

Objectives:

- a. Ensure appropriate controls are in place to promote, monitor, and report on accuracy throughout the Vendor's organization.
- b. Ensure the Plan's auditors have appropriate and timely access to required data and personnel.
- c. Ensure the North Carolina Office of the State Auditor has appropriate and timely access to required data and personnel.
- d. Ensure the Plan has access to data, workflows, personnel, and reports needed to monitor and analyze the Vendor's results and, when appropriate, initiate process improvements.

5.2.13.2 Services

- a. **The Plan requires a Vendor that 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 and a targeted sample selected from a comprehensive analysis of all claims by the Plan's audit vendor. The random claims sample of these Standard Audits will be used to validate Performance Guarantees. Both the random claims sample and the targeted sample will be used to identify overpayments owed to the Plan. A separate audit by Plan auditors and/or the North Carolina Office of the State Auditor will be used to support the Comprehensive Annual Financial Report (CAFR). For purposes of Standard Audits, claims accuracy will be measured based on the following criteria:**
 - i. **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.
 - ii. **Payment Accuracy:** The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
 - iii. **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, the fact that the Vendor may have identified and/or recovered an overpayment or underpayment prior to the audit is irrelevant in determining whether an error occurred.

The Vendor shall confirm and describe each of the following:

- iv. Vendor will support ongoing quarterly claims accuracy audits, or Standard Audits, performed by the Plan's auditors. An audit plan will be provided prior to the initial quarterly audit that will define the ongoing Standard Audit timelines.
- v. Vendor will provide claims files to the Plan's auditors on a monthly basis.
- vi. Vendor will provide the Plan's auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits.
- vii. Vendor will provide remote view only access to the claims adjudication system used by claims processors to review any and all claims in Vendor's claims and eligibility processing system(s).
- viii. Vendor will provide the Plan's auditors access to detailed documentation associated with the Electronic Document Processing (EDP) system and all subsystems relevant to services provided under this Contract, at the Vendor's facilities.
- ix. Vendor will share provider contracts and system pricing with the Plan's auditors for review and audit.

- x. Vendor will provide on-site office space at the Vendor's facilities that are actually processing Plan claims including system access for the Plan's auditors, the Plan, or the North Carolina Office of the State Auditor.
 - xi. 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.
 - xii. Vendor will accept the Plan's auditor's claims audit methodology and audit results to measure claims accuracy for Performance Guarantees on a quarterly basis.
 - xiii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within thirty (30) days of the final report or another timeframe as specified by the Plan.
 - xiv. For any audit findings that reveal systemic or easily repeatable issues, the Vendor will provide full impact reports and review and recover out-of-sample claims. These out of sample claim recoveries will not impact performance guarantee measures.
 - xv. Vendor shall describe any limitations and/or issues meeting requirements a.iv. – xiv., above.
- b. The Plan requires a Vendor that in addition to supporting ongoing quarterly claims accuracy audits will 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. For purposes of Focus Audits and Comprehensive Electronic Audits regarding claims, claims accuracy will be measured based on the following criteria:**

- i. **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.
- ii. **Payment Accuracy:** The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
- iii. **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, the fact that the Vendor may have identified and/or recovered an overpayment or underpayment prior to the audit is irrelevant in determining whether an error occurred.

The Vendor shall confirm and describe each of the following:

- iv. Vendor will support multiple audits simultaneously. Although the Plan will work with the Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.
- v. Vendor will support Focus Audits such as, but not limited to, COB Audits, duplicate claim audits, pricing audits, eligibility audits, and Comprehensive Electronic Audits with a minimum of sixty (60) days-notice, on an as needed basis. An audit plan will be provided prior to the beginning of the audit.
- vi. Vendor will provide any additional claims data or supporting documentation within two (2) weeks of the Plan's auditors' request to facilitate the audit.
- 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.
- viii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within thirty (30) days of the final report or another timeframe as specified by the Plan.

The Vendor shall confirm the following:

- ix. Upon finalization of any audit, including, but not limited to, a Standard Audit, Focus Audit, or Comprehensive Electronic Audit, and within 30 days of receipt of a demand from the Plan, the Vendor shall reimburse the Plan the full amount of any overpayments or improper payments discovered by the Plan's auditors, whether from an in-sample or out-of-sample claim, that had not been detected and recovered by the Vendor prior to the Plan's auditors' disclosure of the audit findings to the Vendor. Reimbursements under this section shall not be offset against administrative expenses and must be repaid separately. Any recoveries undertaken by the Vendor related to these amounts shall be used solely to mitigate the Vendor's losses under this section, if any, and shall not be used to offset any amounts due the Plan.
 - x. In addition to reimbursement, if the Plan's auditors determine that there are systematic issues affecting the adjudication of the Plan's claims, the Vendor shall coordinate with the Plan to develop and immediately implement a corrective action plan subject to the Plan's approval.
 - xi. Vendor shall describe any limitations and/or issues meeting requirements b.iv. – x., above.
- c. The Plan requires a Vendor that will support any other audits relative to services provided, fees, performance of operational areas, operational support areas, and enterprise support areas as directed by the Plan, the Plan's auditors, or by the North Carolina Office of the State Auditor.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will support any other audits conducted by the Plan's auditors.
- ii. Vendor will support any other audit requested by the North Carolina Office of the State Auditor.
- iii. Vendor will support any other audit requested by the Plan.
- iv. Vendor will provide on-site office space at the Vendor's facilities for which Plan claims or other operational Plan services are provided, including system access for the Plan's auditors, the Plan, or the North Carolina Office of the State Auditor.
- v. Vendor shall describe any limitations and/or issues with meeting requirements c.i.-iv., above.

The Vendor shall describe each of the following:

- vi. The preferred methodology for supporting any of the audits described in this section.
 - vii. The process for any Plan auditors to access systems and/or to send and receive Data Files.
 - viii. Any limitations to providing data to the Plan's auditors.
 - ix. Any access restrictions to onsite claims reviews.
- d. The Plan seeks a Vendor that places a high value on the accuracy of all its deliverables, demonstrates a dedication to quality in all aspects of its operation, and is willing to share internal and external accuracy and audit results.**

The Vendor shall confirm and describe each of the following:

- i. Vendor has internal audit programs and will share internal audit results, as requested by the Plan. Include a list of all the audit programs associated with the services to be performed in support of this Contract.
- ii. If requested, Vendor will customize the Vendor's standard audit reports to meet the Plan's specific audit needs.

- iii. Vendor will provide benchmark and book of business results in addition to Plan specific results when reporting accuracy.
- iv. Vendor will create an audit and/or quality control program if necessary to meet the requirements under this Contract.
- v. Vendor shall describe any limitations and/or issues with meeting requirements d.i.-iv., above.

The Vendor shall describe each of the following:

- vi. How records for Medicare eligible members are audited to ensure accurate claims payment (Medicare COB). Include the frequency of these audits.
 - vii. How doctors' orders and certificate of medical necessity documents are audited to ensure Durable Medical Equipment (DME) claims are processed accurately. Include the frequency of these audits.
 - viii. How fee schedules and other pricing tools are audited for accuracy. Include the frequency of these audits.
- e. **The Plan requires a Vendor that upon request, will provide workflows, data, and other materials for process review and when necessary, meet with the Plan within thirty (30) days of the request.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide requested workflows, data, and other materials needed to review the Vendor's process within thirty (30) days of request.
 - ii. Vendor will demonstrate the Vendor's process to the Plan within thirty (30) days of request.
 - iii. Vendor will work with the Plan to develop process improvement plans.
 - iv. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-iii., above.
- f. **The Plan requires a Vendor that will collaborate on process improvement initiatives.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will allow the Plan to perform onsite reviews and validations of the Vendor's internal processes.
- ii. Vendor will collaborate with the Plan on process improvement initiatives.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements f.i.-ii., above.

5.2.14 Recovery and Investigations

5.2.14.1 Overview and Expectations

The Plan seeks a Vendor with strong overpayment identification and recovery programs. The Vendor should routinely identify pre-payment and overpayment trends, perform root cause analysis, and institute process and technology improvements to address gaps. The Plan, at its discretion, may use its own vendors to seek recoveries; therefore, the Vendor must support the Plan's recovery vendors by providing claims data, adjusting claims, and posting payments. The 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.

Objectives

- a. Ensure the Vendor has a progressive and aggressive overpayment identification and recovery program.
- b. Ensure the Vendor has a comprehensive pre-payment program.

- c. Ensure the Vendor uses state of the art technology and programs to detect and reduce fraud, waste, and abuse.
- d. Ensure the Vendor is able to support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. Chapter 105A, Article 1) by identifying debtors who owe money to the Plan and qualify for refunds with the North Carolina Department of Revenue.
- e. Ensure the Vendor is able to support the Plan's Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29) by identifying debtors who owe money to the Plan and are receiving retirement and/or disability benefits administered by the Department of State Treasurer's Retirement Systems Division.
- f. Ensure the Vendor is willing to partner with the Plan on process and technology improvements to reduce overpayments and fraud.
- g. Ensure the Vendor will provide the necessary reports to monitor recoveries, cost savings dollars, special investigations, and fraud cases.
- h. Ensure the Plan, at its discretion, is able to utilize outside vendors for specific recoveries and special investigation services and that those vendors will be supported by the Vendor.

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

5.2.14.2 Services

- a. The Plan requires a Vendor that will provide strong pre-payment audit programs and that is willing to provide monthly reports to the Plan with summary and detail information outlining the programs' results.**

The Vendor shall confirm and describe the following:

- i. Vendor will provide comprehensive pre-payment programs. Include in the description the pre-payment or "avoidance" savings for the Vendor's book of business associated with the programs in place for each of the last two (2) calendar years.
 - ii. Vendor will provide Plan specific pre-payment savings dollars reports on a monthly basis that include both summary and detail information outlining the programs' results.
 - iii. Vendor will customize the reports, if requested by the Plan.
 - iv. The Plan, at its discretion, may use its own vendors to establish pre-payment audits. The Vendor shall provide all necessary data and onsite access to the Plan's pre-payment audit vendors. Include in the description, the preferred methodology for supporting the Plan's pre-payment audit vendors, including the process for the Plan's vendors to access the appropriate data in the Vendor's systems to complete the audits and coordinate claims payment/denial of the claims.
 - v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.-iv., above.
- b. The Plan requires a Vendor that can provide strong overpayment identification and recovery programs and meet the accounts receivable requirements of the North Carolina Office of State Controller. The Vendor must be willing to follow all statutes and state policies governing debts and accounts receivable. The Vendor will also be required to support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. 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). This requirement also applies to any claims or reimbursements made by a Subcontractor, such as, but not limited to, a Subcontractor that processes HRA reimbursements. Finally, the Vendor must support Plan vendors that seek recoveries on the Plan's behalf.**

The Vendor shall confirm and describe:

- i. Vendor will provide overpayment identification and recovery programs. Include in the description, overpayment recovery results for the Vendor's book of business, including the overpayment reason (paid after termination date, Commercial COB, Medicare COB, duplicate claim, third party liability recovery, etc.) for each of the last two (2) calendar years.
- ii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.
- iii. Vendor will customize the reports, if requested by the Plan.
- iv. Vendor will implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.
- v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. Chapter 105A, Article 1).
- vi. Vendor will submit a bi-weekly debtor file to the North Carolina Department of Revenue.
- vii. Vendor will provide the Plan the actual debt owed for each debtor within two (2) days of receiving the Debt Setoff recovery list from the Plan.
- viii. Vendor will adjust any Debt Setoff recovery monies within 30 days of receiving approval from the Plan.
- ix. Vendor will support the Plan's participation in the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29). Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.
- x. Vendor will support the Plan's participation in Wage Garnishment (N.C.G.S. § 135-48.37A). Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.
- xi. Vendor will support the Plan's right to pursue debts against Providers through Credit Card Intercepts (N.C.G.S. § 1-359).
- xii. Vendor will support the Plan's recovery vendors by providing data, adjusting claims, and posting payments. The Vendor shall provide all necessary data and onsite access to the Plan's recovery vendors. Include in the description, the preferred methodology for supporting the Plan's recovery vendors and the process for Plan recovery vendors to access systems and/or to send and receive Data Files.
- xiii. Vendor will implement debt collections processes with a collection agency approved by the North Carolina Attorney General's Office. The list of approved collections agencies may change within the life of the Contract, as required by the North Carolina Attorney General's Office.
- xiv. 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 the Vendor to ensure the claims are appropriately adjusted and recoveries are deposited in the Plan's depository accounts.
- xv. Vendor will deposit into the Plan's depository account any recoveries received on behalf of the Plan, including, but not limited to, those from State Collections Agencies, Plan vendors, or Members within twenty-four hours of receipt as required in 5.2.3.2.a.i. and include the recoveries in the appropriate reports.

- 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 that shall not exceed twelve (12) months without the Plan's prior approval.
- 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.
- xviii. Vendor will consider anyone to be in default who misses one (1) payment. If anyone sends in a partial payment, he or she must be caught up in one (1) month or he or she will be considered to be in default.
- xix. Vendor shall not enter into a settlement on the Plan's behalf without first obtaining the Plan's approval.
- xx. Vendor will track and report actual cost savings dollars against targets and benchmarks.
- xxi. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.
- xxii. 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).
- xxiii. Vendor shall describe any limitations and/or issues with meeting requirements b.i.-xxii., above.

The Vendor shall describe each of the following:

- xxiv. Total recovery dollars requested and received as a result of Vendor error, for the Vendor's book of business for each of the last two (2) calendar years.
 - xxv. Transactions that automatically trigger a recovery review. (Example: retroactive termination, retroactive update of other insurance information, etc.)
 - xxvi. Processes and edits in place to identify improper provider billing. This includes, but is not limited to, up-coding, excessive charges, unbundling of services, multiple surgical procedures performed during one operation, and duplicate billing submissions including billing across programs (e.g., pharmacy and physician office or pharmacy and DME) and multiple provider TINs.
 - xxvii. Quality review of claims to ensure compliance with medical management determinations, medical claims policies, appropriate provider reimbursement arrangement, plan-specific benefits, and other measures.
 - xxviii. Any Subcontractor utilized for recoveries.
 - xxix. The Vendor's ability to aggregate, track, and collect interest and costs of collection for debts owed to the Plan, if the Plan decides to add these in the future.
- c. **The Plan requires a Vendor that demonstrates a dedication to fraud and abuse detection, reduction, and recovery as well as a willingness to assist in the prosecution of those who commit fraud.**

The Vendor shall confirm and describe:

- i. Vendor will have an investigation or similar unit to investigate possible fraud and abuse.
- ii. Vendor will share details about specific investigations that impact the Plan, including the names of the providers involved.
- iii. Vendor will provide Plan specific investigation reports on a monthly basis.

- iv. Vendor will customize the reports, if requested by the Plan.
- v. Vendor will provide copies of demand letters, settlement agreements, or other documents related to investigations.
- vi. Vendor will cooperate with the Plan in litigation against those who are suspected of committing fraud.
- vii. Vendor will use anti-fraud technology and/or software to prevent and detect fraud and abuse.
- viii. Vendor shall not enter into a settlement on the Plan's behalf without first obtaining Plan approval.
- ix. The Plan, at its discretion, may use its own vendors to investigate possible fraud and abuse and seek the appropriate recoveries. The Vendor shall provide all necessary data and onsite access to the Plan's investigation vendors. Include in the description, the preferred methodology for supporting the Plan's investigation vendors and the process for Plan vendors to access systems and/or to send and receive Data Files.
- x. Vendor will support the Plan's investigation vendors by providing data, adjusting claims, and posting payments.
- xi. Vendor will not establish a payment plan for a provider or active or inactive Member that exceeds twelve (12) months without the Plan's prior approval.
- xii. Vendor shall describe any limitations and/or issues with meeting requirements c.i. - xi., above.

The Vendor shall describe each of the following:

- xiii. How Vendor's fraud and abuse recovery targets are measured and what industry benchmarks are used to measure success.
- xiv. Investigation methodology.
- xv. Investigation targets and results from each of the last two (2) years.
- xvi. Type and frequency of training provided to fraud and abuse detection and recovery staff.
- xvii. Specifics about the resources available to the Plan to assist in the prosecution of those suspected of committing fraud and abuse.
- xviii. Process for referral of those suspected of fraud and abuse. Include in the description the criteria for and process by which providers are removed from the Vendor's network.

d. The Plan prefers a Vendor that will partner with the Plan on an ongoing basis on all aspects of recovery and investigation efforts.

The Vendor shall confirm and describe:

- i. Vendor will share root cause analysis of recoveries required because of Vendor error.
- ii. Vendor will provide requested workflows, data, and other materials needed to review the Vendor's process within thirty (30) days of request.
- iii. Vendor will partner on process improvements to address root causes uncovered as a result of recovery discovery.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements d.i. - iii., above.

The Vendor shall describe each of the following:

- v. Process for prioritizing and addressing process and system gaps uncovered through routine analysis of processing and system errors.
- vi. Types of claims edits and bundling technology and/or software used to prevent overpayments.

5.2.15 Initial and Ongoing Implementation**5.2.15.1 Overview and Expectations****Initial Implementation**

The Plan seeks to partner with a Vendor having the systems and resources to support on-time implementation of all programs and services included in this Contract. The Vendor must provide dedicated resources and expertise to support simultaneous implementation of multiple work streams. Those work streams include, but are not limited to:

- Group Set-Up, enrollment, and premium billing
- Banking and finance
- Vendor integration and EDI
- Provider Network, (North Carolina State Health Plan Network)
- Program development (to determine which of the Vendor's programs may be implemented)
- 2022 benefit offerings
- Customer experience – e.g., customer service, member communications, employing unit training, etc.

During the initial implementation, the Vendor will work with the Plan to document which programs will be implemented when all services commence on January 1, 2022, how the programs will be rolled out to Plan Members, and what customizations may be required by the Plan. The Vendor shall also work with all Plan vendors to implement customized EDI files to and from the Vendor. Any other customized Data Files required to support programs to be in place on January 1, 2022 will also be designed and implemented.

The Vendor will also have to implement and integrate the Plan's custom network, the North Carolina State Health Plan Network, prior to January 1, 2022. This will include the transfer of provider data, the implementation of reimbursement methodology as outlined in Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, the integration required to load and maintain the Vendor's provider search tool, and the establishment of ongoing maintenance of all provider data interfaces.

To meet the Plan's expectations of providing a superior Customer Experience, the Vendor must have the resources available to assist with review and customization of all Member facing materials, including, but not limited to, communications provided to Members via the secure Member portal, any letters provided to Members, EOBs, and the Plan's Benefit Booklets. The Vendor must also work with other Plan vendors to set up the appropriate call transfer protocols and build any new workflow schematics that may be required. The Plan will work with the Vendor to ensure the Vendor's staff is appropriately trained and understands all Plan policies and requirements.

To meet the Plan's requirements for Group Set-Up and Enrollment, and to support the Open Enrollment period for the 2022 Benefit Year, the Vendor must be able to accept EDI files prior to January 1, 2022 and produce the first Group Premium Invoices in December 2021 for January 2022 coverage. The Vendor shall work with Plan staff and other Plan vendors to determine the Group set-up requirements and develop and implement a roll-out strategy for all Groups which includes, but is not limited to, providing regional and web training for the more than four hundred and fifty (450) Groups. The Vendor will also support the Plan during Open Enrollment events throughout the fall of 2021.

Ongoing Implementations

Throughout the life of the Contract, the Plan will implement new benefits, services, and Plan vendors that will require the 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. In all instances, the Plan will work with the Vendor to develop an Implementation Plan that is mutually agreeable to the Vendor, the Plan, and to the other Plan vendors involved. Depending on the scope of the project, 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 the Vendor as soon as feasibly possible about all proposed changes.

Annual Benefit Change Schedule

The Plan's *preferred schedule for annual benefit changes is to confirm the next year's benefits by February of the preceding year. To meet this schedule, the Vendor must be available to work with the Plan in the preceding months to design benefit change recommendations, and the Board of Trustees must vote and confirm benefits during the February Board meeting. Example of preferred 2022 Benefit Timeline Development Schedule:

- September 2020 – December 2020: Complete development of 2022 benefit recommendations
- January – February 2021: Present 2022 benefit recommendation to the Board
- February – September 2021: Plan, Vendor, and Plan vendors implement 2022 benefits
 - End to End testing of new benefits, including EDI and claims payout
 - Rate configuration
 - Process overview
 - Audit of new configuration
- October 2021: Open Enrollment commences for all Plan Members

****While this is the preferred method, as noted earlier, the implementation timeline may be much shorter.***

5.2.15.2 Services Initial Implementation

- a. **The Plan requires a Vendor with the resources, expertise, and technology to support the Plan's implementation schedule. In addition to completing group set-up, benefit configuration, data transfer, Plan, HBR, and Member training prior to the January 1, 2022 commencement of services, the Vendor must be able to successfully establish EDIs with the Plan and Plan vendors, bill the Employing Units, and issue ID cards.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will have a fully assembled implementation team ready to begin work within two 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, and Group Premium Billing.
 - 2) Banking and Finance.
 - 3) Plan vendor Integration and EDI which includes, but is not limited to:
 - a) EES vendor Integration.
 - b) PBM vendor Integration.
 - c) Billing vendor Integration.
 - d) Billing Client Integration.
 - e) Plan Data Warehouse Integration.
 - f) Plan Custom Network (Data Files to the Plan).
 - 4) Custom Provider Network.
 - 5) Program Development.
 - 6) 2022 Benefit Offerings.
 - 7) Customer Experience which includes, at a minimum:
 - a) Member Communications.
 - b) Employing Unit Training.
 - c) Customer Service.

The Vendor shall confirm and describe each of the following, including the types of resources to be assigned and the names and profiles of the work stream project leads.

- ii. Vendor will provide a dedicated implementation manager whose sole account is the Plan, who in coordination with the dedicated account manager and account management team, will effectively manage the implementation of this program. The dedicated implementation manager must continue to support the Plan a minimum of 90 days after the implementation date of January 1, 2022, 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.
- iii. Vendor will develop Functional Requirements Documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation for each work stream derived from the Plan's business requirements. These documents must be mutually agreed upon by the 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.
- iv. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live. To support testing, the 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 the 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.
- v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.–iv., above.

The Vendor shall provide each of the following:

- vi. Description of the implementation and project management approach along with a high-level project timeline that includes durations and tasks by resource required, for the Vendor, the Plan, and Plan vendors.
 - vii. Description of the training approach for Vendor's staff.
 - viii. Description of the cooperation and resources that may be required from the Plan's current claims processing vendor to meet the implementation timeline.
 - ix. Description of the process for other Plan vendors to access systems and/or to send and receive Data Files.
 - x. List any access restrictions or Data File requirements for the Plan or Plan vendors.
 - xi. Describe any actions the Plan will need to take to assist with the performance of the proposed services, such as letters of authorization to other Plan vendors, information regarding organizational structure and reporting relationships, and similar matters.
 - xii. A description of how Vendor's operational, program, and project teams will be built or expanded to support the Plan.
- b. The Plan requires a Vendor with the resources to meet the initial implementation schedule which will include some services that must be in place prior January 1, 2022.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will support the 2022 Open Enrollment which will be in October of 2021, but may be rescheduled to a different time in the Plan's sole discretion. The 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.
- ii. Vendor will produce and deliver Group Premium Bills in December of 2021 for January 2022 premiums.
- iii. Vendor will complete all work to support a PBM "Carve-Out" which includes the data integration to support deductible and out-of-pocket accumulators between the medical and pharmacy benefits by January 1, 2022.

- iv. Vendor will have the depository bank accounts setup and tested at least forty-five (45) days prior to January 1, 2022.
- v. Vendor will deposit and properly report premium receipts for the first month of coverage into the Plan's bank account prior to the effective date of coverage.
- vi. Vendor will collect premium receipts on behalf of the Plan and deposit into the Plan's bank account within 24 hours to comply with cash management policies in December 2021.
- vii. Vendor will have all elements of the Plan's custom network, the North Carolina State Health Plan Network, implemented prior to January 1, 2022. This includes, but is not limited to, the transfer of provider data from the prior TPA, the implementation of reimbursement methodology as outlined in Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, the integration required to load and maintain the Vendor's provider search tool, and the establishment of ongoing maintenance of all provider data interfaces.
- viii. There will be 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.
- ix. Vendor shall describe any limitations and/or issues with meeting requirements b.i. –viii., above.

c. The Plan requires a Vendor with the resources and expertise to work with the Plan to implement benefits for the 2022 Plan Year.

The Vendor shall confirm and describe the following:

- i. Vendor can load the current 2020 benefits without exception. Benefits are outlined in the benefit booklets at the following link: <https://www.shpnc.org/2020-benefit-information>.
- ii. Vendor will work with the Plan to develop and implement any required benefit changes for the 2022 benefit year.
- iii. Vendor will work with the Plan to develop an implementation plan to ensure all Members who enroll by December 1, 2021 with a 2022 effective date will have ID cards, and if appropriate, prior to January 1, 2022.
- iv. 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, 2022.
- v. Vendor shall describe any limitations and/or issues with meeting requirements c.i. –iv., above.

d. The Plan requires a Vendor that will provide business and technical resources to review all programs and services provided through this Contract, and work with the Plan to document which programs and services will be in place at Go-Live.

The Vendor shall confirm each of the following:

- i. Vendor will provide business and, if necessary, technical resources to review all programs and services available through this Contract and complete any customization required by the Plan prior January 1, 2022. If requested by the Plan, Vendor will support a readiness review and/or implementation audit at least sixty (60) days prior to January 1, 2022. Vendor shall participate in all readiness review and/or implementation audit activities conducted by the Plan or Plan vendors to ensure the Vendor's operational readiness.
- ii. Vendor shall describe any limitations and/or issues with meeting requirement d.i., above.

5.2.15.3 Services: Post Initial Implementation

- a. **The Plan requires a Vendor that will partner with the Plan to deliver new initiatives, Plan Design changes, and Plan vendor changes, as requested by the Plan. This will require the Vendor to have the business and project management resources available to support these items on an ongoing basis. When possible, the delivery date will be determined by the project life cycle, but in many instances the delivery date will be pre-determined.**

The Vendor shall confirm each of the following:

- i. Vendor will develop Functional Requirement Documents, Implementation Plans, Test Plans, Deployment Plans, and Close Out Documentation for each work stream derived from the Plan's business requirements. These documents must be mutually agreed upon by the Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator regarding day-to-day activities is authorized to sign these documents for the Plan.
- ii. Vendor will support both Unit Testing and End-to-End Testing for new initiatives, Plan Design changes, and vendor changes, prior to deployment. To support testing, the Vendor must not only have the technical and business resources, but also the appropriate test environments. As mentioned above, the Test Plan will be mutually agreed upon by the Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator regarding day-to-day activities is authorized to sign these documents for the Plan.
- iii. Vendor will support and participate in End-to-End Testing that may be required to support enhancements developed by other Plan vendors.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iii., above.

5.2.16 Reporting

5.2.16.1 Overview and Expectations

The Plan seeks a partner that can support its custom reporting requirements which includes 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, the Vendor must have the resources and expertise to assist the Plan as needed.

5.2.16.2 Reporting Services

- a. **The Plan requires a Vendor with the ability to provide canned reports and ad hoc self-service reporting capabilities to the Plan, Plan vendors, and Partners in various formats.**

The Vendor shall confirm:

- i. Vendor will provide required reports to the Plan in each of the following formats:
 - 1) Excel.
 - 2) PDF.
 - 3) Text.
 - 4) XML.
 - 5) HTML.
 - 6) CSV (raw format).
 - ii. Vendor shall describe any limitations and/or issues meeting requirement a.i., above.
- b. **The Plan prefers a Vendor with deep expertise in data analytics and modeling that can partner with the Plan to meet its strategic priorities.**

The Vendor shall confirm and describe that the Vendor will provide the following:

- i. Innovative thought leadership using advanced modeling techniques on trouble spots, population health management opportunities, fraud, waste and abuse, geographic, or other trends.
- ii. Accurate and insightful analyses as requested by the Plan that will help identify areas of opportunity for improved services or reduced costs.
- iii. Cost driver analyses, including the identification of cost drivers such as demographic changes, plan design changes and market occurrences (i.e., changing clinical protocols), as requested by the Plan.
- iv. Trending analyses on such measures as cost, utilization, clinical outcomes, and enrollment migration, as requested by the Plan.
- v. Predictive analyses on such measures as Member migration (plan migrations, physical migrations, utilization migrations, etc.).
- vi. Cost impact analyses of an aging population.
- vii. Clinical, cost, and productivity impact analysis of chronic conditions.
- viii. Wellness Indicators analysis, including, but not limited to:
 - 1) Smoking/Tobacco Use.
 - 2) Drug Abuse/Misuse/Diversion (illicit and prescribed drugs).
 - 3) Overweight/Obesity/Sedentary or Inactive lifestyle.
 - 4) Stress, Depression, Anxiety.
- ix. Benchmarking and comparative analyses. Specify the sources utilized for benchmarking/comparison of data (i.e., First Databank, Medispan, Agency for Healthcare Research and Quality (AHRQ), and National Quality Foundation (NQF)).
- x. Comparative analyses (historical, current state, and predictive) of the Plan's total Member population (or stratification thereof) compared to comparable cohorts.
- xi. Identification and characterization (clinical and financial) for Episodes of Care.
- xii. Advanced modeling capabilities and tools including longitudinal analysis (forward and historical) predictive analyses, data-driven decision trees, data segmentation, data mining, text mining, visual statistics, neural networks, etc.
- xiii. State-of-the-art, interactive tools for consumption and visualization of reporting and analytic results. Include sample reports/demos of visualization results.
- xiv. Queries, business logic, and other information to provide in depth understanding of the results and the ability to recreate the results based on the data within the Plan's Data Warehouse.
- xv. Data monitoring dashboards that allow multiple groups within the Plan to access, view, and analyze key performance data across vendors / Partners / carrier integration.
- xvi. Vendor shall describe any limitations and/or issues meeting requirements b.i - xv., above.

The Vendor shall describe the following:

- i. Experience with risk scoring methodology, link analysis, and graph pattern analysis.

- ii. Modeling technologies and tools used, including available open source technology.
- iii. Machine learning capabilities.
- iv. Any external, third party and/or subscription-based data sources available for driving better insights and analytic results.
- v. How the use of Vendor's advanced modeling capabilities helped drive a client solution.
- vi. The options for providing and accessing analytic modeling results (e.g., email, portal, tool access, etc.).

The Vendor shall provide:

- vii. Client examples where the aforementioned capabilities and tools have been utilized.
- viii. An overview of the Vendor's methodology for grouping services and care into bundled episodes. Provide peer-reviewed validation of the methodology to grouping care into episodes.
- ix. Sample screenshots/demos/reports/generic login access to these tools or capabilities.
- x. Sample reports that reflect experience with population adjustments such as risk scores, episodes of care, treatment groupers, etc.
- xi. Protocols outlining the process that the Vendor will follow with the Plan if there is a discrepancy in data or analytics between the Vendor and the Plan.
- xii. An overview of commitment to transparency, the approach, and how Vendor will work with the Plan to resolve any discrepancies.

c. The Plan requires a Vendor that provides superior customer reporting.

The Vendor shall confirm and describe each of the following:

- i. Vendor will customize any report, as requested by the Plan.
- ii. Vendor will combine claims and financial data in reporting.
- iii. Vendor will email all standard reports, to the email addresses provided by the Plan. If PHI is included, the reports shall be sent securely.
- iv. Vendor will provide all standard reports on the reporting schedule outlined in Attachment K.
- 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.
- vi. 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, tenure.
 - 3) Geography.
 - a) Zip Code.

- b) County.
 - c) Hospital Service Area (has).
 - 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) Primary Care Physician (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).
- vii. Vendor will provide innovative reporting functionality including interactivity, remote access, embedded graphics, data mapping, decision tree logic, and data drill downs as well as dashboard reporting.
- viii. The Vendor shall describe any limitations and/or issues with meeting requirements c.i. – vii. above.

The Vendor shall describe and provide samples of each of the following:

- ix. Standard reports that will be available to the Plan.
- x. Ad hoc reporting capabilities.
- xi. Availability of dashboards and enhanced reporting tools.

5.2.16.3 Standard Reports

- a. **The Plan requires a Vendor that offers standard reports to satisfy the Plan's needs.**

The Vendor shall confirm that it will provide each of the following reports or reporting packages. The method for providing the report will be determined during implementation. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements. (See Attachment K: Reports, for due dates.)

- i. Weekly membership reports that include, but are not limited to, the following information:
 - 1) Group Number.
 - 2) All internal and external member Identification numbers.
 - 3) Subscriber number.
 - 4) Coverage effective date.

- 5) Coverage expiration date.
- 6) Current benefit effective date.
- 7) Current benefit expiration date.
- 8) Member First Name.
- 9) Member Last Name.
- 10) Member SSN.
- 11) Member date of birth.
- 12) Member tier.
- 13) Member benefit identifier code(s).
- 14) Member date of birth.
- 15) Medicare primary flag.
- 16) Medicare Coverage.
 - a) Medicare A.
 - b) Medicare B.
- 17) Medicare effective date.
- 18) Medicare expiration date.

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

- 1) Enrollment by Plan Design, Entity, Group, Tier and Medicare Status.
- 2) In-state Member counts by county broken down by Plan Design and then totaled.
- 3) Out-of-state Member counts by state or country broken down by Plan Design then totaled.
- 4) Enrollment by Group number broken down by Subscriber and Dependent then totaled.
- 5) Graphs (Pie Charts) that include.
 - a) All Members by Plan Design.
 - In-state Members by Plan Design.
 - Out-of-state Member by Plan Design.
 - b) All Members by Coverage Tier.
 - c) Top 10 Counties.

iii. Monthly PCP Election report that includes, but is not limited to:

- 1) Total number of Members that have elected a PCP broken down by Plan Design.
- 2) Statistics about the Members who see the PCP on their card and those that see other PCPs.
- 3) Types of PCP elected (i.e. General practice, pediatrician, family medicine, etc.).
- 4) List of elected providers and number of Members who have elected them as their PCP.

iv. Describe any limitations and/or issues with meeting requirements a.i.-iii. above.

5.2.16.4 Banking and Finance Reports

a. The Plan requires a Vendor that can provide banking and finance reports that satisfy the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Monthly accounts receivable aging report that includes, but is not limited to:

- 1) The amount of premiums due, but not received.
- 2) The amount of any unapplied premiums.
- 3) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days and over 120 days.
- 4) Supporting documentation from which these amounts are derived.

ii. Quarterly report of any uncollectible accounts (including premiums or recoveries)

- 1) Recommended for debt write-off which includes, but is not limited to:
 - a) Account name.
 - b) Subscriber number, if applicable.
 - c) Description/justification of the reason for write-off.
 - d) The provider code, if applicable.
 - e) Dollar amount and date originally paid, if applicable.
 - f) Payee status.
 - g) Identifying number (e.g. invoice, claim, case).
 - h) Total amount proposed for write-off.

- 2) Recommended for exhausted debt (debt the Vendor should stop tracking and pursuing when agreed upon recovery process has been completed) which includes, but is not limited to:
 - a) Account name.
 - b) Subscriber number, if applicable.
 - c) Description/justification of the reason for exhausted debt.
 - d) The provider code, if applicable.
 - e) Dollar amount and date originally paid, if applicable.
 - f) Payee status.
 - g) Identifying number (e.g. invoice, claim, case).
 - h) Total amount proposed for exhausted debt.

- iii. Monthly prepaid premiums report which includes, but is not limited to:
 - 1) Employing Unit group number.
 - 2) Employing Unit group name.
 - 3) Date payment received as well as payment due date.
 - 4) Amount paid and amount due.
 - 5) Monthly totals for all groups/Members.
 - 6) Upon request, ability to produce Member level detail.

- iv. Daily deposited premiums and other receipts reporting package, reported separately by Product type, e.g., PPO, HSA, HRA, etc., including:
 - 1) Summary report, which includes, but is not limited to:
 - a) Date of deposit.
 - b) Total amount received by check.
 - c) Total amount received by ACH.
 - d) Distinct identification of which amounts relate to premiums and which amounts relate to other types of deposits.
 - e) Descriptive labeling of other deposits.
 - f) Grand total of the daily deposits.

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

 - 3) Daily deposit supporting documentation report, which includes, but is not limited to:
 - a) Employing Unit group number.
 - b) Employing Unit group name.
 - c) Type of deposit, i.e. checks, ACH, and/or wire.
 - d) Amount of deposit for each group and a grand total per deposit type.
 - e) Upon request, ability to produce Member level detail.

- f) Any other reports or information to support other types of deposits, e.g. recoveries, claims refund, etc.
- v. Daily NSF report listing all for the previous month which includes:
 - 1) Group number, if applicable.
 - 2) Subscriber number, if applicable.
 - 3) Date returned.
 - 4) Dollar amount.
- vi. Monthly misapplied deposits and/or collections report (e.g. applied premium deposit to wrong group or wrong client) which includes date originally deposited and how they were corrected.
- vii. Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:
 - 1) Number of checks processed weekly.
 - 2) Number of EFTs processed weekly.
 - 3) Payments amount(s) by type e.g. claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.
 - 4) Weekly total by type.
 - 5) Month to date total by type.
 - 6) 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.
- viii. Monthly deposit reconciliation which includes, but is not limited to:
 - 1) Date of each daily deposit.
 - 2) Total amount of deposit for each day.
 - 3) Breakdown of amount by type of deposit, i.e. checks, wires, ACH (drafts).
 - 4) Monthly total of each type.
- ix. Monthly reconciliation of claims and other disbursements which includes, but is not limited to:
 - 1) Daily transactions listed individually with a daily total as well as a summary total.
 - 2) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds and other disbursements.
- x. As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:
 - 1) Final due date to escheat the warrants/checks.
 - 2) Name of state and dormancy period for each state.
 - 3) Number of warrants for each state and dollar amount.
 - 4) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all product types. Explanation of any special circumstances or issues.
- xi. 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.
- xii. Monthly Statement of Account (SOA) which includes all charges including claims, administrative fees, and all premiums paid. It is a full picture of all income/expenses for the month.
- xiii. Vendor shall describe any limitations and/or issues meeting requirements a.i. - xii., above.

5.2.16.5 Financial Performance Reports

a. **The Plan requires a Vendor that will provide financial performance reports that meet the Plan's needs.**

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

- i. Performance Guarantees (PG), as outlined in Section 6.3.4, reports as follows:
 - 1) Monthly PG status report.
 - 2) Quarterly PG report cards.
 - 3) Annual PG report cards that include summary data and year end PG results.

- ii. Monthly Performance Matrix reports as outlined in Exhibit 19, Matrix Reports, and listed below:
 - 1) Reports 1 and 2: Charge Summary Paid and Incurred Reports.
 - 2) Reports 3 and 4: Charge Summary Trend Paid and Incurred.
 - 3) Reports 5 and 6: Coinsurance & Deductible, Full Population-Paid and Incurred.
 - 4) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.
 - 5) Reports 9 and 10: Copay-Incurred and Paid.
 - 6) Report 11: Copay-Incurred (Claims Run out).
 - 7) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
 - 8) Reports 14 and 15: Financial Summary-Paid and Incurred.
 - 9) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.
 - 10) Report 18: Premium Billing.
 - 11) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

- iii. Monthly Triangulations reports with the following stratifications:
 - 1) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.
 - 2) Plan design and/or product, including a summary based on total membership.

- iv. Monthly prompt payment interest claims report that include, but are not limited to:
 - 1) Prompt pay for adjusted claims.
 - 2) Prompt pay for new claims.
 - 3) Claim count.
 - 4) Total interest paid.

- v. Weekly group premiums arrears reports that indicates the "paid through date" or "hold" date for any Group that is delinquent.

- vi. Weekly or on-demand premium payment report that provides payment detail for each Group.

- vii. Vendor shall describe any limitations and/or issues meeting requirements a.i. - vi., above.

5.2.16.6 Claims Reports

a. **The Plan requires a Vendor that can provide claims reports that meet the Plan's needs. The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.**

- i. Monthly Processed claims reports that include, but are not limited to:

- 1) Claims type.
 - 2) Total claims billed.
 - 3) Total claims paid.
- ii. Monthly Deductible and Out-of-Pocket reports, by plan design, by month.
 - iii. Monthly COB reports that identify savings associated with both Medicare and Commercial COB.
 - iv. Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:
 - 1) Denial reason.
 - 2) Number of claims for each denial reason.
 - 3) Total charges for each denial reason.
 - v. 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):
 - 1) Member ID.
 - 2) Plan ID.
 - 3) Member age.
 - 4) Diagnosis.
 - 5) Service start date.
 - 6) Encounter service type.
 - 7) Place of service.
 - 8) Provider specialty description.
 - 9) Paid amount.
 - vi. Monthly medical and pharmacy appeals reports that include, but are not limited to:
 - 1) Number of first level appeals received.
 - 2) Number of first level appeals approved.
 - 3) Number of first level appeals denied.
 - 4) Number of second level appeals received.
 - 5) Number of second level appeals approved.
 - 6) Number of second level appeals denied.
 - 7) Statistics on types of appeals received, approved and denied at both first and second level.
 - vii. A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:
 - 1) Member ID.
 - 2) Member First Name.
 - 3) Member Last Name.
 - 4) Type of Appeal Review Decision.
 - 5) Type of Appeal Category.
 - 6) Date Appeal Initiated.
 - 7) Final Written Date.
 - 8) Appeal Decision Description.
 - 9) Medication Name, Strength and Dosage.
 - viii. A monthly pharmacy appeals **resolved detail** report that includes, but is not limited to, the following:
 - 1) Member ID.
 - 2) Member First Name.
 - 3) Member Last Name.
 - 4) Type of Appeal Review Decision.

- 5) Type of Appeal Category.
- 6) Final Written Date.
- 7) Appeal Decision Description.
- 8) Medication Name, Strength and Dosage.
- 9) Method Appeal Received.
- 10) Appeal Origin.
- 11) Drug Class.

ix. Vendor shall describe any limitations and/or issues with meeting requirements a.i. - viii. above.

5.2.16.7 Network Management Reports

a. The Plan requires a Vendor that can provide network management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

- i. Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.
- ii. Vendor shall describe any limitations and/or issues with meeting requirements a.i., above.

5.2.16.8 Medical / Utilization / Outcomes Reports

a. The Plan requires a Vendor that can provide medical management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following Medical Management reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

- i. 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.
- ii. Quarterly Case Management Clinical Outcomes.
- iii. Quarterly Preventive Care Service Utilization.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iii., above.

b. The Plan requires a Vendor that can provide Utilization Management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following Utilization Management reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

- i. 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.
- ii. Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii., above.

- c. **The Plan requires a Vendor that can provide Opportunities and Outcomes reports that meet the Plan's needs.**

The Vendor shall confirm that it will provide each of the following Opportunities and Outcomes reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

- i. Quarterly Clinical Quality Improvement: Opportunities and recommendations to improve clinical quality.
- ii. Annual Medical Policy Revisions: Result of reviews, changes, and/or proposed changes to medical policies coverage for new technologies and/or services.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – ii., above.

5.2.16.9 Pharmacy Management Reports

- a. **The Plan requires a Vendor that can provide pharmacy management reports that meet the Plan's needs.**

The Vendor shall confirm that it will provide each of the following reports:

- i. A quarterly utilization report detailing specialty pharmacy Rebates.
- ii. A quarterly medical specialty pharmacy utilization report by specialty drug broken into the following subcategories:
 - 1) Active Employees.
 - 2) Non-Medicare Members in the Direct Bill and Retirement Groups.
 - 3) Medicare Members in the Direct Bill and Retirement Groups.
- iii. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.- ii., above.

5.2.16.10 Customer Experience Reports

The Plan requires a Vendor that can provide a Weekly Operations Dashboard by the end of the day each Thursday and include records received and/or processed Sunday through Saturday of the previous week.

The Vendor shall confirm that it will provide:

- i. The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:
 - 1) Total Member calls received.
 - 2) Weekly ASA rate for Member calls.
 - 3) Weekly first contact resolution rate.
 - 4) Weekly second contact resolution rate.
 - 5) Weekly inquiry on time completion rate.
 - 6) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.
 - 7) TAT for completing manual enrollment updates.
 - 8) TAT for the production of monthly premium invoices.
 - 9) Number and percentage of clean claims processed ≤ 30 days.
 - 10) Number and percentage of claims processed > 30 days.
 - 11) Number and percentage of claims processed > 60 days.
 - 12) Number and percentage of claims processed > 90 days.
- ii. A Monthly Web Trends Report that provides stats on Plan Members transaction history on Vendor's web pages and web tools.

iii. Vendor shall describe any limitations and/or issues with meeting requirements a.i.- ii., above.

5.2.16.11 Recovery and Special Investigation Reports

a. The Plan requires a Vendor that can provide recovery and special investigations reports that meet the Plan's needs.

The Vendor shall confirm that it will provide:

- i. Book of business data.
- ii. Monthly recovery reporting package that includes, but it not limited to the following:
 - 1) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).
 - 2) Total requested or saved, by recovery type and recovery subcontractor.
 - 3) 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.)
 - 4) Total by subcontractor, including Plan recovery Vendors.
 - 5) Quarter and year to date results.
 - 6) Trends.
 - 7) If available, benchmark data.
- iii. Monthly Plan specific investigation reports that include, but are not limited to, the following data:
 - 1) Name of provider.
 - 2) Number of members impacted.
 - 3) Date case opened.
 - 4) Basis for review.
 - 5) Summary of case.
 - 6) Status of the case.
 - 7) Total projected Plan claims dollars associated with the case.
 - 8) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.
- iv. A quarterly medical audit repayment report that includes, but is not limited to, the following data:
 - 1) Date of Service.
 - 2) Member Name.
 - 3) Subscriber Number.
 - 4) Claim Number.
 - 5) Original Paid Amount.
 - 6) Appropriate Paid Amount.
 - 7) Overpayment Amount.
 - 8) Amount Repaid to the Plan.
 - 9) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.
 - 10) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.
- v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.- iv., above.

5.2.17 Meeting Requirements

a. The Plan requires a Vendor that has the resources and availability to establish standard ongoing meetings with the Plan as well as to be available to meet with the Plan, as requested. Some meetings will be on site and others will be held telephonically. The standard meeting schedule will be developed during implementation and may be modified from time to time, as requested by the Plan.

The Vendor shall confirm and describe each of the following:

- i. Vendor will establish routine, ongoing meetings with the Plan and provide the appropriate subject matter experts and decision makers to facilitate the meetings. These meetings may be held at the Plan's offices or held telephonically.
- ii. Vendor will meet with the Plan on an as needed basis to discuss issues, initiatives, or other items, as requested by the Plan.
- iii. Vendor will attend public meetings of the Plan's Board of Trustees.
- iv. Vendor shall describe any limitations or issues with meeting requirements a.i. - iii. above.

5.3 COST PROPOSAL REQUIREMENTS

If any cost information is included in the Technical Proposal and/or if any technical information is included in the Cost Proposal, the information may not be considered or the entire proposal may be rejected.

The Vendor shall:

- a) Submit a Cost Proposal and include the Cost Proposal separate from the Technical Proposal; and
- b) Submit the Cost Proposal in accordance with Attachment A: PRICING. A Microsoft Excel version of Attachment A may be obtained by sending a request to: Sharon.smith@nctreasurer.com with a copy to shpcontracting@nctreasurer.com.

6.0 CONTRACT ADMINISTRATION

By submitting a proposal, the Vendor agrees to meet all stated requirements in this Section as well as any other specifications, requirements, and terms and conditions stated in this RFP.

6.1 DISPUTE RESOLUTION

The Parties agree that it is in their mutual interest to resolve disputes informally. A claim by the Vendor shall be submitted in writing to the State's Contract Administrator for resolution. A claim by the State shall be submitted in writing to the Vendor's Contract Administrator for resolution. The Parties shall negotiate in good faith and use all reasonable efforts to resolve such dispute(s). During the time the Parties are attempting to resolve any dispute, each shall proceed diligently to perform their respective duties and responsibilities under this Contract. If a dispute cannot be resolved between the Parties within thirty (30) days after delivery of notice, either Party may elect to exercise any other remedies available under this Contract, or at law. This term shall not constitute an agreement by either party to mediate or arbitrate any dispute.

6.2 CONTRACT CHANGES

Contract changes, if any, over the life of the contract shall be implemented by contract amendments agreed to in writing and signed by authorized representatives of the State and Vendor.

6.3 DELIVERABLES, PERFORMANCE GUARANTEES, AND FEE REDUCTIONS**6.3.1 General Information**

- a) The Vendor shall be subject to certain reductions in fees or payments based on performance and delivery of contracted services outlined in the Section 5.0 Technical & Cost Proposal Requirements & Specifications and the schedules in Section 6.3.3. Unless otherwise specified, the reductions in fees shall be calculated as a flat dollar amount or as a percentage (%) of administrative fees paid by the Plan.

- b) Vendor shall remit payment associated with any reductions in fees through the Automated Clearing House (ACH). Prior to the remittance of payment, Vendor shall notify the Plan of the forthcoming payment via email. Any such Performance Guarantee payment shall be due to the Plan within thirty (30) days of the request. Credit memo or invoice adjustment is prohibited.
- c) Failure of the Vendor to accept reductions in fees according to the schedules in Section 6.3.3 for any non-compliant contract Deliverable listed in this section shall be, at the Plan's discretion, grounds for immediate termination of the Contract.
- d) Reductions in fees may be waived by the Plan in the event there are circumstances outside the Vendor's control which resulted in failure to meet the established timeframe or Deliverable. However, as specified in Attachment C. 25. "No Waiver," the waiver by the State of any right or remedy on any one occasion or instance shall not constitute or be interpreted as a waiver of that or any other right or remedy on any other occasion or instance.
- e) Any delay in the submission of any contract Deliverable requires a written explanation and written approval by the Plan's Executive Administrator. However, such explanation and approval will not constitute automatic waiver of any associated reduction in fee.
- f) The Vendor shall provide a written explanation to the Plan no later than thirty (30) calendar days prior to the due date of any deliverable if a delay is anticipated. This notice shall not relieve the Vendor of its responsibility, or any reduction in fees, for untimely completion of deliverables in accordance with the Contract.

6.3.2 Audits of Records and Performance

The Plan reserves the right to conduct an audit of the Vendor's records as specified in Attachment C. 12. Access to Persons and Records to validate the results of Vendor's performance. Vendor will be required to resolve any material discrepancies identified to the satisfaction of the Plan.

6.3.3 Performance Guarantee Timeliness Guidelines and Definitions

- a) All files received from the Plan's EES vendor are considered enrollment data files; including but not limited to daily change files, audit files, and Member lists. Once complete information is received, the information should be updated without manual intervention into the Vendor's core system.
- b) Manual enrollment updates represent all manually executed actions necessary to ensure access to care, accurate claims processing and seamless experience for Plan Members. Notification of the need for a manual update may come from any source. Scripts that are manually initiated will be considered a manual enrollment update.
- c) EDI delivery and receipt schedules will be developed during the implementation. Any Performance Guarantee related to the delivery or receipt of an EDI file will be based on the schedule developed during implementation and documented in the Implementation Plan. The ongoing EDI schedule will become a separate table that will be incorporated into this Contract.
- d) Group Premium Invoicing schedule will be reviewed monthly. The schedule may change each month to align with Group payroll dates. Timely production of invoices includes availability and presentment to Groups online.
- e) First Contact Resolution (FCR) is the number of interactions with Plan Members and HBRs resolved during the initial contact divided by the total number of interactions handled in the period. If Vendor must follow up with the inquirer, First Contact Resolution was not achieved. This is a cumulative, quarterly measure. For example, if there are 700 Member interactions (500 calls, 100 emails, 100 instant messages) and 300 HBR interactions (150 calls, 150 emails) there are a total of 1000 interactions to be counted towards FCR. If only 850 of the above interactions are resolved on initial contact, the FCR score would be 85%.

- f) Second Contact Resolution is the same formula as above using only what was not resolved on first contact. This is a cumulative, quarterly measure. Continuing with the example above, from the remaining 150 interactions, if only 100 are resolved with the follow up contact the SCR score would be 67%. Specific details on interactions not resolved on second contact must be shared with the Plan for tracking through completion.
- g) Inquiry On Time Completion is the number of inquiries responded to timely divided by the number of inquiries responded to. Completion dates must be communicated to the inquirer when responding to an inquiry that cannot be resolved on first contact. When no completion date is communicated, a one State business day target should be assumed for Members and two State business day target should be assumed for all others.
- h) Attachment K. outlines the due dates for reports. Reports without a specific time of day noted on the report are due by 5:00 p.m. ET. If any report due date falls on a weekend or holiday, the deliverable is the first State Business Day after the scheduled date.

6.3.4 Performance Guarantee Accuracy Definitions

- a) EDI throughput is measured as the number of successful automatic transactions divided by the number of the total number of transactions eligible for automation. For daily EES files eligible transactions will be all that passed upfront system edits. These edits will be reviewed and documented during implementation and any future changes will be introduced with an ADM.
- b) Manual entry accuracy is reviewed at the family level and calculated at the Member level. There should be one point assigned at the Member level. If any field on the record is inaccurately entered, the score for that Member is zero. For example, the statistically valid sample size is 10% and 100 items were keyed manually. Ten policies are pulled for audit. Two (2) contain policies for families of four (4) and eight (8) are for individual policies. Total points available for this audit are sixteen (16) points. Upon audit, it is determined that an address was misspelled on one (1) policy and two (2) COB records were inaccurately updated on one family. Thirteen (13) out of sixteen (16) enrollments were completed accurately; therefore, the accuracy score is 81%. If additional inaccurate updates are identified (by the Group, Member, Plan, vendors, etc.), the additional error and transaction should be included in that month's accuracy score. The statistically valid sample size will be determined by the Plan and the audit will be conducted by the Vendor. The accuracy results will be reported monthly.
- c) Invoice accuracy measures the accuracy of each Group's invoice. The information presented on each Group's monthly invoice should reflect all payments, premium adjustments, interest due, and enrollment changes accurately. If any inaccuracy is identified on an invoice, the entire invoice is considered incorrect. All invoices should be audited each month. For example, if 450 groups are invoiced and there is a system issue that causes 15 invoices to show an incorrect amount for Subscribers, then only 435 invoices were accurate. This would equate to a 97% accuracy score. If additional inaccurate updates are identified (by the Group, Member, Plan, vendors, etc.), the additional error and invoice should be included in that month's accuracy score.
- d) Inquiry Accuracy measures the accuracy of the resolution provided to the inquirer. If any part of the information provided to the inquirer about Plan rules, benefits, or claims is inaccurate, the interaction is inaccurate. During implementation, the Plan shall document the audit process and outline expectations for the Vendor to provide requested interactions. The Vendor's telephonic accuracy audit results will be utilized to measure this Performance Guarantee. If additional inaccurate interactions are identified (by the Group, Member, Plan, vendors, etc.), the additional error and interaction should be included in that month's accuracy score.
- e) Financial Accuracy (Claims): 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.
- f) Payment Accuracy (Claims): The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.

- g) Processing Accuracy (Claims): The number of claims processed with no procedural errors divided by the total number of claims processed.
- h) The Deposit Error Rate will be determined by dividing the total number of inaccurate daily deposits identified during the performance period by the total number of daily deposits for the performance period. A deposit will be considered inaccurate when:
 - i. Detailed backup documentation does not agree to the bank balance reported on applicable Plan depository accounts. This includes confirming the premium receipt information as well as any other types of deposits are accurate in relation to the detail report. (See Section 5.2.3.)
 - ii. Plan deposits are made to the wrong account and/or receipts belonging to other entities are incorrectly deposited to the Plan's account.
- i) The Disbursements error rate will be determined by dividing the total number of inaccurate weekly disbursements identified during the performance period by the total number of disbursements for the performance period. A disbursement will be considered inaccurate when:
 - i. Weekly refunds and other disbursements, including system generated checks, EFTs, voids and reissues, cancelled and manual checks, EFT adjustments and any other adjustments are found to be incorrect. (See Section 5.2.3.)
 - ii. Plan's disbursements are drawn on the wrong account and/or payment obligations belonging to other entities are incorrectly drawn on the Plan's account.
- j) ID Card Accuracy requires that the following data elements are correct:
 - i. Plan Logo.
 - ii. Plan Network.
 - iii. Group Name (Examples: Dept of State Treasurer, Wake County Public Schools, State Retirement Systems, etc.).
 - iv. Member's PCP Information.
 - v. RxBin/Group.
 - vi. Plan Design (Examples: 80/20, 70/30, and HDHP).
 - vii. Plan Vendor Phone Numbers.

During implementation, the Vendor shall submit an ID card audit proposal to the Plan for approval. The Vendor's ID Card accuracy audit results will be utilized to measure this Performance Guarantee.

- k) Benefit changes accuracy requires that the benefits administered by the Vendor are configured correctly with any new benefits and/or cost-shares requested by the Plan.

6.3.5 Summary of Performances Guarantees and Instructions for Completing Schedule II. Third Party Administration Performance Guarantees

The Performance Guarantee section is comprised of schedules indicating the measure, description, standard, and fees at risk for each Performance Guarantee. Included are one-time Performance Guarantees around implementation of services and additional Performance Guarantees measured on a quarterly basis throughout the term of the Contract. The Performance Guarantees around implementation of services have been set by the Plan in Schedule I. However, for quarterly Performance Guarantees, Vendor shall populate Schedule II. with the amounts Vendor agrees to place at risk. Limitations on those amounts are described in the paragraph below.

The minimum amount that Vendor can place at risk for Performance Guarantees measured on a quarterly basis is fifteen percent (15%) of quarterly administrative fees paid by the Plan; however, Vendor may choose to risk more than fifteen (15%). The percentage (%) of fees Vendor is placing at risk is to be allocated among the various Performance Guarantees.

Each Performance Guarantee must have an allocation of at least one quarter percent (0.25%) of the total at risk fees unless otherwise indicated. The Plan has established greater minimums for certain Performance Guarantees; those minimum risk requirements are identified in the far right column of the chart. Vendor is instructed to allocate the amount at risk among the Performance Guarantees keeping in mind that a minimum of one quarter percent (0.25%) must be placed at risk for any one Performance Guarantee unless a different minimum is indicated. If Vendor is willing to risk more than fifteen percent (15%) of fees required, then the total for the various allocations will add up to the amount being placed at risk.

Continues on next page.

6.3.6 Schedules of Performance Guarantees

<p align="center">Schedule 1. Implementation Performance Guarantees</p> <p align="center"><i>All performance targets and results are Plan, not book of business, specific.</i></p>		
Measure	Implementation	Fee Reduction/ Monetary Risk
Insurance	Proof of insurance required in Attachment C: 14. “Insurance” to be provided to the Plan within fifteen (15) calendar days of execution of Contract.	Vendor shall pay \$10,000 for each day the proof of insurance is late.
Performance Bond	Proof of purchase of bond to be provided to the Plan within thirty (30) State Business Days of execution of Contract.	Vendor shall pay \$10,000 for each day the proof of purchase of bond is late.
Timeliness	Initial enrollment Data File from Plan’s EES vendor is processed in Vendor’s system by 5:00 p.m. EST by the second State Business day after receipt. The target delivery date of the Enrollment Data File will be determined during implementation and documented in the Implementation Plan.	Vendor shall pay \$10,000 for each day the file is not processed in Vendor’s system beyond the target date.
Timeliness	Initial implementation ID cards mailed within two (2) State Business Days of the target date established in the Implementation Plan.	Vendor shall pay \$5,000 for each day beyond the target date.
Timeliness	Depository bank accounts are set-up, tested, and operational at least forty-five (45) days prior to January 1, 2022.	Vendor shall pay \$5,000 for each day beyond the target date.
Timeliness	If applicable, disbursing bank accounts are setup, tested, and operational at least thirty (30) days prior to January 1, 2022.	Vendor shall pay \$5,000 for each day beyond the target date.
Accuracy	Initial implementation ID card accuracy is 100% accurate.	Vendor shall pay \$2,500.00 plus the cost of reissuing the cards.
Timeliness	The Plan’s custom network, the North Carolina State Health Plan Network, is tested and loaded in Vendor’s system(s) by October 1, 2021 to facilitate Members’ ability to search for providers via the Vendor’s provider search tool.	Vendor shall pay 1-15 days late: \$10,000 per day; 15+ days late: \$20,000 per day.
Timeliness	All provider rates and reimbursement methodologies are loaded and tested in Vendor’s system(s) by January 1, 2022 and Vendor is able to begin processing all Plan claims using these rates and methodologies on January 3, 2022.	Vendor shall pay 1-15 days late: \$10,000 per day; 15+ days late: \$20,000 per day.
Timeliness	All other Services under the Contract are fully implemented by the “go-live” dates which will be determined during the implementation and documented in the Implementation Plan.	Vendor shall pay 1-15 days late: \$10,000 per day; 15+ days late: \$20,000 per day.

Schedule II. Third Party Administration Services Performance Guarantees				
Measure	EDI & Enrollment Maintenance	Target	Risk	Minimum Risk Required
Timeliness	All enrollment data files received from Plan’s EES vendor processed ≤ 24 hours of receipt	98%		0.25%
Timeliness	Complete any manual enrollment update for Plan Members ≤ five (5) State Business Days of notification	99%		0.5%
Timeliness	Plan’s outbound files sent daily, as scheduled	98%		0.25%
Accuracy	EDI Throughput	95%		0.25%
Accuracy	Manual entry accuracy rate	98%		0.5%
Measure	Group Premium Billing	Target	Risk	Minimum Risk Required
Timeliness	Produce Group Premium Invoices within one (1) State Business Day of approved billing schedule	98%		0.25%
Accuracy	Invoice accuracy	99%		0.25%
Measure	Customer Experience	Target	Risk	Minimum Risk Required
Timeliness	First Contact Resolution ≥ 85%	100%		0.25%
Timeliness	Second Contact resolution ≥ 95%	100%		0.25%
Timeliness	Inquiry On-Time completion ≥ 98%	100%		0.5%
Accuracy	Inquiry Accuracy	98%		1.0%
Accuracy	Claims Financial Accuracy Rate	99%		0.5%
Accuracy	Claims Payment Accuracy Rate	99%		0.5%
Accuracy	Process Accuracy Rate	99%		0.5%
Measure	Pharmacy Benefit	Target	Risk	Minimum Risk Required
Timeliness	Specialty pharmacy rebates made out to the Vendor are to be delivered to the Plan no later than ten (10) State Business Days after Vendor received payment from drug manufacturer.	100%		0.25%

Performance Guarantees				
<i>All performance targets and results are Plan, not book of business, specific</i>				
Measure	Financial Performance Reporting	Target	Risk	Minimum Risk Required
Timeliness	Deliver Fiscal Year End Matrix reports by the July 15 th each year	100%		0.25%
Timeliness	Deliver Fiscal Year End Triangulation reports by July 15 th each year	100%		0.25%
Measure	Banking and Finance	Target	Risk	Minimum Risk Required
Timeliness	Group premium and other receipts deposited within twenty-four (24) hours of receipt	98%		0.25%
Timeliness	Daily reporting package of deposits (See Section 5.2.3) provided to the Plan on schedule	98%		0.25%
Timeliness	Weekly disbursement released only upon Plan approval	100%		1%
Accuracy	Daily deposit error rate	≤ 2%		0.5%
Accuracy	Weekly disbursements error rate	≤ 2%		0.5%
Total At Risk (To Be Completed by Vendor)				
Measure	Open Enrollment	Target	Risk	Minimum Risk Required
Timeliness	ID Cards are issued not more than two State Business Days from the mutually agreed upon dates of Open Enrollment project plan	100%	N/A	Vendor shall pay \$5,000 for each day beyond the target date.
Accuracy	ID card accuracy is 100% accurate	100%	N/A	Vendor shall pay \$2,500.00.
Accuracy	Accurate configuration of new plan benefits	100%	N/A	Vendor shall pay \$5,000 for each day beyond the target date.
TOTAL				

ATTACHMENT A: PRICING

INSTRUCTIONS FOR DATA ACCESS and COST PROPOSAL

This section contains the submission requirements and instructions for worksheets and data files required to be submitted by the Vendor.

Submission of Signed Non-Disclosure Agreement Required for Access to Attachment A: Pricing (Attachments/worksheets) and Data Files

Each Vendor must submit a signed Attachment I: **Non-Disclosure Agreement (NDA)** to the Plan in order to gain access to Attachment A: Pricing and data files. The NDA is included as part of the Minimum Requirements and must be submitted with the Minimum Requirement Responses.

If all Minimum Requirements are met, the Plan will provide the Vendor's designated recipient the cost proposal worksheets. The Plan will also notify its Actuarial/Analytical and Health Benefits Consulting vendor, Segal of NDA receipt. Segal will issue, to the Vendor's designated recipient, a link to a secure workspace, established separately for each qualified Vendor, within Segal's Secure File Transfer system. The designated recipient may access the secure site and download the data files that will be used for the repricing exercise and other requirements within the cost proposal. Segal will not release any data files to any Vendor without a signed NDA.

For informational purposes, the Segal point of contact is as follows:

Gina Sander, FMLI
GSander@SegalCo.com
678-306-3158

1.1 Network Access

The Plan is looking to have a provider network in place that best meets the program's long-term needs. This includes a broad provider network with the least disruption and competitive pricing. Vendors are encouraged to include an additional option for a narrow, high-quality provider network. This section will address access to the proposed network of health care providers.

1.1.1 Access Reports

Vendors are required to submit an accessibility report (Optum™, GeoAccess®, GeoNetworks, or comparable software) for the proposed provider network. Vendor must submit separate reporting for each network proposed. Access must be reported by county.

The Vendor will be required to provide a summary of participants with and without access to network providers/facilities within the established mileage parameters listed below:

Continues on next page.

Provider Type	Urban and Out-of-State	Suburban	Rural
Facilities			
Hospitals	1 within 20-miles	1 within 25-miles	1 within 35-miles
Ambulatory Surgical Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Urgent Care facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
Imaging Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Inpatient Behavioral Health Facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
Professional Services			
Primary Care			
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	2 within 10-miles	2 within 15-miles	2 within 20-miles
OB/GYN (female members, age 12 and older)	2 within 10-miles	2 within 15-miles	2 within 20-miles
Pediatrician (birth through age 18)	2 within 10-miles	2 within 15-miles	2 within 20-miles
Specialists			
Endocrinologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Urologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Cardiologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Dermatologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Allergist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Psychologist/Psychiatrist	2 within 20-miles	2 within 25-miles	2 within 35-miles
General Surgeon	2 within 20-miles	2 within 25-miles	2 within 35-miles
Hematologist/Oncologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Chiropractor	2 within 20-miles	2 within 25-miles	2 within 35-miles

The submitted access reports (mapping and accessibility analysis) must demonstrate provider availability for EACH provider group type listed in the table above. In the production of the reports, please note the following:

The Vendor must utilize Optum™, GeoAccess®, GeoNetworks or comparable software.

- The access report must indicate, by county, those participants with access and those without access according to the provider network access standards listed above.
- The access reports should include providers under contract as of January 1, 2020, and may also include providers that have executed a legally-binding letter of intent or letter of agreement with the Vendor.
- The Vendor is required to provide separate reporting for each proposed provider network.

A census file will be provided in a format detailed in **Attachment A-1**. Vendors should use this file to support the accessibility report.

The Vendor must submit the summary grids, included in **Attachment A-2**, for each proposed provider network, along with the detailed access report(s). There are separate summaries for urban, suburban, and rural county designations. Out-of-State Members will follow Urban parameters.

1.1.2 Providers by County

Vendors are required to submit a summary of the number of providers (under contract or with signed letter of intent) by county and category, consistent with the access reports in **Attachment A-2**.

1.1.3 Provider Listing

Vendors are required to submit a listing of the entire proposed provider network in **Attachment A-2**. The file should contain information for each proposed network, using the format disclosed, and identifying whether each provider is currently under contract or has entered a legally-binding letter of intent with the Vendor.

1.2 Network Pricing

The Plan is looking to contract with an organization(s) that has proven success in managing provider costs and will submit data timely, in the required formats. The RFP was designed with knowledge of the capabilities of the market, and it is expected that each Vendor will comply with these requirements. If any issues or complications are expected, Vendors should submit questions as directed in RFP Section 2.5.

1.2.1 Repricing File

A repricing file, containing participant claims experience for calendar year 2019, will be made available through a secure file transfer protocol to Vendors meeting the minimum requirements.

The layout of the fields that will be included in the repricing file are detailed in **Attachment A-3**. This attachment also contains supporting field descriptions that may be beneficial to the Vendor.

Using the repricing file referenced above, **Vendors are to provide the contracted allowed amount for each service in the file**. Vendors are 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.

Six fields must be populated:

- NetStatus1 (representing the Vendor's broad network) and NetStatus2 (representing the Vendor's narrow network, if applicable) – Y / L / N
 - Y – Currently under contract
 - L – Letter of intent
 - N – Not under contract or Out-Of-Network provider
- ContAmt1 and ContAmt2 – contract amount (Allowed Amount) for each network
- ContType1 and ContType2 (contract type, representing each network) – (A, B, C, F, D, O)
 - A – Ambulatory Payment Classification
 - B – Bundled payment
 - C - Capitated
 - D – Discount off eligible charges
 - F – Fee schedule
 - O – Other contract arrangement

The file should be repriced for each provider network being offered by the Vendor, including narrow network alternatives.

Vendors are required to complete and submit summary results of the repricing exercise in the exact formats requested. The tabs have been pre-populated with the repricing source data and will require Vendors to supplement the fields identified. Vendors should complete the following for each network proposed:

- **Repricing by Service Category Summary – Attachment A-4:** Vendors should provide aggregate information on the contractual amount (aka, 'Allowed Amount') for each county and detailed service category, identified by the Service Category Codes in the repricing file.

- **Repricing by Provider Summary – Attachment A-5:** Vendors should provide aggregate allowed information for each provider listed.
- **Contract Improvements – Attachment A-6:** Vendors should identify any known contract improvements.

It is imperative that Vendors return data in the exact formats prescribed. Failure to do so may cause the Vendor's proposal to be rejected. Attachments A4 and A5 should be financially identical to the detail data submitted and will be utilized to cross-check results and submissions.

Vendors must submit the complete repriced file along with any requested supporting documentation. Failure to comply may cause the Vendor's proposal to be rejected.

1.3 Administrative Fees

The Vendor must provide the monthly administrative fee per subscriber for each of the five (5) years in the contract period. Fees must be provided on separate tabs for both the traditional approach and the custom network. An exhibit with detailed instructions is included in **Attachment A-7**.

Table A-7.1 is broken out by administrative service item.

Table A-7.1 also requests per member per month (PMPM) pricing for some additional, optional services, in case the Plan wants the TPA to perform those services.

If there are additional one-time credits and fees, providers should list them in Table A-7.2. Finally, Table A-7.3 requests per participant pricing for specified biometric screenings.

Tables A-7.1 through A-7.3 must include all costs except actual claim payments for covered Members. Unspecified administrative fees will not be paid by the Plan.

1.4 Network Pricing Guarantees

The Vendor must provide network discount guarantees, guarantees not to exceed a percentage of Medicare fees, and a trend guarantee, and may provide other pricing guarantees recommended by the Vendor. A detailed exhibit with instructions is provided in **Attachment A-8**. Vendors are required to submit guarantees and provide details on recommended metrics, methodology, and the amount that will be at risk. Guarantees shall be provided on separate tabs for both in state and out of state.

1.5 Self-Insured Projection

This section allows the Vendor to estimate the expected claim and administrative cost for the proposed provider network(s). Based on the claims experience provided in the repricing file, the Vendor is asked to estimate the expected future costs under its medical management and pricing arrangements with providers. It is expected that the Vendor will map the repricing data to the proposed network. This is to be the Vendor's best estimate and should be performed as accurately as possible, in good faith.

The summary projection requires thoughtful inputs at a very high level, recognizing that a detailed projection would be performed differently for each Vendor. There are two inputs required of the Vendors:

- **Utilization Adjustment:** If the Vendor feels that its medical management will alter current utilization, the Vendor should enter the expected utilization adjustment percentage. An explanation of anticipated changes is required.
- **Allowed Adjustment:** The submitted/billed charge per service is included in the summary and requires the Vendor to provide an adjustment to allowable charge per service. It is understood that this is not discounts alone and will represent movement between provider charges. The goal is to get to what the Vendor believes to be its per-service cost in the proposed network.

This section provides an opportunity for the Vendor to demonstrate the strength of its network. A separate **Attachment A-9** must be populated for each proposed network.

1.6 Data Certification

There is a required certification (**Attachment A-10**) of all information submitted, including data, guarantees, pricing worksheets, etc. The Vendor's actuary should sign the certification, but signature by either the Vendor's CFO or CEO will also be accepted. Appropriate language can be provided by the Vendor.

1.7 Attachments for Attachment A: Pricing

The following attachments taken together make up Attachment A: Pricing.

- Attachment A-1: Census File Format
- Attachment A-2: Network Access
- Attachment A-3: Repricing Layout
- Attachment A-4: Repricing Summary – Service Category
- Attachment A-5: Repricing Summary – By Provider
- Attachment A-6: Contract Improvements
- Attachment A-7: Administrative Services Fees
- Attachment A-8: Network Pricing Guarantees
- Attachment A-9: Self Insured Financial Projection
- Attachment A-10: Actuarial Certification

ATTACHMENT A: PRICING

Attachments A-1. through A-10. comprise Attachment A: Pricing, the Cost Proposal.

Proposal Number: 270-20191001TPAS

Vendor: