ROI guarantee will be measured against the Contractor's performance. OGB will generate a Cost Savings Report by comparing the Value Report to OGB's Monthly Capitated Primary Plan participant fee. This will be used to determine if Contractor has met its guaranteed ROI. Any shortfall will be paid to OGB within 90 days of the end of the measurement period. Fifteen (15%) of the payment under the resulting contract for contract calendar year 3 and contract calendar year 5 will be withheld until the ROI guarantee is provided to OGB.
Provider visit wait time	5% of annual fees	Greater than one percent (1%) of Plan Participant visits were seen by the provider in greater than thirty (30) minutes from arrival time, whether the network provider visit is on a walk-in or appointment basis.
Independent Assurance Reporting	$1,000 per day	Submit annual independent assurance report as provided in Attachment I: Sample Contract, Section 19, no later than September 30 of each Contract year.

ROI and provider visit wait time performance guarantees must be reconciled on an annual basis for each Contract Year. ROI and provider visit wait time performance guarantee penalties owed to OGB shall be paid within ninety (90) days after the end of each Measurement Period.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Periods: The first period to be measured shall be March 1, 2019, through February 28, 2020. The second period will be for Contract year March 1, 2020 through February 28, 2021, and the third period will be for Contract year March 1, 2021 through February 28, 2022. The fourth and fifth periods, subject to the renewal option, will be for Contract years March 1, 2022 through February 28, 2023; and March 1, 2023 through February 28, 2024, respectively.

ATTACHMENT IV: ENROLLMENT INFORMATION BY PLAN AND ENROLLMENT INFORMATION BY REGION

ORIGINAL TEXT:

ATTACHMENT IV: ENROLLMENT INFORMATION BY PLAN AND ENROLLMENT INFORMATION BY REGION

ENROLLMENT BY PLAN	
Plan Description	**Plan Participant Count**
Blue Cross – Magnolia Local	627
Blue Cross – Magnolia Open Access	22,553
Blue Cross – Magnolia Local Plus	84,274
Blue Cross – Pelican HRA	3,880

*Enrollment information by plan as of October 26, 2018

ENROLLMENT BY REGION	
Plan Participant Region	**Plan Participant Count**
Region 1 Parishes Orleans, Saint Bernard, Plaquemines and Jefferson	14,716
Region 2 Parishes East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana	25,101
Region 3 Parishes Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes	3,923
Region 4 Parishes Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary	10,541
Region 5 Parishes Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron	6,121
Region 6 Parishes Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles	17,567
Region 7 Parishes Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto	6,877
Region 8 Parishes Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas	10,404
Region 9 Parishes Washington, Saint Tammany, Saint Helena and Tangipahoa	11,028
Out of State	5,056

REVISED TEXT:

ATTACHMENT IV: ENROLLMENT INFORMATION BY PLAN AND ENROLLMENT INFORMATION BY REGION

ENROLLMENT BY PLAN	
Plan Description	**Plan Participant Count**
Blue Cross – Magnolia Local	995
Blue Cross – Magnolia Open Access	35,062
Blue Cross – Magnolia Local Plus	155,130
Blue Cross – Pelican HRA	6,661

*Enrollment information by plan as of November 28, 2018; includes covered dependents.

ENROLLMENT BY REGION	
Plan Participant Region	**Plan Participant Count**
Region 1 Parishes Orleans, Saint Bernard, Plaquemines and Jefferson	23,906
Region 2 Parishes East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana	48,906
Region 3 Parishes Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes	7,207
Region 4 Parishes Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary	19,110
Region 5 Parishes Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron	11,362
Region 6 Parishes Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles	31,122
Region 7 Parishes Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto	11,431
Region 8 Parishes Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas	17,489
Region 9 Parishes Washington, Saint Tammany, Saint Helena and Tangipahoa	20,004
Out of State	7,311

*Enrollment information by region as of November 28, 2018; includes covered dependents

ENROLLMENT BY PLAN						
Plan Description	**Primary Plan Participants Count**	**All Plan Participants Count Breakdown**				
Blue Cross – Magnolia Local	626		Employee	Spouse	Child	Total
		Active:	485	102	212	799
		Retiree:	141	41	14	196
Blue Cross – Magnolia Open Access	25,157		Employee	Spouse	Child	Total
		Active:	5,623	1,196	2,075	8,894
		Retiree:	19,534	5,905	729	26,168
Blue Cross – Magnolia Local Plus	84,377		Employee	Spouse	Child	Total
		Active:	57,886	14,493	44,207	116,586
		Retiree:	26,491	8,622	3,431	38,544
Blue Cross – Pelican HRA1000	3,892		Employee	Spouse	Child	Total
		Active:	2,877	675	1,633	5,185
		Retiree:	1,015	345	116	1,476

*Enrollment information by plan as of November 28, 2018; the primary plan participants count for each plan equals the sum of the employee counts for the same plan.

ENROLLMENT BY REGION						
Plan Participant Region	**Primary Plan Participants Count**	**All Plan Participants Count Breakdown**				
Region 1 Parishes	14,738		Employee	Spouse	Child	Total
Orleans, Saint Bernard, Plaquemines and Jefferson		Active:	9,854	1,949	5,490	17,293
		Retiree:	4,884	1,278	451	6,613
Region 2 Parishes	27,746		Employee	Spouse	Child	Total
East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana		Active:	16,906	4,023	12,770	33,699
		Retiree:	10,840	3,165	1,202	15,207
Region 3 Parishes	3,909		Employee	Spouse	Child	Total
Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes		Active:	2,376	750	1,806	4,932
		Retiree:	1,533	589	153	2,275
Region 4 Parishes	10,608		Employee	Spouse	Child	Total
Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary		Active:	6,180	1,593	4,920	12,693
		Retiree:	4,428	1,573	416	6,417
Region 5 Parishes	6,135		Employee	Spouse	Child	Total
Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron		Active:	3,709	1,097	3,054	7,860
		Retiree:	2,426	868	208	3,502
Region 6 Parishes	17,560		Employee	Spouse	Child	Total
Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles		Active:	10,089	2,563	7,897	20,549
		Retiree:	7,471	2,448	654	10,573

Region 7 Parishes Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto	6,869		Employee	Spouse	Child	Total
		Active:	3,803	957	2,497	7,257
		Retiree:	3,066	874	234	4,174
Region 8 Parishes Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas	10,400		Employee	Spouse	Child	Total
		Active:	5,974	1,463	3,966	11,403
		Retiree:	4,426	1,385	275	6,086
Region 9 Parishes Washington, Saint Tammany, Saint Helena and Tangipahoa	11,032		Employee	Spouse	Child	Total
		Active:	6,519	1,833	5,091	13,443
		Retiree:	4,513	1,581	467	6,561
Out of State	5,055		Employee	Spouse	Child	Total
		Active:	1,461	238	636	2,335
		Retiree:	3,594	1,152	230	4,976

*Enrollment information by region as of November 28, 2018; the primary plan participants count for each region equals the sum of the employee counts for the same region.

ADD: ATTACHMENT XI: FILE LAYOUT

HEALTH ELIGIBILITY FILE SPECIFICATION FOR OGB CAPITATED PRIMARY CARE

This file is snapshot of enrollment from OGB's Impact enrollment system as of a certain date (see the Header record). A member will only have a single record of a certain type.

We have a separate layout for files where multiple records of a single type must be sent.

Currently, we can only accommodate the ASCII character set.

COMMENTS

- This file is a delimited file type. The default delimiter is a pipe character – |. Other delimiters can be used if necessary. Fields with string values will be quotes with double quotes – ", so instances of the delimiter used inside of string fields will not be removed.
- All dates should be in CCYYMMDD format.
    - For infinity dates, which Impact stores as blanks, we will send **99991231** if the date is relevant to an open ended record, and leave the field blank if it is not, such as Life term dates for members with no Life coverage.
- Currency fields will be decimal numbers with no '$' and no leading '0's.
- Fields not relevant to a given member will be left blank.

RECORD LAYOUTS

HEADER RECORD/FILE METADATA

Field	Field Name	Data Type	Subscriber-Only Fields	Maximum Size	Description
1.	Record Type	CHAR		3	Indicates the type of record to follow: • **HEADER** • SUBSCRIBER • DEPENDENT
2.	File Version	NUM		3	
3.	Effective As Of Date	DATE		8	The date used as the focal point of this snapshot.
4.	File Creation Date	DATE		8	
5.	File Creation Time	TIME		6	HHMMSS

MEMBER & ENROLLMENT DATA

Field	Field Name	Data Type	Subscriber-Only Fields	Maximum Size	Description
1.	Record Type	CHAR		3	Indicates the type of record to follow: • HEADER • **SUBSCRIBER** • **DEPENDENT**
			DEMOGRAPHICS FIELDS		
2.	Subscriber SSN	NUM		9	The Subscriber's SSN. No dashes. This will link families together as all dependents should have their qualifying subscriber's SSN in this field
3.	Member SSN	NUM		9	The SSN of this individual. For the subscriber, this should match the Subscriber SSN field.
4.	Relationship Code	NUM		2	Relationship to the subscriber • 01 = Subscriber • 02 = Spouse • 03 = Non-Spouse Dependent
5.	Last Name	CHAR		20	
6.	First Name	CHAR		15	
7.	Middle Initial	CHAR		1	
8.	Sex Code	CHAR		1	• M = male • F = female • U = unknown
9.	Date of Birth	DATE		8	
10.	Date of Death	DATE		8	
11.	Handicap Flag	CHAR		1	• Y = Yes • N = No
12.	Marriage Date	DATE		8	
13.	Mailing Address Field 1	CHAR		35	
14.	Mailing Address Field 2	CHAR		35	
15.	Mailing City	CHAR		30	
16.	Mailing State	CHAR		2	
17.	Mailing Zip	NUM		5	
18.	Mailing Country Code (ISO)	CHAR		2	A blank country code should be considered equivalent to "US".
19.	Physical Address Field 1	CHAR		35	Physical Address Fields will only be populated if they are different than the Mailing Address

20.	Physical Address Field 2	CHAR		35	
21.	Physical City	CHAR		30	
22.	Physical State	CHAR		2	
23.	Physical Zip	NUM		5	
24.	Physical Country Code (ISO)	CHAR		2	
25.	GOHSEP Region	NUM		2	
	EMPLOYMENT STATUS				
26.	Employment Status	CHAR	Y	3	• ACT = Active • RET = Retired • REH = Rehired Retiree • CB = COBRA • SP = Surviving Spouse • SD = Surviving Dependent
27.	Agency Code	CHAR	Y	5	The four digit agency code.
28.	Agency Location Code	CHAR	Y	5	A secondary agency code
29.	Agency Name	CHAR	Y	35	
30.	Hire Date	DATE	Y	8	
31.	Retirement Date	DATE	Y	8	
	HEALTH ENROLLMENT				
32.	Descriptive Health Plan	CHAR		120	See the table provided for a list of valid Health products and the associated Impact identifiers. The table will be provided when a test file is sent.
33.	Health Network Code	CHAR		5	Impact Health Network Code
34.	Health Product Code	CHAR		5	Impact Health Product Code
35.	Health Plan Code	CHAR		4	Impact Health Plan Code
36.	Health Level of Coverage	CHAR		2	Level of coverage for this health plan. • EE = employee only • ES = employee & spouse • EC = employee & child • FM = family

37.	Health Earliest Effective Date in Plan	DATE		8	This date reflects the earliest date this member enrolled in this health product.
38.	Health Effective Date in Level of Coverage	DATE		8	
39.	Health Term Date	DATE		8	
MISCELLANEOUS					

Any new types of data can be appended to the file here.