5.2 TECHNICAL REQUIREMENTS – List of Confidential and Trade Secret Information

All confidential and trade secret information throughout our submission is enclosed in a box, per the instructions in item 14 of Attachment B. Any page containing a red box has been marked "**CONFIDENTIAL**" at the top and bottom of each page in bold, red.

Below is a list of confidential and trade secret information that has been redacted throughout our proposal.

Table 5.2-2. List of Confidential and Trade Secret Information

	Confidential and Trade Secret Response Description	RFP Section Number and Page Number of Response
1	Signature	Execution Pages, Page 2
2	Signature	Addendum 2, Page 1
3	Subcontractor information	Attachment F, Pages 1-5, contents of table

STATE OF NORTH CAROLINA
North Carolina Department of State Treasurer

Refer *ALL* Inquiries regarding this RFP to: ***Vanessa Davison, Contracting Agent*** ***vanessa.davison@nctreasurer.com with a copy to SHPContracting@nctreasurer.com***	**Request for Proposal # 270-20220830TPAS**
	Proposals will be publicly opened: November 7, 2022, 10:00 a.m. ET
	Contract Type: Open Market
	Commodity No. and Description: 851017 – Health Administrative Services
	Using Agency: The North Carolina State Health Plan for Teachers and State Employees
	Requisition No.: 270-2022083TPAS

Sealed, mailed responses ONLY will be accepted for this solicitation.

EXECUTION

In compliance with this Request for Proposals (RFP), and subject to all the conditions herein, the undersigned Vendor offers and agrees to furnish and deliver any or all items upon which prices are bid, at the prices set opposite each item within the time specified herein. By executing this proposal, the undersigned Vendor certifies that this proposal is submitted competitively and without collusion, that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the North Carolina General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934. Furthermore, by executing this proposal, the undersigned certifies to the best of Vendor's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency. The undersigned Vendor certifies that it, and each of its Subcontractors for any Contract awarded as a result of this RFP, complies with the requirements of Article 2 of Chapter 64 of the North Carolina General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system. N.C.G.S. § 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By execution of this response to the RFP, the undersigned certifies, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

Failure to execute/sign proposal prior to submittal shall render proposal invalid and it WILL BE REJECTED. Late proposals cannot be accepted.

VENDOR:		
Blue Cross Blue Shield of North Carolina		
STREET ADDRESS: 1965 Ivy Creek Blvd	P.O. BOX:	ZIP:
CITY & STATE & ZIP: Durham, NC 27707	TELEPHONE NUMBER: 919-765-3117	TOLL FREE TEL. NO: 800-446-8053

PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE (SEE INSTRUCTIONS TO VENDORS ITEM #10):	
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF VENDOR: Roy Watson, Vice President of Group and State Segment	FAX NUMBER: (919) 765-1920
[redacted] **DATE:** 11/2/2022	EMAIL: Roy.Watson@bcbsnc.com

Offer valid for at least 180 days from date of proposal opening, unless otherwise stated here: _____ days.

ACCEPTANCE OF PROPOSAL

If any or all parts of this proposal are accepted by the State of North Carolina, an authorized representative of the NC Department of State Treasurer, State Health Plan Division shall affix his/her signature hereto and this document and all provisions of this Request For Proposal along with Vendor proposal response and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

FOR STATE USE ONLY:

Offer accepted and Contract awarded this_____ day of _____, 20_____, as indicated on the attached certification, by

_____

(Authorized Representatives of the NC Department of State Treasurer and State Health Plan Division).

Date:	October 14, 2022
RFP Number:	270-20220830TPAS
RFP Description:	Third Party Administrative Services
Addendum Number:	2
Using Agency:	The North Carolina State Health Plan for Teachers and State Employees
Purchaser:	Vanessa Davison
Opening Date / Time:	November 7, 2022 @ 10:00 a.m. ET

INSTRUCTIONS:

1. This Addendum is issued in response to questions submitted.
2. Return two (2) properly executed originals of this Addendum Number 2 with your Technical and Cost Proposal. Failure to sign and return this Addendum Number 2 may result in the rejection of your proposal.

****

Execute Addendum Number 2, RFP Number 270-20220830TPAS:

Vendor: Blue Cross Blue Shield of North Carolina

Authorized Signature: [redacted]

Name and Title (Print): Roy Watson

Vice President of Group and State Segment

Date: November 2, 2022

No.	Reference	Vendor Question	Answer
1.	1.1, page 8	Would the Plan consider the awarded vendors narrow network as a potential solution to the Clear Pricing Project (CPP) in the future?	The Plan will evaluate network options during the implementation of the Contract. While a narrow network may be an option at some point, the Plan has a commitment to the independent providers that joined CPP; therefore, continuing to support these providers is important to the Plan.
2.	1.2, page 10	Can the State Health Plan provide the current self-funded administration fees and identify what programs are included in the fees?	The base administrative fees for the Plan include claims, customer service, ID cards, utilization review, medical management, network access, appeals, group premium billing, enrollment and EDI reconciliation, outbound Data Files, secure Member portal, audits, standard and custom reports, self-service analytical tool, actuarial support for benefits and programs, information-technology-data management, provider network, management, and services.
3.	2.4 RFP SCHEDULE, page 12	Will a finalist meeting for each vendor be held during the BAFO window or at some other time?	The Plan did not include finalist meetings in the RFP Schedule and does not anticipate the need to add a finalist meeting to the schedule at this time.
4.	2.6 c) ii, page 13	Due to the size, should the completed claims repricing files we received from Segal via the SFTP link on 9/30/22 (NCSHP_Medical_RFP_Medical_File_Part1.zip and NCSHP_Medical_RFP_Medical_File_Part2.zip) be uploaded back to the same SFTP link, and not be included in electronic format in our hard copy/USB proposal response?	Yes, Vendor should upload its response to Attachment A-3 to the Segal SFTP workspace where Vendor accessed the RFP data files and attachments. In addition to uploading the response to the Segal SFTP workspace, all cost proposal attachments are required to be submitted in hard copy and USB per Section 2.7.2 “Technical and Cost Proposal Contents.” However, note that Section 2.6.3 “Technical and Cost Proposal Submission” states that individual attachments, exhibits, and/or supporting documentation greater than 50 pages in length may be submitted in electronic copy only on flash drives. If so, the hard copy responses must specifically identify the file names and location of the individual attachments, exhibits, and/or supporting documentation.

5.	2.7.2, page 14, 2.6.3 page 15 and 5.3, page 74	Should the technical proposal as laid out in section 2.7.2 just have a page in letter d) referring to a separate cost proposal binder, in which all cost items should be contained?	Confirmed. In accordance with the order of preference laid out in Section 2.7.2 "Technical and Cost Proposal Contents," a page in d) as a marker for the cost proposal indicating a separate binder including all cost items is acceptable.
6.	2.7.2, page 16	Can you confirm "ATTACHMENT B: INSTRUCTIONS TO VENDORS" only needs to be included in the proposal in whole, and does not need to be signed?	Correct. Attachment B: "Instructions to Vendors" does not require a signature. Vendor is required to submit a copy of Attachment B: "Instructions to Vendors" in accordance with RFP Section 2.7.2 "Technical and Cost Proposal Contents."
7.	2.7.2, page 16	Will the Plan permit vendors to include a Cover Letter and/or Executive Summary highlighting their offering?	No. The Plan will not review nor evaluate as part of the Contract, if awarded, any Cover Letters or Executive Summaries.
8.	4.15 Conflict of Interest, Page 32	Please confirm if the information requested in section 4.15 is required upon award, or if it should be included with our RFP response?	The obligation to make certain disclosures under Section 4.15 "Conflict of Interest" is created upon the signing of the Execution Page. Therefore, any information rising to the level of a necessary disclosure under Section 4.15 "Conflict of Interest" should be submitted with the RFP Response.
9.	4.18 page 33, and Attachment B, #9, page 86	Can you confirm the Certificate of Authority to Transact Business (and any other required licenses or certificates) would need to be provided upon award, and should not be included with our proposal response?	Correct. The provisions of Section 4.18 "Registration and Certification" requiring a Certificate of Authority to Transact Business is a condition of Contract award. It should not be included with proposal responses, but Vendors must be prepared to furnish any necessary documents at the point of award.
10.	5.1.4 (c), page 38	Please describe the customization anticipated for incentive Plan Design features.	The current Plan Design features include a copay incentive as referenced in Requirement 5.1.4.b. There are also copay incentives for CPP specialists and mid-tier providers. These are outlined as Wellness Incentives in the Plan's Benefit Booklet. The Plan may also develop additional incentives or value based benefit designs in the future.
11.	5.2.1.1, page 44	What custom Product Solutions will be needed to support the Plan?	The Plan intends to evaluate Vendor's network and product offerings during the implementation of the Contract.

			Any customizations will be determined at that time and evaluated on an annual basis.
12.	5.2.2 Finance and Banking Technical Requirements b ii, page 47 and exhibit 1 on page 121	Can the Claims Overpayment recoveries be deposited into one account, or do they need to be separated into different accounts based on different agencies or other needs?	Claim Overpayment recoveries can be deposited into one account.
13.	5.2.2 Finance and Banking Technical Requirements b iii, page 47 and Exhibit 11 page 120-121	The Diagram indicates DST will do positive pay reconciliation and receives cleared items from the bank. Is this diagram applicable to this health care business? From RFP pg. 47, "iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable." Will DST do a parallel reconciliation with the contractor and/or the bank? If so, would DST then require updates for stops and voids from the contractor? Does DST decision positive pay exception items at the bank or does contractor handle exceptions? Does DST send cleared items to the contractor in order that the contractor can reconcile in parallel and identify stale dated escheatable items?	This diagram is applicable. Department of State Treasurer (DST) Accounting will do a parallel reconciliation of disbursing accounts using the reconciliation sent by Vendor. DST Accounting requires information for stops and voids from Vendor via the weekly disbursement report. In addition, DST Accounting requires a separate report on any return items that will be included subsequently with the weekly disbursement report. DST Banking is responsible for decisioning positive pay exception items on a daily basis. DST Banking makes available cleared items in order to aid Vendor in reconciliation and identification of stale dated escheated items.
14.	5.2.2 Finance and Banking Technical Requirements b x, xi, page 47	Does the Plan wish to review individual claims for payment approval or is the entire batch approved in total? Will the State cap disbursements based on an aggregate amount? If a batch or individual claims are held, who decides which claims are held? How is Late Claim Interest handled for claims the state holds?	The disbursement request is approved in total. If the Plan has to limit the weekly disbursement, the Plan will provide Vendor with the amount to be disbursed and Vendor can determine which claims to release. Vendor is only responsible for late payment penalties as a result of Vendor's action, inaction, or system failure.
15.	5.2.2 Finance and Banking Technical Requirements xix, page 48	Can you define what "settlement" means, as used in this item? How often does it occur in the current contract that you have an ad hoc settlement to the member?	As noted in Requirement 5.2.8.2.a.iii, the Plan must follow N.C.G.S. § 135-48.24. This applies to both claims and enrollment appeals; therefore, the Plan may reach a financial "settlement" with a Plan Member as a result of this process. On average the Plan reaches a settlement with a Member every 45 – 60 days.
16.	5.2.2.2 Finance and	(Inline check processing) Our check production begins with blank, security enhanced check stock.	This process is acceptable to the Plan. During the implementation of

	Banking, page 46-Banking Services link. And page 47 item iii in reference to Check Stock and preprinted contents	Upon it, the relevant customer and banking information, including MICR, is printed in real time. Please confirm this is acceptable versus preprinted stock that would include NC specific details.	the Contract, the Plan would require a test check that could be approved prior to production.
17.	5.2.3.2.b.iii	Please define "payment rules" and "utilization management."	Payment rules are intended to capture the specific requirements Vendor has implemented to consistently administer claims. If Vendor, for example, requires prior authorization for a service to be covered, this “payment rule” should apply to services incurred in North Carolina as well as any other state. The penalty for not following the rule should be the same too. If, for example, the network provider is responsible for obtaining the prior authorization, that should be the rule in every state, not just North Carolina. The same is true for utilization management. If there are medical necessity, appropriateness, and efficiency of the use of certain services, the same criteria should be applied in all states.
18.	5.2.3.2.b.iii	Please confirm that the definitions of “payment rules” and “utilization management” apply to all locations, including outside of North Carolina.	Confirmed. See response to Question #17 above.
19.	5.2.3.2 (b) v, page 49	Can virtual visits be billed through the claims wire?	All claims must be funded through the weekly disbursement process.
20.	5.2.4.2 (a) iii, page 51	Can you provide a sample of a value-based incentive plan and any other concepts you may be considering or implementing in the future?	The Plan is currently developing a capitation pilot program with a provider group. This will be a retrospective program layered on top of fee for service. If successful, the Plan anticipates expanding that program. The Plan also anticipates deploying other, yet to be determined, value-based and/or incentive programs in the future.
21.	5.2.4.2.b.viii	Please provide an example of an integration request the Plan may be considering.	If the Plan’s current pilot program with a provider, described in the response to Question #20 above, is successful, a future phase may require integration

			with the Plan's TPA. That is all yet to be determined.
22.	5.2.4.2 (b) ix, page 52	Is the HRA offered to anyone enrolled in both the Enhanced or Basic PPO plans today?	The Plan does not currently offer an HRA, but may decide to do so again in the future.
23.	5.2.4.2 (b) ix, page 52	Do the Employer funds on the HRA pay upfront?	While Members earn funds "upfront," the account would be virtual; which means the Plan would pay the claims from the HRA as they are incurred.
24.	5.2.4.2 (b) ix#14,page 52	Does the plan have any specifications on the HRA that might be offered with the Enhanced PPO copay based plan (80/20)?	The Plan does not have any specifications about the HRA at this time.
25.	5.2.5.2 (b) ii , page 53 5.2.5.2 (b) viii, page 54	Will SHP allow TPA's to bill services behavioral Health capitation through the claims wire? Are Radiology utilization management services allowed to be processed through the claims wire or invoice? Are any fees paid to access networks outside NC?	All claims should be paid via the weekly disbursement. A determination about whether the Plan will support a capitated payment will have to be determined during the implementation of the Contract. Vendor should include any PSPM or PMPM fees for utilization management programs in Attachment A-7: Administrative Fees. The Plan does not currently pay separate network access fees.
26.	5.2.5.2 (b) ii, page 53	Please provide a copy or a sample of any current clinical policies that have been customized or concepts you may be considering implementing in the future?	While the Plan does not currently have any custom clinical policies, the Plan has implemented new benefits, such as applied behavioral analysis, that at the time were not a standard benefit of the TPA and therefore required a custom medical policy. Additionally, the Plan has exclusions that may impact a Vendor's clinical policies. It would be the Vendor's responsibility to administer the claims and policies in accordance with the Plan's benefit booklet.
27.	5.2.5.2 (b) vii, page 53	Can you provide an overview of the specific types of wellness programs and services you are looking for as a part of the bid to support plan members?	The Plan does not have a specific type of wellness program requirement. The Plan expects Vendor to include some wellness programs as part of its standard offering.
28.	5.2.5.2 (b) x, page 54	What is the scope of conditions and health risks to be covered as part of the Disease Management health coaching program?	The Plan has not defined the Disease Management program for this Contract.

29.	5.2.5.2 (b) x, page 54	How does the Plan want the services delivered: 1:1 telephonic, group coaching or digitally?	The Plan does not have a specific requirement about how the services will be delivered.
30.	5.2.5.2 (b) x, page 54	Are there expectations for the vendor to provide coaching services onsite? If so, in which locations?	There are no on-site coaching service requirements.
31.	5.2.5.2 (b) x, page 54	Will the Plan allow for disease management services to be charged on a per engagement basis?	If disease management services are being offered as an Additional Service, the Plan will consider fees on a per engagement basis.
32.	5.2.6 Enrollment, EDI and Data Management 5.2.6.2 Services, b, ii item 4; page 57	Confirm what vendor connections and types of data are being requested to be use for API's?	While the Plan has utilized APIs in the past, the Plan does not currently have any APIs in place. As a reminder, Vendor will have to integrate with the Plan's EES vendor's systems.
33.	5.2.6 Enrollment, EDI and Data Management 5.2.6.2 Services, b, items xxxiii, xxxiv, xxxv & xxxvi; page 58	1095-B forms are used by fully insured carriers for all size business and self-funded groups with fewer than 50 full-time employees and/or full-time equivalents. Confirm if these items are applicable to this RFP.	Many of the Employing Units enrolled on the Plan have less than 50 employees; therefore, 1095-B forms are applicable.
34.	5.2.7.2 (b) v and 5.2.7.2 (b) vi, page 59	To protect the privacy of members, it is our practice to redacted sensitive PHI information from recorded calls. Will this process meet the Plan's requirements?	Vendor shall provide copies of non-redacted recorded calls in response to this Requirement as the Plan expects to receive all information related to calls.
35.	5.2.7.2 (b) xii, page 60	Please elaborate on the number of unique digital platform experiences you will require for your wellness program. How many different wellbeing incentives are being administered? For example, do state employees receive a different experience from state colleges, employer groups or local governments?	The Plan does not require a specific number of digital platform experiences in support of wellness programs, but the Plan expects there to be some standard digital offerings. There are currently no wellbeing incentives for Plan Members.
36.	5.2.7.2.b.xxi	Please describe the type of online forums and live chat groups that would be on the member portal.	The Plan is not currently hosting online forums or live chats but has successfully utilized these in the past to engage Members in wellness challenges. The Plan would like to engage in these types of activities in the future.

37.	5.2.7 Customer Experience 5.2.7.2 Services, b, xxiii item 4; page 61	Confirm how many single sign-on (SSO) connections will be requested to build the State's vendor partnerships?	At a minimum, there will be an SSO between the Plan's EES vendor and the TPA, and an SSO between the Plan's PBM vendor and the TPA. Some type of integration will be required between the Plan's EES vendor and the TPA's PCP Selection tool, as outlined in Requirement 5.2.6.2.a.xxi.
38.	5.2.7.2. (b) xxxi, page 62	Can you please describe how many onsite wellness events you anticipate having annually?	In 2022, there has been one onsite wellness event. There are currently no wellness events planned for 2023.
39.	5.2.8.2 (b) xiv, page 63	Can you confirm EOB Election would be done at the employee/family level, rather than the individual level?	Correct. EOB Election will be done at the employee/family level, rather than the individual level.
40.	5.2.8 Claim Processing and Appeals Management 5.2.8.2 Services, b, xvi; page 64	Can you describe or give examples of the "gate-keeper" rules?	Currently, Plan Members can select a PCP, but they are not required to use that PCP. At some point, the Plan may decide to tighten up the PCP selection requirements in such a way that the Member would be required to select and utilize the PCP.
41.	5.2.9.2 (b) xxiv, page 66 5.2.8.2 (b) viii, page 63	It is typical for a TPA to subcontract with vendors for recovery for claims that may have been overpaid, fraudulent, paid in error, misdirected including subrogation. When recoveries are made, the vendor charges a fee for those services. The fee is based on the recovery savings and billed through an invoice or claim wire. Can the TPA bill for those services through an invoice process or through the claims wire? Other services that may be billed through invoice or claims wire may include: -Subrogation -Coordination of Benefits -Third Party Claims and Code Review -Out of Network claims review negotiation of charges -Radiology Utilization Management -Behavioral Health	Any fees that Vendor intends to invoice to the Plan must be outlined in the Cost Proposal, Attachment A-7 and billed on a monthly basis as part of the administrative fees.
42.	5.2.11 Reporting 5.2.11.2 Services, b, viii items 2 b & c; page 69	Confirm if items b & c should read country or county?	Requirements 5.2.11.2.b.viii.2) b) and c) appropriately read "country".

43.	Phase II - General Question	Can you clarify the scoring metrics for each of the required attachments A-L?	Attachment A: "Pricing" and Attachment L: "Technical Requirements Response" will be scored in accordance with RFP Section 3.4 "Evaluation Criteria." There are no points allocated to Attachments B through K. However, Attachment B: "Instructions to Vendors" and Attachment F: "Supplemental Vendor Information" are required to be submitted in accordance with RFP Section 2.7.2 "Technical and Cost Proposal Contents." Attachments C, D, E, G, H, I, J, and K were submitted in response to RFP Sections 2.7.1 "Minimum Requirements Proposal Contents" and 5.1 "Minimum Requirements."
44.	Attachment A	Please confirm that no component of the cost proposal may be redacted.	Correct. Vendors are required to submit a non-redacted cost proposal for evaluation.
45.	Attachments and execution pages	Please confirm that the plan will accept digital signatures on the technical and cost proposals as was accepted on the minimum requirements.	Correct. Digital signatures are acceptable and binding for all forms requiring signatures, including the Execution Pages, as stated in response to Question #18 in Addendum #1.
46.	Attachment A - Pricing	Please provide a detailed description of your current clinical care management programs.	The Plan does not have detailed descriptions of the current clinical management programs. These programs are managed by the Plan's TPA and change from time to time.
47.	Attachment A - Pricing	Can you please share what the State's medical trend has been over the past few years?	The trend rates listed below are based on incurred dates of service in the respective calendar years. Obviously, COVID-19 had a big impact. The average over this time period is 6.3% for medical trend. 2017: 3.5% 2018: 5.0% 2019: 3.8% 2020: 2.9% 2021: 16.2%
48.	Attachment A-page 81	Can you confirm additional quotes for alternate/narrow networks will not be accepted as part of this RFP?	Correct. Additional quotes for alternative/narrow networks will not be accepted at this time.
49.	Attachment A - Pricing	What does the Plan consider an eligible not considered record? (For example, TIN, dental RX, mental health, chiropractic, RAPL, claim, etc.)	All records in the data file are eligible claims to be considered. If Vendor is not able to reprice a claim, Vendor

	1.1 Network Access		should indicate “NA” in the “NetStatus” field, $0 in the “ContAmt” field, and the reason for not repricing the claim in the “ContType” field.
50.	Attachment A - Pricing 1.1 Network Access	What percentage of network disruption will the Plan find satisfactory?	The Plan has not established a disruption percentage.
51.	Attachment A 1.1.1, page 82	Can the Plan provide a zip code listing of which members they would like the Geo Access reports run for OB/GYNs (female members, age 12 and older) and Pediatricians (members, birth through age 18) or guidance on what starting date bidders should base the age on?	Vendors should use 10/1/2022 to calculate the age of all Members.
52.	Attachment A 1.1.1, page 82	Do bidders need to provide full geo access reports, in addition to completing the Network Access Urban, Network Access Suburban and Network Access Rural tabs? Can you confirm actual maps are not required?	Yes, Vendor needs to provide full geo access reports, in addition to completing the Network Access Urban, Network Access Suburban, and Network Access Rural tabs. Vendor needs to complete the exhibits provided in Attachment A-2 and provide documentation that the access reports were run consistent with the parameters requested in Attachment A: “Pricing” of the RFP, which includes mapping.
53.	Attachment A 1.1.3, page 83	Can you confirm providers requested in the “Provider Listing” tab should be our North Carolina broad network?	Vendor’s broad network should be used.
54.	Attachment A, 1.2.1, page 83	Is it acceptable to provide our response to the repriced claims file with just these four fields in the final file: -SG_ROWID (Unique record identifier) -NetStatus (Network Status) -ContAmt (Network Contracted Amount) -ContType (Type of Network Contract)	Yes, it is acceptable for Vendor to return the claims repricing files with only these four (4) fields. -SG_ROWID (Unique record identifier) -NetStatus (Network Status) -ContAmt (Network Contracted Amount) -ContType (Type of Network Contract)
55.	Attachment A - Pricing 1.2.1 Claims Repricing File	Due to the confidentiality of the repricing exercise and the limited number of people with access to that information, is possible for our designated recipient to return the repricing exercise results through the Segal SFTP site?	Yes. Vendor should upload its response to Attachment A-3 to the Segal SFTP workspace where Vendor accessed the RFP data files and attachments. In addition to uploading the response to the Segal SFTP workspace, all cost proposal attachments are required to

			be submitted in hard copy and USB per Section 2.7.2 "Technical and Cost Proposal Contents." However, note that Section 2.6.3 "Technical and Cost Proposal Submission" states that individual attachments, exhibits, and/or supporting documentation greater than 50 pages in length may be submitted in electronic copy only on flash drives. If so, the hard copy responses must specifically identify the file names and location of the individual attachments, exhibits, and/or supporting documentation.
56.	Attachment A - Pricing 1.2.1 Claims Repricing File	What is the Plan's evaluation process specific to the review of the repricing (Attachments A) with the qualified vendors? Will there be any question/answer, clarifications or other types of exchanges during the review process in order for the State to fully understand the network value put forth by the vendor? If so, how will those exchanges be handled?	Attachment A: "Pricing" will be evaluated and scored in accordance with RFP Section 3.4.c) "Evaluation Criteria – Cost Proposal." The Plan will communicate with Vendors as needed through the written request for clarification process.
57.	Attachment A-1.2.1, page 84	Will Contract improvements indicated in Exhibit A-6 be considered in the network pricing scoring, or are they informational-only?	Responses to Attachment A-6, along with all pricing attachments, will be considered in the evaluation of proposals.
58.	Attachment A-1.3 Administrative Fees, page 84	Should bidders provide pricing for on Flexible Spending Accounts (healthcare and dependent care) and/or Limited Purpose Flexible Spending Account, in addition to the HRA and HSA pricing?	No. Vendor should not provide pricing for Flexible Spending Accounts.
59.	Attachment A 1.6, page 85	Can you confirm a typed signature is acceptable for Attachment A10 Actuarial Certification?	No. Typed signatures are unacceptable. Vendor shall either provide wet signatures, preferably in blue ink, or digital signatures, as stated in response to Question #19 in Addendum #1.
60.	Attachment A-3	What is the intention of the table with the Medicare control totals? Attachment A-3 includes a tab called Medicare Summary which shows control totals. The data files don't appear to have a way to identify those same charges? Are the Medicare charges included in the 15M line data sample?	The "Medicare Summary" tab includes informational data on the Medicare primary lives and claims Vendor is expected to administer as part of this Contract. The data in the "Medicare Summary" tab are not control totals and these Medicare claims are not included in the claim data files provided for claims repricing.
61.	Attachments A-3 and A-6	Please confirm the claim time period to be used for the repricing analysis is incurred January 2021 through December 2021, paid through June 2022.	The claims data provided for repricing represents incurred January 1, 2021, through December 31, 2021, paid

		Please confirm the instructions on attachment A-6 indicate that we should use results on attachment A-3 to illustrate contract improvements for 2025.	through June 30, 2022. In its response to Attachments A-3, A-4, and A-5, Vendor is expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing. Vendor's response to Attachment A-6 should reflect anticipated improvements in its reimbursement arrangements from after the claims repricing analysis (i.e., not reflected in the claims repricing) to January 1, 2025.
62.	Attachment F - Supplemental Vendor Information	We would like to better understand the states expectations on HUB certified tier-2 suppliers. How can we demonstrate integrating our current initiatives as we build tier-2 suppliers in partnership with the State?	Attachment F: "Supplemental Vendor Information" is not a scored document, rather it is intended for informational purposes only. Responses should reflect current relationships, and responses may be amended or revised over the life of the Contract.
63.	Attachment F - Supplemental Vendor Information	What is the numerical points value for Attachment F: Supplemental Vendor Information?	There are no points allocated for Attachment F: "Supplemental Vendor Information"; however, Vendor is required to complete and submit Attachment F: "Supplemental Vendor Information" in accordance with Section 2.7.2 "Technical and Cost Proposal Contents."
64.	Attachment L, page 118	Can you confirm that the Attachment L- Technical Requirements Response Document that was posted to the Ariba site only needs to be returned in the Hard Copy/UBS submission once complete, and does not need to be reposted to the Ariba site?	Correct, Vendor should not upload its completed Attachment L: "Technical Requirements Response" into Ariba. Vendor is required to submit its completed Attachment L: "Technical Requirements Response" in accordance with RFP Sections 2.6.3 "Technical and Cost Proposal Submission" and 2.7.2 "Technical and Cost Proposal Contents."
65.	Addendum #1, in whole	Can you confirm that a signed copy of Addendum #1 does not need to be re-included with our response, since we included in the Minimum Requirements response?	Correct, Vendor does not need to include a signed copy of Addendum #1 in its Technical Requirements response in addition to its Minimum Requirements response.

4.10 ADMINISTRATORS FOR THE CONTRACT AND HIPAA PRIVACY OFFICER

The contract administrators are the persons to whom notices provided for in this Contract shall be given and to whom matters relating to administration or interpretation of this Contract shall be addressed. Either party may change its administrator or his or her address and telephone number by written notice to the other party.

a) The Plan's Contract Administrator for day to day activities, Contract Administrator for all contractual issues, and HIPAA and Contract Compliance Coordinator are listed below:

North Carolina State Health Plan Contract Administrator regarding day-to-day activities herein:

Caroline Smart, Senior Director of Plan Integration
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, NC 27604
Phone: (919) 814-4454
Email: Caroline.Smart@nctreasurer.com

North Carolina State Health Plan Contract Administrator for all contractual issues listed herein:

Vanessa Davison, Contracting Agent
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, NC 27604
Phone (919) 814-4421
Email: Vanessa.Davison@nctreasurer.com

North Carolina State Health Plan HIPAA and Contract Compliance Coordinator for all privacy related matters herein:

Chris Almberg, HIPAA Privacy Officer
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, NC 27604
Phone (919) 814-4428
Email: Chris.Almberg@nctreasurer.com

North Carolina Department of State Treasurer Information Security Officer for all data security related matters herein:

Renee Bourget, Information Security Manager
North Carolina Information Technology Division
3200 Atlantic Avenue
Raleigh, NC 27604
Phone (919) 266-3925
Email: Renee.Bourget@nctreasurer.com

b) Vendor's contract administrator for day to day activities, contract administrator for all contractual issues, and HIPAA and Contract Compliance coordinator are listed below:

Vendor's contract administrator regarding day-to-day activities herein:

Name:	Ashley Bledsoe
Title:	Principal Business Operations Advisor
Agency:	N/A
Address:	Blue Cross NC 1965 Ivy Creek Blvd Durham, NC 27707
Phone:	855-641-8848
Email:	Ashley.Bledsoe@bcbsnc.com

Vendor's contract administrator for all contractual issues listed herein:

Name:	Roy Watson
Title:	VP, Group and State Segment
Agency:	N/A
Address:	Blue Cross NC 1965 Ivy Creek Blvd Durham, NC 27707
Phone:	919-765-3117
Email:	Roy.Watson@bcbsnc.com

Vendor's HIPAA Privacy or Compliance Officer for all privacy related matters herein:

Name:	Lynne Hamlet
Title:	Director, Privacy, Ethics & Corporate Policy Offices
Agency:	N/A
Address:	Blue Cross NC 1965 Ivy Creek Blvd Durham, NC 27707
Phone:	919-765-7416
Email:	Lynne.Hamlet@bcbsnc.com

Vendor's Information Security Officer for all data security related matters herein:

Name:	Rick Chilton
Title:	Chief Information Security Officer

Agency:	N/A
Address:	Blue Cross NC 1965 Ivy Creek Blvd Durham, NC 27707
Phone:	919-765-2021
Email:	Rick.Chilton@bcbsnc.com

ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE

ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE is posted on the Ariba landing page and can be accessed at the following link: http://discovery.ariba.com/rfx/13956411

Vendor shall complete ATTACHMENT L by only marking either "Confirm," or "Does Not Confirm" as a response for each Technical Requirement. Under no circumstances will narrative or text from Vendor be accepted as a response.

5.2.1 Account Management

5.2.1.1 Overview and Expectations

The Plan seeks to partner with a Vendor that has the experience, knowledge, and resources to support all the services outlined in this RFP. Vendor must be transparent when partnering with the Plan on initiatives or providing internal processes, data, or other information, as requested by the Plan. Vendor must also show a willingness to develop custom networks and Product solutions to support the Plan. Finally, Vendor must be responsive and have the resources to support Plan operations, implementations, and ongoing data needs.

5.2.1.2 Resources

a. Vendor addressed the following in the Minimum Requirements Table or ATTACHMENT K:

   i. Vendor has provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives. Vendor shall provide the Plan with contact information for one (1) such client to complete a reference call related to the services in this RFP.

   ii. Vendor has one (1) or more current or former ASO clients with more than 25,000 Medicare primary members.

   iii. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.

   iv. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.

   v. Vendor has a "firewall" between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.

b. Vendor shall confirm it will provide a dedicated resource for each of the following roles:

   i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to Plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.

   Confirm ☑ Does Not Confirm ☐

ii. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment and Group Set-Up.

Confirm ☑ Does Not Confirm ☐

iii. **Member Services Manager** – Responsible for all customer service functions and reporting.

Confirm ☑ Does Not Confirm ☐

iv. **Claims Services Manager** – Responsible for claims payments and recoveries.

Confirm ☑ Does Not Confirm ☐

v. **Enrollment and Group Set-Up**– Responsible for all enrollment, enrollment files, and reconciliation services.

Confirm ☑ Does Not Confirm ☐

vi. **Data Manager** – Responsible for providing expertise in data analytics and modeling as well as coordinating data requests, data testing, and data exchanges, including any data files to Plan vendors, Plan partners, and the Plan.

Confirm ☑ Does Not Confirm ☐

vii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process and must continue to support the Plan for a minimum of 90 days after the implementation date of January 1, 2025, if requested by the Plan. Such support includes, but is not limited to, weekly calls with the Plan and the designated account management team; maintenance of issue tracking logs; and issue resolution.

Confirm ☑ Does Not Confirm ☐

c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed. Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:

i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.). This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic initiatives.

Confirm ☑ Does Not Confirm ☐

ii. **Director of Network Management** – Responsible for overall management of Vendor's network including provider contracting, network development, and/or provider relations functions. This resource will work with the Plan to develop, implement, and maintain custom provider reimbursement models or other provider initiatives as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iii. **Actuary** - Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating Return on Investment (ROI) in order to measure financial effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) as well as alternate payment models (Accountable Care Organizations, Clinically Integrated Networks, etc.). Will be required, upon request, to provide sufficient data and documentation to the Plan to independently verify calculations. The Actuary shall be a Fellow of the Society of Actuaries with a primary focus in Health Benefit Systems.

Confirm ☑ Does Not Confirm ☐

iv. **Privacy Officer** - Responsible for ensuring compliance with all applicable laws and regulations, including, but not limited to, HIPAA, Patient Protection and Affordable Care Act (PPACA), and the Employee Retirement Income Security Act of 1974 (ERISA). Responsible for maintaining internal controls to protect Protected Health Information (PHI) and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.

Confirm ☑ Does Not Confirm ☐

v. **Attorney** - Responsible for communicating program and policy updates to the Plan and coordinating as necessary with the Plan's internal counsel and staff. Responsible for promptly reviewing materials for Vendor and providing appropriate, legally justifiable, feedback to the Plan. This person must be well-versed in Chapter 135 of the North Carolina General Statutes and Chapter 58 of the North Carolina General Statutes, to the extent that North Carolina Department of Insurance (DOI) regulations apply to the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.1.3 The Plan requires a Vendor that is both responsive and transparent.

a. Vendor shall confirm each of the following:

i. Vendor will meet with the Plan within two (2) weeks of a new request or initiative and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan. Meeting topics could include, but would not be limited to, data requests, network and/or Product development, pilots, and other initiatives.

Confirm ☑ Does Not Confirm ☐

ii. Once a project or initiative is underway, Vendor will meet with the Plan within one (1) week of the request and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will respond to Plan inquiries regarding legal, financial, or operational matters within 48 hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will respond to Plan inquiries regarding customer and provider matters within 24 hours of the request, unless extended by the Plan.

Confirm ☑ Does Not Confirm ☐

v. Vendor will work with the Plan and other Plan vendors as needed to resolve issues. This includes providing the specific Vendor resources and expertise needed to address the specific issue(s), not just the account management team; and multiple meetings per week prior to and after Go-Live before all services are normalized.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will keep the Plan informed of changing state and federal rules, mandates, or other requirements to ensure compliance.

Confirm ☑ Does Not Confirm ☐

vii. Upon request, Vendor will provide written documents outlining internal processes and procedures and, when requested by the Plan, agree to alter internal processes to meet the needs of the Plan.

Confirm ☑ Does Not Confirm ☐

viii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.2 Finance and Banking

5.2.2.1 Overview and Expectations

The Plan seeks a Vendor that can provide a full range of best in class financial and accounting services in support of TPA services. These services include, but are not limited to, claims processing, provider payments, and recoveries. Vendor must be able to process and deposit receipts each day as well as batch claims and other disbursements on a weekly basis as required by the Plan. Vendor must be able to implement processes for all financial transactions that are compliant with State banking guidelines, including the policies and regulations of the Office of State Controller and the Department of State Treasurer, and provide timely documentation and reporting to support the Plan's financial reporting. As a State Agency, the Plan may have unique limitations or special requirements around funding claims and handling deposits and other financial transactions.

5.2.2.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.

ii. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website: https://www.nctreasurer.com/media/3791/open

iii. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.

iv. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.

v. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:

1) State banking: https://www.nctreasurer.com/media/3791/open
2) Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
3) Escheats: https://www.nccash.com/holder-information-and-reporting
4) High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."

vi. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.

b. Vendor shall additionally confirm each of the following:

i. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.

Confirm ☑ Does Not Confirm ☐

v. Vendor will provide access to up to three (3) years of historical receipts and claims funding data.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide electronic submission of deposit reports and disbursement funding as well as detailed backup documentation to support the transactions.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide historical check register detail and receipts as well as claims funding data.

Confirm ☑ Does Not Confirm ☐

viii. Vendor has internal quality control programs and audits that will ensure the accuracy of all financial reporting to the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will batch claims and other disbursements for payment via check or automatic clearing house (ACH) from the Plan's bank account on a weekly basis as determined by the Plan.

Confirm ☑ Does Not Confirm ☐

x. Vendor will hold payment of weekly claims and other disbursements until funding is authorized and requisitioned by the Plan.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will limit the aggregate dollar amount of claims paid each week if requested by the Plan to manage cash flow.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will deposit checks received into the Plan's bank account within 24 hours of receipt to comply with the State's banking and cash management requirements.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide a daily reporting package of deposited receipts as required by the Plan (see Reporting Section 5.2.11).

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will provide a weekly reporting package of claims and other disbursement as required by the Plan (see Reporting Section 5.2.11).

Confirm ☑ Does Not Confirm ☐

xv. Vendor will customize the reporting of any deposits, disbursements, or other financial transactions as required by the Plan.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will notify and report on all warrants/checks to be escheated prior to the submitting state filings, and if required by the Plan, adhere to a prior approval process for escheats.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor will recommend uncollectible accounts for write-off and adhere to a prior approval process.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor will notify and consult with the Plan at least 60 days in advance, or as soon as practical, of any system or business process change as it relates to handling, processing, or reporting of the Plan's financial transactions.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will process ad hoc check requests, such as a settlement check to a Member, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.3 Network Management

5.2.3.1 Overview and Expectations

The Plan requires a Vendor that will provide a strong network in all 100 counties of North Carolina and throughout the United States. This Vendor must also partner with the Plan on network initiatives that provide affordable, quality care and increase transparency, predictability, and value for Plan Members. For example, the Plan's most recent network initiative was the implementation of a network of independent North Carolina providers, and a few smaller hospitals that were reimbursed on a Medicare reference-based pricing model. The effort is known as the Clear Pricing Project. The network, the North Carolina State Health Plan Network, was managed and supplemented by the TPA. Through this effort, the Plan built some key provider partnerships and demonstrated the viability of the reference-based pricing reimbursement methodology. While reference-based pricing continues to be a strategy the Plan intends to pursue, the specific types of alternative payment models to be implemented at the Go-Live of the Contract will be determined during implementation. Regardless of the payment model, the Plan intends to find a way to continue the tiered network strategy that rewarded Plan Members, via lower cost-shares, for utilizing CPP providers. Therefore, selecting a TPA partner that will support this type of custom provider reimbursement arrangement, or any other custom network, is essential to the Plan's provider strategy.

5.2.3.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor agrees the Plan is a government payor.

ii. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.

iii. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.

iv. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

v. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.

vi. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.

vii. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.

viii. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.

ix. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.

x. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.

xi. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.

xii. Vendor will administer other reference-based pricing models, if requested by the Plan.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support transparency by allowing the Plan, at its request, to directly view any contracts associated with Vendor's network. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules. The Plan will take steps to protect Vendor's confidential data and proprietary information in accordance with applicable state and federal laws and regulations.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will provide services to Members who travel outside the United States and have an urgent medical need.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.

Confirm ☐ Does Not Confirm ☑

iv. Vendor will customize "hidden providers" (e.g., an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon) payment policies, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

v. Vendor will work with the Plan to ensure reimbursement rates for virtual visits with network providers are set appropriately.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide transition of care services to assist Members when their provider is no longer in the network.

Confirm ☑ Does Not Confirm ☐

vii. Vendor offers a "narrow" network in North Carolina that may be utilized by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

Confirm ☑ Does Not Confirm ☐

viii. Vendor has a network management team that will support the Plan on any custom or private label network solutions.

Confirm ☑ Does Not Confirm ☐

ix. Vendor has a provider credentialing team that could be utilized to credential potential network providers if the Plan were to develop a network solution that may include providers that are not currently enrolled in Vendor's other networks.

Confirm ☑ Does Not Confirm ☐

x. Vendor has the ability to communicate directly with providers and will communicate Plan specific information to providers, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for specific services such as, but not limited to, specialty pharmacy.

Confirm ☑ Does Not Confirm ☐

xii. Vendor has experience with each of the following alternative models of care or clinically integrated systems and will work with the Plan to deploy Vendor's solution or develop a similar custom solution for the Plan. Vendor shall confirm it has experience with each alternative payment model listed below:

1) Patient-Centered Medical Homes.

Confirm ☑ Does Not Confirm ☐

2) Hospital At Home Programs.

Confirm ☑ Does Not Confirm ☐

3) Accountable Care Organizations.

Confirm ☑ Does Not Confirm ☐

4) Community Care Organizations.

Confirm ☑ Does Not Confirm ☐

5) Integrated Delivery Networks.

Confirm ☑ Does Not Confirm ☐

6) Shared Risk/Savings.

Confirm ☑ Does Not Confirm ☐

7) Pay-for-Performance.

Confirm ☑ Does Not Confirm ☐

8) Global Payment/Capitation.

Confirm ☑ Does Not Confirm ☐

9) Primary Care Incentives.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will support the integration and ongoing operations of any of the aforementioned alternative payment models or clinically integrated systems that may be designed and managed by other Plan vendors.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor has the system capability to support capitated payments.

Confirm ☑ Does Not Confirm ☐

xv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.

Confirm ☑ Does Not Confirm ☐

xvi. If the Plan deploys a custom network or reimbursement models, Vendor's provider portal will allow Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.

Confirm ☑ Does Not Confirm ☐

xvii. If the Plan deploys a custom network, Vendor will administer Plan specific provider contract documents which may include, but is not limited to, network participation agreements (NPA), reimbursement exhibits, pricing policies, fee schedules, and pricing development and maintenance policies.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor acknowledges any NPA developed to support a custom network for the Plan is not subject to review by DOI since the Plan is self-funded and not subject to DOI regulations except for those specifically noted in Chapters 58 and 135 of the North Carolina General Statutes.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support any custom alternative payment models or networks implemented for the Plan.

Confirm ☑ Does Not Confirm ☐

xx. Vendor will provide a dedicated provider call center, with a Plan specific phone number and greeting if the Plan implements a full, custom provider network.

Confirm ☑ Does Not Confirm ☐

5.2.4 Product and Plan Design Management

5.2.4.1 Overview and Expectations

The Plan seeks a Vendor that offers innovation in both Product and Plan Designs. Vendor should have an efficient business rules-based claims system that can not only support state, federal, and other custom benefits but also accommodate unique medical and claims processing policies. Vendor should be nimble in its approach to piloting new programs and demonstrate "speed to market" when rolling out new Products, Plan Designs, and benefit features to meet the challenges facing state government health plans.

5.2.4.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.

1) Enhanced PPO Plan (80/20): https://www.shpnc.org/media/2583/download?attachment
2) Base PPO Plan (70/30): https://www.shpnc.org/media/2582/download?attachment
3) HDHP: https://www.shpnc.org/media/2584/open

ii. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the PCP listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.

iii. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.

iv. Vendor will integrate real-time or near real-time deductible and/or OOP accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.

v. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.

vi. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.

vii. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

b. Vendor shall additionally confirm each of the following:

i. Vendor's systems will support each of the following Plan Design features. Vendor shall confirm each Plan design feature below:

1) Applying a copay and a deductible to the same service.

Confirm ☑ Does Not Confirm ☐

2) Applying a copay based on the providers network tier.

Confirm ☑ Does Not Confirm ☐

3) Waiving the emergency room copay when the Member is admitted for an inpatient stay and/or an observation stay.

Confirm ☑ Does Not Confirm ☐

4) Applying a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
a) PCP.

Confirm ☑ Does Not Confirm ☐

b) Specialist.

Confirm ☑ Does Not Confirm ☐

c) Urgent Care.

Confirm ☑ Does Not Confirm ☐

d) Emergency Room (ER).

Confirm ☑ Does Not Confirm ☐

e) Physical Therapy.

Confirm ☑ Does Not Confirm ☐

f) Occupational Therapy.

Confirm ☑ Does Not Confirm ☐

g) Speech and Hearing Therapy.

Confirm ☑ Does Not Confirm ☐

h) Outpatient Behavioral Health.

Confirm ☑ Does Not Confirm ☐

i) Per Inpatient Confinement.

Confirm ☑ Does Not Confirm ☐

5) Setting benefit limits by age.

Confirm ☑ Does Not Confirm ☐

6) Setting benefit limits by frequency of service.

Confirm ☑ Does Not Confirm ☐

7) Setting benefit limits by confinement.

Confirm ☑ Does Not Confirm ☐

8) Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.

Confirm ☑ Does Not Confirm ☐

ii. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will, upon request, administer a four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an out-of-area (OOA) benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

v. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will administer member cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will implement incentive programs where Plan Members are given gift cards, or other incentives, for seeing certain providers and/or completing certain tasks.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will, upon request, integrate with other Plan vendors or Partners to deliver value-based and/or incentive benefits.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will, upon request, implement a Health Reimbursement Account (HRA) for Plan Members with each of the following features. Vendor shall confirm each HRA feature below:

1) HRA annual balances based on the number of family Members enrolled.

Example:

Subscriber only = $600 starting balance.

Subscriber + one (1) Dependent = $1200 starting balance.

Subscriber + two (2) or more Dependents = $1800 starting balance.

Confirm ☑ Does Not Confirm ☐

2) Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.2.

Confirm ☑ Does Not Confirm ☐

3) HRA account reconciliation services to support the Plan's banking and financial reporting requirements.

Confirm ☑ Does Not Confirm ☐

4) Proration that reduces the starting HRA amount for Members who enroll after the beginning of the Benefit Year.

Confirm ☑ Does Not Confirm ☐

5) Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.

Confirm ☑ Does Not Confirm ☐

6) Automatic claims reimbursement functionality from the HRA.

Confirm ☑ Does Not Confirm ☐

7) Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.

Confirm ☑ Does Not Confirm ☐

8) Annual HRA rollover functionality.

Confirm ☑ Does Not Confirm ☐

9) Ability to customize the HRA Member portal, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

10) Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

11) HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.

Confirm ☑ Does Not Confirm ☐

12) HRA Debit Card.

Confirm ☑ Does Not Confirm ☐

13) Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.

Confirm ☑ Does Not Confirm ☐

14) Ability to provide an HRA on a copay-based plan like the Enhanced PPO Plan (80/20).

Confirm ☑ Does Not Confirm ☐

15) Ability to customize HRA reports, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

x. Vendor offers Health Savings Account (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.

Confirm ☑ Does Not Confirm ☐

xi. Upon request, Vendor will administer a self-funded Group Medicare Supplement Plan.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will work with the Plan to implement benefits that may not be finalized and/or approved until close to the effective date. While it is the Plan's preference to have all benefits approved by the Board more than six (6) months in advance, there are dependencies, such as final budget approval by the North Carolina General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.

Confirm ☑ Does Not Confirm ☐

5.2.5 Medical Management Programs

5.2.5.1 Overview and Expectations

The Plan seeks a Vendor that demonstrates versatility and innovation in managing the complex medical environment. Vendor should provide high quality, evidence-based, member centric, cost-efficient clinical management programs that support Members with the most appropriate, effective, and high-value benefits to improve their health while fostering an optimum Member experience**.**

5.2.5.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.

ii. Vendor will carve-out PBM services from this Contract.

iii. Vendor will customize any of the Medical Management programs, if requested by the Plan.

b. Vendor shall additionally confirm each of the following:

i. Vendor will customize any medical policy, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will provide comprehensive, holistic, evidence-based medical policies and Medical Management of Members' physical and behavioral health, including substance misuses, which focus on quality, positive Member outcomes, and cost efficiencies.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will keep the Plan apprised of disease trends within the population and provide reporting that summarizes overall Plan health.

Confirm ☑ Does Not Confirm ☐

v. Vendor will appropriately identify and engage Members in each of the following types of programs:

1) Transition of Care (TOC) programs;

Confirm ☑ Does Not Confirm ☐

2) High utilizer outreach and management programs; and,

Confirm ☑ Does Not Confirm ☐

3) Complex case management programs.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide "Hospital at Home" and/or other programs to promote transition from inpatient-hospital to home setting when appropriate.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will offer wellness and prevention programs to support Plan Members.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, Vendor, and any other Plan vendors or Plan Partners involved in the program administration.

Confirm ☑ Does Not Confirm ☐

x. Vendor will provide disease management Health Coaching Services.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will transition specific specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide claims and analytical data to support the transition of specific specialty medications to the Plan's PBM.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will meet with the Plan and the Plan's PBM to coordinate medical and pharmacy management programs.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.

Confirm ☑ Does Not Confirm ☐

5.2.6 Enrollment, EDI, and Data Management

5.2.6.1 Overview and Expectations

The Plan seeks a Vendor with a platform that can support the Plan's enrollment rules, as defined by North Carolina General Statutes Chapter 135, Article 3B. Vendor must also be able to support the Plan's Group set-up requirements which include setting up and maintaining over 400 Employing Units, the Retirement Group, and the other non-active Groups including the Direct Bill Group, the COBRA Group and the Sponsored Dependents Group. Vendor must also have extensive experience with Medicare eligibility as the Plan has both Medicare primary and Medicare secondary Members.

5.2.6.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will support the Plan's Group set-up structure which includes establishing, maintaining, and reporting on more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. A list of the Plan's current Group structure, which includes Group and Entity identifiers, can be found in Exhibit 3, "Group Structure."

ii. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.

iii. Vendor will have the capability to accept and at least 500,000 transactions in a single file transmission.

iv. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.

v. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.

vi. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."

vii. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.

viii. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.

ix. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.

x. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer

Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

xi. Vendor will serve as the Plan's RRE under Section 111 of MMSEA Expanded Reporting Option.

xii. As an Expanded Reporter, Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to obtain Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare rules, to determine which Plan Members' Medicare information requires updating.

xiii. Vendor will update Vendor's system with the necessary updates from the Medicare audit and send Members' updated Medicare information to the Plan's EES vendor.

xiv. Vendor will store and utilize the MBI, in addition to other Member identification numbers, such as SSN.

xv. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.

xvi. Vendor will maintain Medicare primacy effective and termination dates.

xvii. Vendor will maintain multiple Medicare entitlement reasons.

xviii. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.

xix. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).

xx. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.

xxi. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.

xxii. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.

xxiii. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a

new PCP. The final workflows will be defined during Contract implementation. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP synchronization requirements.

xxiv. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)

1) Plan's logo.
2) Plan's messaging.
3) Plan's network (if applicable).
4) Out-of-NC network.
5) Member out-of-pockets.
6) Plan's Rx BIN and PBM information.
7) Group Name (e.g., Wake County Schools, University of North Carolina, Department of Transportation).
8) Member's unique ID number.
9) Member's selected PCP.

xxv. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of CCC and reporting needs under sections 6055 and 6056 of the IRS code.

xxvi. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.

xxvii. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.

xxviii. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.

xxix. Vendor will implement a process with the Plan to respond to DQ issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.

xxx. Vendor will release data to the Plan as described in state and federal law.

xxxi. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support Plan eligibility as defined by North Carolina General Statutes Chapter 135, Article 3B, Part 4.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will accept industry standard and/or custom data files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:

1) ASC X12 EDI transaction sets.

2) XML files.

3) Flat/ Fixed Files.

4) APIs.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will accept and process multiple data files within the same day.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will accept and process multiple concurrent file transmissions.

Confirm ☑ Does Not Confirm ☐

v. Vendor will process "change" records as either terminated or added records.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will load and process "terminated" and "add" transactions for the same Members within the same day.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will exchange the enrollment and eligibility data using secure protocols.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide a copy of outbound files delivered to other Plan vendors to the Plan via SFTP or SharePoint based on instructions from the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.

Confirm ☑ Does Not Confirm ☐

x. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits. Thresholds will be determined during implementation.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will have a Load-Rate of at least 98% on accurate transactions received via EDI from the Plan's EES vendor.

Confirm ☑ Does Not Confirm ☐

xii. In addition to accepting and processing daily enrollment data file from the Plan's EES vendor, Vendor will manually load any data that cannot be processed automatically within three (3) State Business Days.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan's EES vendor.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Members.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will accept and store multiple Member ID numbers from the Plan's EES vendor such as a unique member ID created by the EES vendor and MBI and/or the Member SSN.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card.

Confirm ☐ Does Not Confirm ☑

xvii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor will accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years. Vendor will not receive enrollment effective dates prior to January 1, 2025.

Example: June 2026, Vendor receives enrollment with a February 1, 2025 effective date. Vendor updates Member with appropriate 2026 and 2025 coverage.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will adjust enrollment effective or termination dates retroactively that may cross Plan Years.

Confirm ☑ Does Not Confirm ☐

xx. Vendor will meet with the Plan and other Plan vendors on a weekly basis, or as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxi. Vendor will display the appropriate Group name on Member ID cards, the secure Member portal and reports. Examples of Group Names:

1) Department of State Treasurer
2) Charlotte Mecklenburg Schools
3) Retirement Systems

Confirm ☑ Does Not Confirm ☐

xxii. Vendor will store a Member's PCP election, including the PCP election effective and termination dates to facilitate the PCP copay incentives outlined in Section 5.2.4, Product and Plan Design Management.

Confirm ☑ Does Not Confirm ☐

xxiii. Vendor will notify providers that they have been selected as a Member's PCP.

Confirm ☑ Does Not Confirm ☐

xxiv. Vendor will support an Open Enrollment (OE) period that generally last two (2) to four (4) weeks and during a time period chosen by the Plan.

Confirm ☑ Does Not Confirm ☐

xxv. Vendor will support multiple OEs in one Plan year, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxvi. Vendor will vary the OE periods by Group and/or Product, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxvii. Vendor will, upon request, receive Member enrollments from the Plan's EES vendor prior to OE that have been "Mapped" to a specific Plan Design for the next Plan Year. The "Mapping" of Members will occur over several weeks prior to the beginning of OE. These "Mapped" Members may be included in the daily EDI Change Files received from the Plan's EES vendor or in a Full File, if chosen by the Plan.

Confirm ☑ Does Not Confirm ☐

xxviii. Vendor will receive and process Member elections from the Plan's EES vendor after OE using a Full File or via daily Change Files that come during OE. The type of file will be determined by the Plan during the initial implementation and will be re-evaluated annually as part of OE planning.

Confirm ☑ Does Not Confirm ☐

xxix. Vendor will produce and distribute ID cards for over 500,000 Members after OE so that Members receive their ID cards prior to the new Plan Year.

Confirm ☑ Does Not Confirm ☐

xxx. Vendor will produce and mail CCCs to Members whose coverage terminates, as required by law.

Confirm ☑ Does Not Confirm ☐

xxxi. Vendor will produce CCCs for Members who reside in states that require annual CCCs.

Confirm ☑ Does Not Confirm ☐

xxxii. Vendor will produce and mail or email CCCs on demand, for Members who request new copies of CCCs.

Confirm ☑ Does Not Confirm ☐

xxxiii. Vendor will produce and mail the 1095-B forms, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxiv. Vendor will provide call center support to respond to both HBRs and Member inquiries about 1095-B forms, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxv. Vendor will file 1094-B and 1095-B forms electronically, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxvi. Vendor will continue filing 1095-B corrections to the IRS throughout the year, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxvii. Upon notification by the Plan's COBRA Administration and Billing (CABS) vendor, Vendor will hold claims for individual Groups that have not paid their premium bill.

Confirm ☑ Does Not Confirm ☐

xxxviii. Vendor will confirm that the monthly, custom claims data file that will be provided to the Plan can be sent as a Full File or Change File. The specific requirements will be developed during the implementation.

Confirm ☑ Does Not Confirm ☐

xxxix. Vendor will confirm that it will provide reference tables and data dictionaries, with thorough field descriptions, to support the monthly, custom claims data files and that the reference tables and data dictionaries will be updated as needed and sent to the Plan within three (3) State Business Days of any change.

Confirm ☑ Does Not Confirm ☐

xxxx. Vendor will conduct a Medicare repricing exercise to benchmark Vendor's network rates against Medicare reimbursement rates. The details of the repricing exercise shall be formalized in an ADM and memorialized via an Amendment to the Contract, as needed.

Confirm ☑ Does Not Confirm ☐

5.2.7 Customer Experience

5.2.7.1 Overview and Expectations

A top priority for the Plan is ensuring a superior Customer Experience with all customer-facing resources and tools. Vendor must show a dedication to constant Customer Experience improvements and be an innovator in Member engagement. Engagement includes web based and mobile technology, transparency tools, and provider search functions that clearly identify low-cost, high-quality providers by specialty. If Plan-specific networks are utilized, these tools must display the Plan-specific information.

5.2.7.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.

ii. Vendor will have a dedicated toll-free number for Plan Members.

iii. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.

iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.

v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.

vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.

vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."

viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.

ix. Vendor will co-brand letters or other materials Vendor sends to Members.

x. Vendor will customize the portal with the Plan's branding (logo).

xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.

b. Vendor shall additionally confirm each of the following:

i. Vendor will receive emails from Plan Members and respond to their inquiries.

Confirm ☑ Does Not Confirm ☐

ii. Upon request, Vendor will provide expanded hours of operation during the OE period at no additional cost to the Plan. The Plan's enrollment and eligibility call center is generally open on Saturdays during OE.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.

Confirm ☑ Does Not Confirm ☐

v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide copies of call notes to Members upon request.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide reports, based on call reason type, to the Plan upon request.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide an escalation team to respond and resolve inquiries from the Plan.

Confirm ☑ Does Not Confirm ☐

x. When appropriate, Vendor will mail apology letters to Plan Members who have been impacted by a Vendor error.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will support single sign-on to and from the Plan's PBM customer portal, the Plan's EES vendor and other Plan vendor sites, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will customize the materials available to Plan Members via the secure Member portal.

Confirm ☑ Does Not Confirm ☐

xiv. In addition to displaying the Plan's branding, Vendor will display the name of the Member's Employing Unit (e.g., Department of State Treasurer, Retirement System, Wake County Schools, etc.) once the Member has logged into the secure member site.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will, upon request, segregate and provide secure Member portal access to a Dependent, or a Dependent's designee, in a court-ordered scenario such as a Medical Support Notice.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor's secure member portal will capture Plan Members' preferences for communication.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor's secure portal will allow a Plan Member to print a temporary ID card that include the Plan's PBM information and custom ID card elements.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor's mobile application and secure portal will allow Members to order a new ID card.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will provide a mobile application that includes a virtual ID card for Members who prefer to use mobile technology.

Confirm ☑ Does Not Confirm ☐

xx. Vendor's portal will provide health/condition-specific resources to Members, such as educational videos, recipes, digital coaching modules, webinars, links to Plan approved/promoted websites, evidenced-based articles, and tools for self-management.

Confirm ☑ Does Not Confirm ☐

xxi. Vendor's member portal will provide and moderate online forums and live chat groups.

Confirm ☑ Does Not Confirm ☐

xxii. Vendor's member portal will receive and display timely data from various providers such as, but not limited to, lab results from large independent labs, prescriptions from pharmacies, and other data from physicians' offices. This information could be used by Plan Members to gather information necessary to complete annual Health Assessment or validate Member actions to earn incentives.

Confirm ☑ Does Not Confirm ☐

xxiii. Vendor's member portal will allow Members to:

1) View claims and claim payment status.

Confirm ☑ Does Not Confirm ☐

2) View and print EOBs.

Confirm ☑ Does Not Confirm ☐

3) View deductible and OOP accumulations.

Confirm ☑ Does Not Confirm ☐

4) Single-Sign-On (SSO) to the HSA vendor, if applicable.

Confirm ☑ Does Not Confirm ☐

5) View HRA claims, if applicable.

Confirm ☑ Does Not Confirm ☐

6) View HRA Balances, if applicable, including, but not limited to:

a) Initial HRA Funding.

b) Rollover Funds.

c) Incentive Funds.

Confirm ☑ Does Not Confirm ☐

7) Order new HRA or HSA debit cards, if applicable.

Confirm ☑ Does Not Confirm ☐

8) Track incentive programs and benefit designs (e.g., cash rewards, health reimbursement account contributions) and administer the reward for participation, as defined by the Plan.

Confirm ☑ Does Not Confirm ☐

9) Complete a Health Assessment that could be customized by the Plan.

Confirm ☑ Does Not Confirm ☐

xxiv. Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:

1) Electronic medical and health records.

Confirm ☐ Does Not Confirm ☑

2) Disease Management Nurse notes.

Confirm ☐ Does Not Confirm ☑

3) Case Management notes.

Confirm ☐ Does Not Confirm ☑

4) Health Coach notes.

Confirm ☐ Does Not Confirm ☑

5) Vendor analytical system alerts, such as gaps in care.

Confirm ☑ Does Not Confirm ☐

6) Progress towards Incentives earned, if applicable.

Confirm ☑ Does Not Confirm ☐

xxv. Vendor will provide the following services whether the Member is logged into the secure member portal or accessing Vendor's external site:

1) Search for providers by specialty.

Confirm ☑ Does Not Confirm ☐

2) Search for procedure/service cost.

Confirm ☑ Does Not Confirm ☐

xxvi. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiative, upcoming Plan mailers and/or events, and develop and implement process improvements between the Plan vendors and Partners.

Confirm ☑ Does Not Confirm ☐

xxvii. Vendor, if instructed by the Plan, will conduct an annual Member Satisfaction Survey for all Plan Members, including Members who are not enrolled in plans administered by Vendor. The Plan will be responsible for communicating the survey to Plan Members and may provide a link to the survey on the Plan's website. Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.

Confirm ☑ Does Not Confirm ☐

xxviii. Vendor will conduct other surveys, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxix. Vendor will attend Plan-hosted OE events to educate members on Plan options. The Plan representatives are generally on the road across the State or hosting online webinars during most of September and October promoting OE. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.

Confirm ☑ Does Not Confirm ☐

xxx. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.

Confirm ☑ Does Not Confirm ☐

xxxi. Vendor will attend Wellness Fairs and other promotional events around the State, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxii. Upon request, Vendor will provide resources to conduct biometric screenings at wellness events. If requested, Vendor shall have the ability to send the biometric results to the Members' PCPs.

Confirm ☑ Does Not Confirm ☐

xxxiii. Vendor will provide language interpreters, including sign language, at events as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxiv. Vendor will, upon request, provide Marketing and Communication resources to the Plan to develop materials.

Confirm ☑ Does Not Confirm ☐

xxxv. Vendor will assist with the Plan's benefit booklet review and/or provide guidance regarding the Plan's benefit booklets which includes individual books for each plan offered.

Confirm ☑ Does Not Confirm ☐

xxxvi. Vendor will develop and implement new letters and/or communication materials for Members and/or Providers to support any programs implemented for the Plan.

Confirm ☑ Does Not Confirm ☐

xxxvii. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPACA.

Confirm ☑ Does Not Confirm ☐

xxxviii. Vendor will suppress specific Member communications, upon request from the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.8 Claims Processing and Appeals Management

5.2.8.1 Overview and Expectations

The Plan seeks a Vendor with an efficient business rules-based claims system that can support required state, federal, and other custom benefits.

5.2.8.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.

ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.

iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.

iv. Vendor will customize any appeals letters, as requested by the Plan.

v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.

vi. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan – Medicare Part B."

vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.

viii. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."

b. Vendor shall additionally confirm each of the following:

i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).

Confirm ☑ Does Not Confirm ☐

iv. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add edits at the Plan's request.

Confirm ☑ Does Not Confirm ☐

v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.

Confirm ☐ Does Not Confirm ☑

vi. Vendor will provide a weekly summary of any claims totaling ≥ $100,000.00 to the Plan's Contract Administrator for day to day activities. The summary shall include the total charge, total allowed amount, Member cost share, and a short description of circumstance of the claim, including a status of the Member's condition.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will coordinate benefits with other commercial payors.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will support all future state and federal requirements at no additional cost to the Plan.

Confirm ☑ Does Not Confirm ☐

x. Vendor will produce EOBs that meet all Federal requirements.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will prevent Subscribers from having access to the Dependents EOBs when the Subscriber does not have custodial rights.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will mail EOBs directly to Dependents 18 years of age or older without a copy to the Subscriber.

Confirm ☑ Does Not Confirm ☐

xiii. Vendors will mail a Dependent's EOB to a different address if a different address exists in the Dependent's demographic record.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will provide a single, combined Medical and HRA EOB, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will implement PCP "gate-keeper" rules, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.9 Claims Audit, Recovery, and Investigation

5.2.9.1 Overview and Expectations

The Plan seeks a Vendor that places great value on the accuracy of its deliverables. Vendor must be open to audits by the Plan's Auditors as well as audits performed by and for the North Carolina Office of the State Auditor. The Plan expects Vendor to be time sensitive to all audit requests and be prepared to support multiple audits simultaneously. The Plan, at its discretion, may use its own vendors to seek recoveries; therefore, Vendor must support the Plan's recovery vendors by providing claims data, adjusting claims, and posting payments. Vendor must also demonstrate a dedication to the detection and reduction of fraud, waste, and abuse. This includes the recovery of fraud dollars and a willingness to assist in the prosecution of those who commit fraud.

Notice: The Plan is not assigning its right to pursue recoveries on its own behalf or through another vendor.

5.2.9.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will support ongoing quarterly claims accuracy audits, or Standard Audits, performed on a statistically valid random claims sample selected by the Plan's audit vendor which will be used to measure claims accuracy for Performance Guarantees on a quarterly basis. Vendor will share provider contracts and system pricing with the Plan's auditors for review and audit. The audit will also include a targeted sample selected from a comprehensive analysis of all claims by the Plan's audit vendor.

An audit plan will be provided prior to the initial quarterly audit that will define the ongoing Standard Audit timelines. Both the random claims sample and the targeted sample will be used to identify overpayments owed to the Plan. For purposes of Standard Audits, claims accuracy will be measured based on the following criteria:

1) Financial Accuracy: Total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute values of the dollars processed in error from the total dollars processed. Underpayments and overpayments are not offset by one another.
2) Payment Accuracy: The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
3) Processing Accuracy: The number of claims processed with no procedural errors divided by the total number of claims processed.

For purposes of the above definitions, if Vendor has identified and recovered an overpayment or processed an underpayment prior to the audit, it is not an error. If Vendor has identified but not recovered the overpayment or processed the underpayment, it is an error.

ii. Vendor will, in addition to supporting ongoing quarterly claims accuracy audits, support Focus Audits, such as, but not limited to, COB audits, duplicate claims audits, eligibility audits, and comprehensive electronic Audits conducted by the Plan's auditor vendor on an as needed basis. All the rules outlined in Section 5.2.9.2.a.i above will apply to these audits.

iii. Vendor's recovery processes will follow all deposit and financial reporting requirements outlined in Section 5.2.2, Finance and Banking.

iv. Vendor will recover any overpayments to Providers by offsetting future payments or by demand without any limitation as to time since the Plan as a government payor is not subject to the two-year limitation established in N.C.G.S. § 58-3-225(h).

v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (North Carolina General Statutes Chapter 105A, Article 1), the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29), Wage Garnishment (N.C.G.S. § 135-48.37A), and Credit Card Intercepts (N.C.G.S. § 1-359) and implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 10, "State Health Plan Recovery Workflows."

vi. Vendor will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, mental health parity, disclosures, reporting, etc.).

vii. Vendor has an investigation or similar unit to investigate possible fraud and abuse and will share details about specific investigations that impact the Plan, including the names of the providers involved.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support any other audit requested by the NC OSA.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will support multiple audits simultaneously. Although the Plan will work with Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will provide the Plan's Auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits including remote, view only access to view the claims adjudication system used by Vendor to process the Plan's claims.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will provide on-site office space at Vendor's facilities that are actually processing Plan claims, including system access for the Plan's Auditors, the Plan, or the NC OSA.

Confirm ☑ Does Not Confirm ☐

v. Vendor will customize any standard audit reports to meet the Plan's specific audit needs.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide claims files to the Plan's Auditors on a monthly basis.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide feedback on all site visit claims within two (2) weeks of the end of the on-site visit. Vendor will also respond to any findings in the draft audit report within two (2) weeks of receipt.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within 30 days of the final report, or another timeframe as specified by the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide full impact reports, and review and recover out-of-sample claims for any audit findings that reveal systemic or easily repeatable issues. These out-of-sample claim recoveries will not impact performance guarantee measures.

Confirm ☑ Does Not Confirm ☐

x. Vendor will not enter into a settlement on the Plan's behalf with a Provider, a Member, or anyone else, without first obtaining the Plan's approval.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will support the Plan's third-party liability vendor, or any other recovery vendor the Plan may work with, by providing data, adjusting claims, and posting payments.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will customize any recovery or investigation reports, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will implement debt collections processes with a collection agency approved by the NC AGO. The list of approved collections agencies may change during the life of the Contract, as required by the NC AGO.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will adjust Member claims based on recoveries received on behalf of the Plan, including, but not limited to, those from the collection agency, Plan vendors, or Members within 30 days of notification. Plan vendors or State Collections Agencies that seek recoveries on behalf of the Plan, must work with Vendor to ensure the claims are appropriately adjusted and recoveries are deposited in the Plan's depository accounts.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will, upon request from a Member covered through an Employing Unit, the Direct Bill Group, the Sponsored Dependent Group, or the COBRA Group, establish a payment plan; however, payment plans shall not exceed 12 months without the Plan's prior approval.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor will, upon request by a Member covered through the Retirement System, establish a payment plan. The payment plan shall not exceed six (6) months without the Plan's prior approval.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor will consider any Member or former Member to be in default who misses one (1) payment. If any Member or former Member sends in a partial payment, Member or former Member must be caught up in one (1) month or Member or former Member will be considered to be in default.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will allow the Plan to perform onsite reviews and validations of Vendor's internal processes.

Confirm ☑ Does Not Confirm ☐

xx. Vendor will provide workflows, data, and other materials to review Vendor's processes within 30 days of request.

Confirm ☑ Does Not Confirm ☐

xxi. Vendor will work with the Plan to develop process improvement plans.

Confirm ☑ Does Not Confirm ☐

xxii. Vendor will provide monthly recovery reports and will customize those reports, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxiii. Vendor will track and report actual cost savings dollars against targets, and if available, benchmarks.

Confirm ☑ Does Not Confirm ☐

xxiv. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.

Confirm ☑ Does Not Confirm ☐

xxv. Vendor will provide Plan specific investigation reports on a monthly basis and customize these reports, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.10 Initial Implementation and Ongoing Testing

5.2.10.1 Overview and Expectations

The Plan seeks to partner with a Vendor that has the resources to support on-time implementation of all programs and services included in this Contract. Vendor must provide dedicated resources and expertise to support simultaneous implementation of multiple work streams. In addition, the Plan will implement new benefits, services, and Plan vendors throughout the life of the Contract that will require Vendor to be nimble and efficient in terms of implementing new processes and/or integrating with new Plan vendors, or support changes to existing Plan vendors' requirements. When possible, the Plan will work with all parties to let the implementation schedule dictate the Go-Live date, but in some instances, such as the annual benefit changes or Plan vendor changes, the Go-Live date will be pre-determined. The Plan will notify Vendor as soon as possible about all proposed changes.

5.2.10.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will have a fully assembled implementation team that includes the appropriate subject matter experts, ready to begin work within two (2) weeks of contract award. The team shall include an overall implementation manager and separate implementation resources for, at a minimum, each of the following work streams:

1) Group Set-Up & Enrollment
2) Plan Vendor Integration & EDI, which includes:
   a) EES vendor Integration. (EDI, PCP Tool, SSOs, Audits)
   b) PBM vendor Integration. (Data files, SSOs, Accumulators)
   c) Billing vendor Integration. (Claims hold, Audits)
   d) Plan Data Warehouse Integration. (Data files)
3) Network Evaluation

Other workstreams will kick-off throughout 2023.

ii. Vendor will have the depository bank account(s) setup and tested at least 45 days prior to January 1, 2025.

iii. If applicable, Vendor will have the disbursement account(s) setup and tested at least 30 days prior to January 1, 2025.

iv. Vendor will have all services, including custom programs, operational by January 1, 2025.

v. Vendor will work with the Plan to document in an ADM all custom processes developed to meet the Plan's unique requirements. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.

vi. Vendor will work with the Plan to finalize Vendor Audit Schedule for 2025 and subsequent years. The Audit Schedule will be updated via ADM. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.

vii. For all technical components of the initial implementation as well as any implementations throughout the lifetime of the Contract, Vendor will develop functional requirements documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation derived from the Plan's Business Requirements. These documents must be mutually agreed upon by Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.

viii. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live of any initiative. To support testing, Vendor must not only have the resources, but also the test environments, necessary to support multiple work streams at one time. As mentioned above, the Test Plan will be mutually agreed upon by Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.

ix. Vendor will support the 2025 Open Enrollment, which is currently scheduled for October 2024, but may be rescheduled to a different time at the Plan's sole discretion. Vendor must have the group set-up complete, the call center open, any required SSOs in place, the PCP selection tool integrated with the Plan's EES vendor and be able to accept EDI from Plan vendors during the month Open Enrollment occurs.

b. Vendor shall additionally confirm each of the following:

i. Vendor will ensure there are no data latency issues that would delay initiating any audits with the Plan's Auditors after the first quarter, or any subsequent quarter, of operation.

Confirm ☑ Does Not Confirm ☐

ii. If during the implementation, a decision is made that Members will need welcome kits, Vendor will ensure that those kits are mailed prior to January 1, 2025.

Confirm ☑ Does Not Confirm ☐

iii. If requested by the Plan, Vendor will support a readiness review and/or implementation audit at least 60 days prior to January 1, 2025. Vendor shall participate in all readiness review and/or implementation audit activities conducted by the Plan or by Plan vendors to ensure Vendor's operational readiness.

Confirm ☑ Does Not Confirm ☐

5.2.11 Reporting

5.2.11.1 Overview and Expectations

The Plan seeks a partner that can support its custom reporting requirements which include reports that are sent to the Plan on a daily, weekly, monthly, quarterly, and annual basis. These reports must be accurate and received on the schedule defined by the Plan. The Plan will also have ongoing ad hoc report requirements; therefore, Vendor must have the resources and expertise to assist the Plan as needed.

5.2.11.2 Services

a. Vendor confirmed the following Minimum Requirement:

i. Vendor will agree to delivering the Standard Reports as described in Section 5.2.11.2.b.viii.2) – xvii.3), and based on the delivery schedule in Exhibit 11, "Standard Reports."

b. Vendor shall additionally confirm each of the following. Note: Final individual report or reporting package format and content will be finalized during implementation and may be updated throughout the lifetime of the Contract via ADM:

i. Vendor will provide standard and ad hoc reports in any of the following formats, as requested by the Plan:

1) Excel.
2) PDF.
3) Text.
4) XML.
5) HTML.
6) CSV (raw format).

Confirm ☑ Does Not Confirm ☐

ii. Vendor will customize any report, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will combine claims and financial data in reporting.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will email all standard reports, to the email addresses provided by the Plan. If PHI is included, the reports shall be sent via secure email.

Confirm ☑ Does Not Confirm ☐

v. Vendor will produce ad hoc reports within 10-15 days of a request to support the Plan's responsibilities to the Board of Trustees and/or North Carolina General Assembly.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will include Book of Business and other internal and/or external benchmarks in reports, when requested by the Plan.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide other enterprise-level, executive reports as well as departmental and ad-hoc reporting, as requested by the Plan. Stratifications may include:

1) Demographics.
   a) Gender.
   b) Age.
   c) Race.
2) Employing unit, work location.
3) Geography.
   a) Zip Code.
   b) County.
   c) Hospital Service Area.
   d) Healthcare Referral Region (HRR).
   e) Out-Of-State.
4) Subscriber versus Member.
5) Active and Retiree (Pre and Post-65).
6) Plan Type.
7) Time period.
   a) Calendar Year (CY).
   b) Year-to-Date (YTD).
   c) Month-to-Month.
   d) Fiscal Year.
   e) Quarterly.
   f) Ad-hoc.
8) Paid, incurred, capitated claims.
9) Provider Level.

a) By NPI, DEA #, In/Out-of-Network, Vendor's unique provider number.

b) PCP, Specialist, Hospital.

10) Network.

a) In/Out-of-Network.

b) Quality Outcomes.

11) Utilization Trends.

a) High Cost Claimants.

b) High Volume Claims Utilizers.

12) Disease Categories via ICD-10, DRG, MDC, or ad hoc criteria.

a) Chronic conditions.

b) Acute conditions.

c) Catastrophic (cost-driving outliers).

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide each of the following enrollment reports or reporting packages. The method for providing the report will be determined during implementation.

1) Weekly membership reports that include, but are not limited to, the following information:

a) Group Number.

b) All internal and external member Identification numbers (i.e., EES assigned ID, SSN, MBI, Employer ID, etc.).

c) Subscriber number.

d) Hire date.

e) Coverage effective date.

f) Coverage expiration date.

g) Current benefit effective date.

h) Current benefit expiration date.

i) Member First Name.

j) Member Last Name.

k) Member SSN.

l) Member date of birth.

m) Member tier.

n) Member benefit identifier code(s).

o) Medicare primary flag.

p) Medicare Coverage.

- Medicare A effective date
- Medicare B effective date.

q) Medicare effective date.

r) Medicare expiration date.

Confirm ☑ Does Not Confirm ☐

2) Monthly Member reporting package based on enrollment the last day of the previous month that includes each of the following:

a) Enrollment by Plan Design, Entity, Group, Tier, and Medicare Status.

b) In-state Member counts by county broken down by Plan Design, then totaled.

c) Out-of-state Member counts by state or country broken down by Plan Design, then totaled.

d) Enrollment by Group number broken down by Subscriber and Dependent, then totaled.

e) Graphs (pie charts) that include:

- All Members by Plan Design.
  - In-state Members by Plan Design.
  - Out-of-state Members by Plan Design.
- All Members by Coverage Tier.
- Top 10 Counties.

Confirm ☑ Does Not Confirm ☐

3) Monthly PCP Election report that includes, but is not limited to:

a) Total number of Members that have elected a PCP broken down by Plan Design.

b) Statistics about the Members who see the PCP on their card and those that see other PCPs.

c) Types of PCP elected (i.e., general practice, pediatrician, family medicine, etc.).

d) List of elected providers and number of Members who have elected them as their PCP.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide each of the following Banking and Finance reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly accounts receivable aging report that includes, but is not limited to:

a) The amount of recoveries due, but not received.

b) The amount of any unapplied receipts.

c) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days; and over 120 days.

d) Supporting documentation from which these amounts are derived.

Confirm ☑ Does Not Confirm ☐

2) Quarterly report of any uncollectible accounts:

a) Recommended for debt write-off which includes, but is not limited to:

- Account name.
- Subscriber number, if applicable.

- Description/justification of the reason for write-off.
- The provider code, if applicable.
- Dollar amount and date originally paid, if applicable.
- Payee status.
- Identifying number (e.g., invoice, claim, case).
- Total amount proposed for write-off.

Confirm ☑ Does Not Confirm ☐

b) Recommended for exhausted debt (debt Vendor should stop tracking and pursuing when agreed upon recovery process has been completed) which includes, but is not limited to:

- Account name.
- Subscriber number, if applicable.
- Description/justification of the reason for exhausted debt.
- Provider code, if applicable.
- Dollar amount and date originally paid, if applicable.
- Payee status.
- Identifying number (e.g., invoice, claim, case).
- Total amount proposed for exhausted debt.

Confirm ☑ Does Not Confirm ☐

3) Daily deposited receipts reporting package, reported separately by Product type, e.g., PPO, HSA, HRA, etc., including:

a) Summary report, which includes, but is not limited to:

- Date of deposit.
- Total amount received by check.
- Total amount received by ACH.
- Distinct identification of which amounts relate to claims and which amounts relate to other types of deposits.
- Descriptive labeling of other deposits.
- Grand total of the daily deposits.

Confirm ☑ Does Not Confirm ☐

b) Any documentation from the banking institution of the deposited amounts posted daily, e.g., bank deposit slips, electronic deposit report, lockbox report, etc.

Confirm ☑ Does Not Confirm ☐

c) Daily deposit supporting documentation report, which includes, but is not limited to:

- Type of deposit, i.e., checks, ACH, and/or wire.

- Amount of each individual deposit and a grand total per deposit type.

Confirm ☑ Does Not Confirm ☐

d) Ability to produce Member level detail when requested by the Plan.

Confirm ☑ Does Not Confirm ☐

4) Daily NSF report listing all NSF for the previous months which includes:

a) Subscriber number, if applicable.

b) Provider information, if applicable.

c) Date returned.

d) Dollar amount.

Confirm ☑ Does Not Confirm ☐

5) Monthly misapplied deposits and/or collections report (e.g., applied deposit to wrong Member or wrong client) which includes date originally deposited and how they were corrected.

Confirm ☑ Does Not Confirm ☐

6) Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:

a) Number of checks processed weekly.

b) Number of EFTs processed weekly.

c) Payment amount(s) by type e.g., claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.

d) Weekly total by type.

e) Month to date total by type.

f) Supporting documentation of all disbursements and an explanation of any adjustments and/or miscellaneous payments, e.g., check register, any system generated reports of check writes, etc.

Confirm ☑ Does Not Confirm ☐

7) Monthly deposit reconciliation which includes, but is not limited to:

a) Date of each daily deposit.

b) Total amount of deposit for each day.

c) Breakdown of amount by type of deposit, i.e., checks, wires, ACH (drafts).

d) Monthly total of each type.

Confirm ☑ Does Not Confirm ☐

8) Monthly reconciliation of claims and other disbursements which includes, but is not limited to:

   a) Daily transactions listed individually with a daily total as well as a summary total.

   b) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds, and other disbursements.

   Confirm ☑ Does Not Confirm ☐

9) As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:

   a) Final due date to escheat the warrants/checks.

   b) Name of state and dormancy period for each state.

   c) Number of warrants for each state and dollar amount.

   d) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all Product types.

   e) Explanation of any special circumstances or issues.

   Confirm ☑ Does Not Confirm ☐

10) Monthly Summary of Billed Charges by State Fiscal Year which includes a summary of claims paid for the period which includes both medical and pharmacy claims.

   Confirm ☑ Does Not Confirm ☐

11) Monthly Statement of Account (SOA) which includes all charges including claims and administrative fees s paid. It is a full picture of all income/expenses for the month.

   Confirm ☑ Does Not Confirm ☐

x. Vendor will provide each of the following Financial Performance reports or reporting packages. The method for providing the report will be determined during implementation.

1) Performance Guarantees (PG), as outlined in Section 6.3, reports as follows:

   a) Monthly PG status report.

   b) Quarterly PG report cards.

   c) Annual PG report cards that include summary data and year end PG results.

   Confirm ☑ Does Not Confirm ☐

2) Monthly Performance Matrix reports as outlined in Exhibit 12, “Matrix Reports,” and listed below:

   a) Reports 1 and 2: Charge Summary Paid and Incurred Reports.

   b) Reports 3 and 4: Charge Summary Trend Paid and Incurred.

   c) Reports 5 and 6: Coinsurance and Deductible, Full Population-Paid and Incurred.

   d) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.

   e) Reports 9 and 10: Copay-Incurred and Paid.

   f) Report 11: Copay-Incurred (Claims Run out).

g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.

h) Reports 14 and15: Financial Summary-Paid and Incurred.

i) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.

j) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

Confirm ☑ Does Not Confirm ☐

3) Monthly Triangulations reports with the following stratifications:

a) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.

b) Plan Design and/or Product, including a summary based on total membership.

Confirm ☑ Does Not Confirm ☐

4) Monthly prompt payment interest claims report that includes, but are not limited to:

a) Prompt pay for adjusted claims.

b) Prompt pay for new claims.

c) Claim count.

d) Total interest paid.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will provide each of the following Claims and Appeals reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly processed claims reports that include, but are not limited to:

a) Claims type.

b) Total claims billed.

c) Total claims paid.

Confirm ☑ Does Not Confirm ☐

2) Monthly Deductible and Out-of-Pocket reports, by Plan Design, by month.

Confirm ☑ Does Not Confirm ☐

3) Monthly COB reports that identify savings associated with both Medicare and Commercial COB.

Confirm ☑ Does Not Confirm ☐

4) Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:

a) Denial reason.

b) Number of claims for each denial reason.

c) Total charges for each denial reason.

Confirm ☑ Does Not Confirm ☐

5) Quarterly high claimant reports that include, but are not limited to (the dollar threshold for including Members on the report will be determined during implementation):

a) Member ID.

b) Plan ID.

c) Member age.

d) Diagnosis.

e) Service start date.

f) Encounter service type.

g) Place of service.

h) Provider specialty description.

i) Paid amount.

Confirm ☑ Does Not Confirm ☐

6) Monthly medical and pharmacy appeals reports that include, but are not limited to:

a) Number of first level appeals received.

b) Number of first level appeals approved.

c) Number of first level appeals denied.

d) Number of second level appeals received.

e) Number of second level appeals approved.

f) Number of second level appeals denied.

g) Statistics on types of appeals received, approved, and denied at both first and second level.

Confirm ☑ Does Not Confirm ☐

7) A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:

a) Member ID.

b) Member First Name.

c) Member Last Name.

d) Type of Appeal Review Decision.

e) Type of Appeal Category.

f) Date Appeal Initiated.

g) Final Written Date.

h) Appeal Decision Description.

i) Medication Name, Strength, and Dosage.

j) Method Appeal Received.

k) Appeal Origin.

l) Drug Class.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide the following Network report or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide each of the following Medical Management reports or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly Medical Cost and Clinical Outcomes reports across diagnosis categories, highly prevalent, costly, and/or determined by the Plan to be clinically significant, to include HEDIS measures, and state, national, and book-of-business data segregated by Plan Designs (70/30, 80/20, HDHP,) Medicare and Non-Medicare primary status, and by Group.

Confirm ☑ Does Not Confirm ☐

2) Quarterly Case Management Clinical Outcomes.

Confirm ☑ Does Not Confirm ☐

3) Quarterly Preventive Care Service Utilization.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will provide each of the following Utilization Management reports or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly Utilization Management Cause, Cost and Clinical Outcomes, including, but not limited to, inpatient admissions, readmissions, emergency department visits, urgent care visits, outpatient services, behavioral health services, ambulance services, private duty nursing, pharmacy services and polypharmacy, primary care physician visits, specialist visits, prior authorizations and approvals, and high cost claims and claimants across Plan Products (70/30, 80/20, HDHP, non-Medicare) and Employing Units.

Confirm ☑ Does Not Confirm ☐

2) Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will provide the following specialty pharmacy management report or reporting package. The method for providing the report will be determined during implementation.

1) A quarterly utilization report detailing specialty pharmacy Rebates.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will provide each of the following Customer Experience reports or reporting packages. The method for providing the report will be determined during implementation.

1) The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:

a) Total Member calls received.

b) Weekly ASA rate for Member calls.

c) Weekly first contact resolution rate.

d) Weekly second contact resolution rate.

e) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.

f) TAT for completing manual enrollment updates.

g) Enrollment accuracy rate for the current month.

h) Number and percentage of clean claims processed ≤ 30 days.

i) Number and percentage of claims processed > 30 days.

j) Number and percentage of claims processed > 60 days.

k) Number and percentage of claims processed > 90 days.

Confirm ☑ Does Not Confirm ☐

2) A Quarterly Web Trends Report that provides statistics on Plan Members transaction history compared to Vendors' Book of Business data.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor will provide each of the following Recovery and Special Investigation reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly recovery reporting package that includes, but it not limited to the following:

a) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).

b) Total requested or saved, by recovery type and recovery subcontractor.

c) Total received, by recovery type and recovery subcontractor included Plan recovery Vendors. (Example: The Plan's Subrogation Vendor's results included in reporting package alongside Vendor's other recovery results.)

d) Total by subcontractor, including Plan recovery Vendors.

e) Quarter and year to date results.

f) Trends.

g) If available, benchmark data.

Confirm ☑ Does Not Confirm ☐

2) Monthly Plan specific investigation reports that include, but are not limited to, the following data:

a) Name of provider.

b) Number of Members impacted.

c) Date case opened.

d) Basis for review.

e) Summary of case.

f) Status of the case.

g) Total projected Plan claims dollars associated with the case.

h) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.

Confirm ☑ Does Not Confirm ☐

3) A quarterly medical audit repayment report that includes, but is not limited to, the following data:

a) Date of Service.

b) Member Name.

c) Subscriber Number.

d) Claim Number.

e) Original Paid Amount.

f) Appropriate Paid Amount.

g) Overpayment Amount.

h) Amount Repaid to the Plan.

i) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.

j) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

Confirm ☑ Does Not Confirm ☐

Attachment A: Pricing

We have reviewed and completed all components of Attachment A, including:

- Attachment A-1: Census file format
- Attachment A-2: Network Access for Non-Medicare Membership
- Attachment A-3: Claims Repricing File Layout
- Attachment A-4: Repricing Summary - Service Category
- Attachment A-5: Repricing Summary - By Provider
- Attachment A-6: Contract Improvements
- Attachment A-7: Administrative Fees
- Attachment A-8: Network Pricing Guarantees
- Attachment A-9: Self-Funded Claims Projection
- Attachment A-10: Actuarial Certification

As requested, these items are included in our Cost Proposal. Please see our separate, Cost Proposal binder.

ATTACHMENT B: INSTRUCTIONS TO VENDORS

1. **READ, REVIEW AND COMPLY:** It shall be Vendor's responsibility to read this entire document, review all enclosures and attachments, and any addenda thereto, and comply with all requirements specified herein, regardless of whether appearing in these Instructions to Vendors or elsewhere in this RFP document.

   Any gender-specific pronouns used herein, whether masculine or feminine, shall be read and construed as gender neutral, and the singular of any word or phrase shall be read to include the plural and vice versa.

2. **LATE PROPOSALS:** Late proposals, regardless of cause, will not be opened or considered, and will automatically be disqualified from further consideration. It shall be Vendor's sole responsibility to ensure delivery at the designated office by the designated time.

3. **ACCEPTANCE AND REJECTION:** The State reserves the right to reject any and all proposals, to waive any informality in proposals and, unless otherwise specified by Vendor, to accept any item in the proposal.

4. **BASIS FOR REJECTION:** The State reserves the right to reject any and all offers, in whole or in part, by deeming the offer unsatisfactory as to quality or quantity, delivery, price or service offered, non-compliance with the requirements or intent of this solicitation, lack of competitiveness, error(s) in specifications or indications that revision would be advantageous to the State, cancellation or other changes in the intended project or any other determination that the proposed requirement is no longer needed, limitation or lack of available funds, circumstances that prevent determination of the best offer, or any other determination that rejection would be in the best interest of the State.

5. **EXECUTION:** Failure to sign the Execution Page (numbered pages 3 -4 of the RFP) in the indicated space will render proposal non-responsive, and it shall be rejected.

6. **ORDER OF PRECEDENCE:** In cases of conflict between specific provisions in this solicitation or those in any resulting contract documents, the order of precedence shall be (high to low) (1) any special terms and conditions specific to this RFP, including any negotiated terms; (2) requirements and specifications and administration provisions in Sections 4, 5 and 6 of this RFP; (3) North Carolina General Contract Terms and Conditions in ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS; (4) Instructions in ATTACHMENT B: INSTRUCTIONS TO VENDORS; (5) ATTACHMENT A: PRICING, and (6) Vendor's proposal.

7. **INFORMATION AND DESCRIPTIVE LITERATURE:** Vendor shall furnish all information requested and in the spaces provided in this document. Further, if required elsewhere in this proposal, each Vendor shall submit with its proposal any sketches, descriptive literature and/or complete specifications covering the products and Services offered. Reference to literature submitted with a previous proposal or available elsewhere will not satisfy this provision. Failure to comply with these requirements shall constitute sufficient cause to reject a proposal without further consideration.

8. **RECYCLING AND SOURCE REDUCTION:** It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable, and less toxic to the extent that the purchase or use is practicable and cost-effective. We also encourage and promote using minimal packaging and the use of recycled/recyclable products in the packaging of commodities purchased. However, no sacrifice in quality of packaging will be acceptable. Vendor remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Vendors are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.

9. **CERTIFICATE TO TRANSACT BUSINESS IN NORTH CAROLINA:** As a condition of contract award, each out-of-State Vendor that is a corporation, limited-liability company or limited-liability partnership shall have received, and shall maintain throughout the term of the Contract, a Certificate of Authority to Transact Business in North Carolina from the North Carolina Secretary of State, as required by North Carolina law.

A State contract requiring only an isolated transaction completed within a period of six months, and not in the course of a number of repeated transactions of like nature, shall not be considered as transacting business in North Carolina and shall not require a Certificate of Authority to Transact Business.

10. **SUSTAINABILITY:** To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all responses meet the following:

    - All copies of the proposal are printed double sided.
    - All submittals and copies are printed on recycled paper with a minimum post-consumer content of 30%.
    - Unless absolutely necessary, all proposals and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable.
    - Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.

11. **HISTORICALLY UNDERUTILIZED BUSINESSES:** The State is committed to retaining Vendors from diverse backgrounds, and it invites and encourages participation in the procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled. In particular, the State encourages participation by Vendors certified by the State Office of Historically Underutilized Businesses, as well as the use of HUB-certified vendors as subcontractors on State contracts.

12. **RECIPROCAL PREFERENCE:** North Carolina adheres to a reciprocal preference requirement to discourage other states from favoring their own resident Vendors by applying a percentage increase to the price of any proposal from a North Carolina resident Vendor. To the extent another state does so, North Carolina applies the same percentage increase to the proposal of a vendor resident in that state. Residency is determined by a Vendor's "Principal Place of Business," defined as that principal place from which the overall trade or business of Vendor is directed or managed.

13. **INELIGIBLE VENDORS:** As provided in N.C.G.S. § 147-86.59 and N.C.G.S. § 147-86.82, the following companies are ineligible to contract with the State of North Carolina or any political subdivision of the State: a) any company identified as engaging in investment activities in Iran, as determined by appearing on the Final Divestment List created by the State Treasurer pursuant to N.C.G.S. § 147-86.58, and b) any company identified as engaged in a boycott of Israel as determined by appearing on the List of restricted companies created by the State Treasurer pursuant to N.C.G.S. § 147-86.81. A contract with the State or any of its political subdivisions by any company identified in a) or b) above shall be void *ab initio*.

14. **CONFIDENTIAL INFORMATION:** To the extent permitted by applicable statutes and rules, the State will maintain as confidential trade secrets in its proposal that Vendor does not wish disclosed. As a condition to confidential treatment, each page containing trade secret information shall be identified in boldface at the top and bottom as "CONFIDENTIAL" by Vendor, with specific trade secret information enclosed in boxes, marked in a distinctive color or by similar indication. Cost information shall not be deemed confidential under any circumstances. Regardless of what a Vendor may label as a trade secret, the determination whether it is or is not entitled to protection will be determined in accordance with N.C.G.S. § 132-1.2. Any material labeled as confidential constitutes a representation by Vendor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C.G.S. §132-1.2. Vendors are urged and cautioned to limit the marking of information as a trade secret or as confidential so far as is possible. If a legal action is brought to require the disclosure of any material so marked as confidential, the State will notify Vendor of such action and allow Vendor to defend the confidential status of its information.

15. **PROTEST PROCEDURES:** To protest a contract award, Vendor shall submit a written request for a protest meeting addressed to: Executive Administrator, North Carolina State Health Plan, 3200 Atlantic Avenue, Raleigh, NC 27604. The request must be received by the Plan within 30 calendar days from the date of

Contract award. The written request shall contain specific reasons and any supporting documentation for the protest. If the request does not contain this information or if the Executive Administrator determines that a meeting would serve no purpose, then the Executive Administrator may, within 10 calendar days from the date of receipt of the request, respond in writing to Vendor and deny the request for a protest meeting.

If the protest meeting is granted, the Executive Administrator will attempt to schedule the meeting within 30 calendar days after receipt of the letter, or as soon as possible thereafter. Within 10 calendar days from the date of the protest meeting, the Executive Administrator will respond to Vendor in writing with the Executive Administrator's decision.

Inclusion of this protest procedure is not intended to, and does not, waive, the Plan's exemption from Article 3 of Chapter 143 of the North Carolina General Statutes or any rules promulgated thereunder. Moreover, pursuant to N.C.G.S. § 135-48.35, a contract dispute involving the Plan is not a contested case under the Administrative Procedure Act, Chapter 150B of the North Carolina General Statutes.

16. **COMMUNICATIONS BY VENDORS:** In submitting its proposal, Vendor agrees not to discuss or otherwise reveal the contents of its proposal to any source, government or private, outside of the using or issuing agency until after the award of the Contract or cancellation of this RFP. All Vendors are forbidden from having any communications with the using or issuing agency, or any other representative of the State concerning the solicitation, during the evaluation of the proposals (i.e., after the public opening of the proposals and before the award of the Contract), unless the State directly contacts Vendor(s) for purposes of seeking clarification or another reason permitted by the solicitation. A Vendor shall not: (a) transmit to the issuing and/or using agency any information commenting on the ability or qualifications of any other Vendor to provide the advertised good, equipment, commodity; (b) identify defects, errors and/or omissions in any other Vendor's proposal and/or prices at any time during the procurement process; and/or (c) engage in or attempt any other communication or conduct that could influence the evaluation or award of a Contract related to this RFP. Failure to comply with this requirement shall constitute sufficient justification to disqualify a Vendor from a Contract award. Only those communications with the using agency or issuing agency authorized by this RFP are permitted.

17. **TABULATIONS:** Proposal tabulations can be electronically retrieved at the Interactive Purchasing System (IPS), https://www.ips.state.nc.us/ips/BidNumberSearch.aspx. Click on the IPS BIDS icon, click on Search for Bid, enter the bid number, and then search. Tabulations will normally be available at this web site not later than one working day after the bid opening. If negotiation is anticipated, tabulations may not be public until award. Lengthy or complex tabulations may be summarized, with other details not made available on IPS, and requests for additional details or information concerning such tabulations cannot be honored.

18. **VENDOR REGISTRATION AND SOLICITATION NOTIFICATION SYSTEM:** The North Carolina electronic Vendor Portal (eVP) allows Vendors to electronically register for free with the State to receive electronic notification of current procurement opportunities available on the Interactive Purchasing System, as well as notifications of status changes to those solicitations. Online registration and other purchasing information is available at the following website: http://ncadmin.nc.gov/about-doa/divisions/purchase-contract.

19. **WITHDRAWAL OF PROPOSAL:** Proposals that have been delivered by hand, U.S. Postal Service, courier, or other delivery service may be withdrawn **only** in writing and if receipt is acknowledged by the office issuing the RFP prior to the time for opening proposals identified on the cover page of this RFP (or such later date included in an Addendum to the RFP). Written withdrawal requests shall be submitted on Vendor's letterhead and signed by an official of Vendor authorized to make such request. Any withdrawal request made after the opening of proposals shall be allowed only for good cause shown and in the sole discretion of the State.

20. **INFORMAL COMMENTS:** The State shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the State during the competitive process or after award. The State is bound only by information provided in writing in this RFP and in formal Addenda.

21. **COST FOR PROPOSAL PREPARATION:** Any costs incurred by Vendor in preparing or submitting offers are Vendor's sole responsibility; the State of North Carolina will not reimburse any Vendor for any costs incurred prior to award.

22. **INSPECTION AT VENDOR'S SITE:** The State reserves the right to inspect, at a reasonable time, the equipment, item, plant, or other facilities of a prospective Vendor prior to Contract award, and during the Contract term as necessary for the State's determination that such equipment, item, plant, or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.

ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION

HISTORICALLY UNDERUTILIZED BUSINESSES

Historically Underutilized Businesses (HUBs) consist of minority, women, and disabled business firms that are at least fifty-one percent owned and operated by an individual(s) from one of these categories. Also included in this category are disabled business enterprises and non-profit work centers for the blind and severely disabled.

The State invites and encourages participation in this procurement process by businesses owned by minorities, women, the disable, disabled business enterprises, and non-profit work centers for the blind and severely disabled. This includes utilizing individual(s) from these categories as subcontractors to perform the functions required in this Solicitation.

The Vendor shall respond to questions below, as applicable.

PART I: HUB CERTIFICATION

Is Vendor a NC-certified HUB entity? ☐**Yes** ☒**No**

If **yes**, provide Vendor #: _____

If **no**, does Vendor qualify for certification as HUB? ☐**Yes** ☒**No**

Vendors that check "yes" will be referred to the HUB Office for assistance in acquiring certification.

PART II: PROCUREMENT OF GOODS - SUPPLIERS

For Goods procurements, are you using Tier 2 suppliers? ☐**Yes** ☒**No**

If yes, then provide the following information:

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid price

PART III: PROCUREMENT OF SERVICES - SUBCONTRACTORS

For Services procurements, are you using Subcontractors to perform any of the services being procured under this solicitation? ☒**Yes** ☐**No**

If yes, then provide the following information:

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid price

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid price
[redacted]							

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid
[redacted]							

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid
[redacted]							

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid
[redacted]							

Need more information?

Questions concerning the completion of this form should be presented during the Q&A period through the process defined in the Solicitation document.

Questions concerning NC HUB certification, contact the **North Carolina Office of Historically Underutilized Businesses** at 984-236-0130 or huboffice.doa@doa.nc.gov.