

The Vendor shall confirm the existence of and describe each of the following programs, including, but not limited to, evidence-based utilization, transformation in disease treatments, patient support and counseling, management reporting, and authorization rules:

- i. Specialty pharmacy Medical Management clinical program.
- ii. Oncology management program.
- iii. Specialty Drug utilization management.
- iv. Other programs and/or policies that reduce specialty pharmacy costs, for example, site of service.
- v. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iv. above.

The Vendor shall describe each of the following:

- vi. How home infused therapies are managed to reduce drug spend.
- vii. Active or pilot oncology initiatives to reduce drug spend.
- viii. Any innovative models of medical specialty pharmacy care pilots or programs planned or under way.
- ix. Any examples of medical specialty pharmacy initiatives or joint ventures with other large clients.

b. The Plan requires a Vendor that will pass medical specialty pharmacy Rebates to the Plan.

The Vendor shall confirm and describe the following:

- i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
- ii. Vendor will process and deposit the Rebate within twenty-four (24) hours if the Rebate is made out to the Plan or ten (10) State Business days if made out to the Vendor.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan requires a Vendor that is willing to transition specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.

The Vendor shall confirm and describe the following:

- i. Vendor will develop and implement a specialty pharmacy transition plan that will transition some or all specialty pharmacy medications from being covered under the medical benefit to being covered under the pharmacy benefit with the Plan's PBM.
- ii. Vendor will provide claims and analytical data to support the transition.
- iii. Vendor will provide specific operational requirements including limitations, necessary to transition specialty pharmacy medication coverage (e.g., grandfathering Members, site of care cost).
- iv. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – iii. above.

d. The Plan requires a Vendor that is willing to share claims data and other data with Plan vendors to support pharmacy benefit or other pharmacy programs that provide value, as requested by the Plan.

The Vendor shall confirm and describe the following:

- i. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.
- ii. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on the Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – ii. above.

e. The Plan requires a Vendor that will support the Plan's PBM carve-out.**The Vendor shall confirm and describe each of the following:**

- i. Vendor will carve-out PBM services from this Contract.
- ii. Vendor will accept PBM claims data to facilitate the medical management of Plan Members. Include a list of PBMs for which Vendor has integrated.
- iii. Vendor will meet with the Plan and the Plan's PBM to trouble shoot any Member enrollment issues.
- iv. Vendor will meet with the Plan and the Plan's PBM to discuss any Vendor initiatives that may impact the data sent to the PBM by the Vendor.
- v. Vendor shall describe any limitations and/or issues with meeting requirements e.i. – iv. above.

f. The Plan requires a Vendor that will integrate Member claims and deductible and/or other out-of-pocket accumulation information with the Plan's PBM.**The Vendor shall confirm and describe each of the following:**

- i. Vendor will integrate Plan Member medical deductible and/or other out-of-pocket accumulations with Plan Member pharmacy claims deductible and/or other out-of-pocket accumulations from the Plan's PBM for Members in a high deductible health plan or other plan design that has a combined medical and pharmacy deductible and/or out of pocket.
- ii. Vendor shall describe any limitations and/or issues with meeting this requirement f.i.

5.2.7 Enrollment and Group Set-Up**5.2.7.1 Overview and Expectations**

The Plan seeks a Vendor with a platform that can support the Plan's enrollment rules, as defined by N.C.G.S. Chapter 135, Article 3B. Vendor must also be able to support the Plan's Group set-up requirements which include setting up and maintaining over 400 Employing Units, the Retirement Group, and Direct Bill Member Groups. The Plan requires a Vendor that can report on Groups at the individual Group level and aggregate at the Entity and Plan levels.

The Vendor must also have extensive experience with Medicare eligibility as the Plan has both Medicare primary and Medicare secondary members. The Vendor must act as the Plan's Responsible Reporting Entity (RRE) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Expanded Reporting Option. As an Expanded Reporter, the Vendor must be willing to submit the Query Only File to get Part A, B, & C information on Plan Members, perform a quarterly audit with Plan Enrollment data in Vendor's system, and make updates as appropriate. The Vendor must have the ability to enroll Dependents when the Subscriber is Medicare primary and enrolled with a Medicare Advantage carrier but the Dependents are not Medicare primary and enrolled on Vendor's plan. Additionally, the Vendor must be able to accommodate Medicare primary and Medicare secondary Members who may be enrolled in the same or different Plan Designs.

Objectives

- a. Support the Plan's eligibility and enrollment rules as defined by N.C.G.S. Chapter 135, Article 3B.
- b. Support enrollment of over 500,000 members.
- c. Support the Plan's Group Set-Up requirements.
- d. Support all Federal and State enrollment requirements.
- e. Support the Plan's open enrollment.
- f. Ensure the Plan's Medicare eligible Members are enrolled in accordance with Plan rules and federal requirements.
- g. Perform a quarterly enrollment audit with data obtained from the Expanded Reporting Option available through Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).
- h. Ensure accurate and timely production of ID cards.
- i. Produce accurate letters and notices.
- j. Support the election of a Primary Care Provider (PCP) for all enrolled Members.
- k. Produce customized Member level ID cards that include, but are not limited to the Plan's logo, messaging, and the Plan's PBM information. See Exhibit 9 for a sample of the Plan's current ID Card.
- l. Ensure a seamless transition of Member enrollment.

5.2.7.2 Services

- a. **The Plan requires a Vendor that can support Plan enrollment as defined by N.C.G.S. Chapter 135, Article 3B, Part 4.**

Vendor shall confirm that it will administer these statutory provisions covering enrollment for all types of Members, including, but not limited to:

- i. Active Employees and Dependents.
- ii. Members who are Medicare primary due to End Stage Renal Disease (ESRD).
- iii. Active Employees on leave of absence.
- iv. Retirees and Dependents.
- v. Extended short term and long-term disability Members and Dependents.
- vi. Surviving Dependents.
- vii. Reduction in Force Employees who stay enrolled with Employing Unit for first twelve (12) months and are responsible for the Employee share of the premium.
- viii. Reduction in Force employees, after the initial twelve (12) months, who are responsible for the full premium and moved to the direct bill group.
- ix. Firemen and rescue workers.
- x. Former legislators and their Dependents.
- xi. COBRA Participants who have COBRA administered by a third-party vendor.

xii. Non-Permanent Employees.

xiii. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xii. above.

- b. The Plan requires a Vendor that will accept and load Member enrollment from EDI received from the Plan's EES vendor and that will load enrollment manually when requested by the Plan and the Plan's EES vendor. The Vendor will have view-only access into the Plan's EES vendor's system to validate enrollment information.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will automatically load Member enrollment from the industry standard 834 HIPAA X12 5010 file received from the Plan's EES vendor.
- ii. Vendor will have a pass-through rate of at least 95% on accurate transactions received electronically from the Plan's EES vendor.
- iii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan's EES vendor.
- iv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Member enrollment.
- v. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – iv. above.

The Vendor shall describe the following:

- vi. Quality controls that are in place to ensure accuracy of eligibility file loads.
- vii. The number of resources that will be dedicated to managing the Plan's enrollment.
- viii. How historical enrollment information is maintained.

- c. The Plan prefers a Vendor that can accept, load, and transmit multiple Member ID numbers.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will accept and store multiple Member ID numbers from the Plan's EES vendor such as a unique member ID number created by the EES vendor, the Member SSN, and an employer ID number.
- ii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors, as requested by the Plan.
- iii. Vendor will use the unique Member ID number provided by the EES vendor on the Member ID Card, if requested by the Plan.
- iv. Vendor will use employer ID number on the electronic invoices, if requested by the Plan.
- v. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – iv. above.

- d. The Plan requires a Vendor that can accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years. The Vendor will not be required to load enrollment with an effective date that is prior to the commencement of services for this Contract.**

Example: June 2023, Vendor receives enrollment with a February 1, 2022 effective date. Vendor updates Member with appropriate 2022 and 2023 coverage.

The Vendor shall confirm and describe each of the following:

- i. Vendor will accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years.
 - ii. Vendor will adjust enrollment effective or terminations dates retroactively that may cross Plan Years.
 - iii. Vendor will adjust enrollment attributes such as premium wellness credits with retroactive effective dates that may cross Plan Years.
 - iv. Vendor will adjust group premium invoices with retroactive enrollment adjustments that may cross Plan Years.
 - v. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iv. above.
- e. The Plan requires a Vendor that can support the Plan's Group set-up structure which includes more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. The Vendor must set up new Groups as requested by the Plan. The Vendor will also be required to report on each Employing Unit individually and aggregate certain Employing Units. A list of the Plan's current Group structure, which includes their Group and Entity identifiers, can be found in Exhibit 10, Group Structure.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will support the Plan's Group set-up structure which includes more than 400 individual Employing Units, the Retirement System Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. Support includes, but is not limited to:
 - 1) Setting-up each Group with the appropriate naming convention which should be displayed on Member ID Cards, the secure Member portal, Group premium invoices, and reports. Examples of Group naming conventions:
 - Department of State Treasurer
 - Charlotte Mecklenburg Schools
 - Retirement Systems
 - 2) Setting-up each Group with the appropriate Plan Designs.
 - 3) Setting-up each Group with the appropriate premium rates.
 - ii. Vendor will vary Plan Design options at the Group level. Example: While all active subgroups may have access to the 80/20, 70/30 and HDHP, a subset may also have access to a regional offering.
 - iii. Vendor will set-up new Groups throughout the year, as requested by the Plan.
 - iv. Vendor will provide enrollment and claims reporting at the individual Employing Unit level and at the aggregate level. The information required to aggregate the Employing Units will be included in the EDI from the Plan's EES vendor and will be further defined during implementation.
 - v. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-iv. above.
- f. The Plan prefers a Vendor that can complete new Group set-up and that can assist the Plan with coordinating Group set-up information with other Plan vendors and if necessary, assist with any new group training.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will coordinate Group set-up with other Plan vendors, as directed by the Plan.
- ii. Vendor will provide training to new Groups, as requested by the Plan.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements f.i. - ii., above.

g. The Plan requires a Vendor that supports both Medicare Primary and Non-Medicare Primary Members within the same Group and Plan Design.**The Vendor shall confirm and describe the following:**

- i. The Vendor will enroll both Medicare Primary and Non-Medicare primary Members into the same group and Plan design.

Example: Employing Unit – Department of State Treasurer

- 80/20 PPO Plan includes:
 - Non-Medicare Primary Members
 - Medicare Primary Members
- 70/30 PPO Plan includes:
 - Non-Medicare Primary Members
 - Medicare Primary Members

- ii. Vendor shall describe any limitations and/or issues with meeting requirement g.i., above.

h. The Plan requires a Vendor with extensive experience with Medicare eligibility that is willing to serve as the Plan's Responsible Reporting Entity (RRE) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Expanded Reporting Option. As an Expanded Reporter, the Vendor must be willing to submit the Query Only File to get Part A, B, & C information on Plan Members and perform a quarterly audit with Plan Enrollment data in Vendor's system and make updates as appropriate. See process in Exhibit 12, CMS Responsible Reporting Entity (RRE) Process.**The Vendor shall confirm and describe each of the following:**

- i. Vendor shall serve as the Plan's Responsible Reporting Entity (RRE) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Expanded Reporting Option.
 - ii. Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to get Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. The Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare primacy rules, to determine which Plan Members' Medicare information requires updating.
 - iii. Vendor will update Vendor's system with the necessary updates from the Medicare Primacy audit and send Members' updated Medicare information to the Plan's EES vendor.
 - iv. Vendor shall describe any limitations and/or issues with meeting requirements h.i. - iii., above.
- i. The Plan requires a Vendor that can accept Medicare information from the Plan's EES vendor as well as update and maintain Member Medicare information based on claim information. The Vendor should also be able to appropriately code Members who are over 65 but not Medicare Primary.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will maintain Medicare Part A and Part B eligibility dates, effective dates, and termination dates.
- ii. Vendor will maintain multiple Medicare primacy effective and termination dates.
- iii. Vendor will maintain multiple Medicare entitlement reasons.

- iv. Vendor will recognize and maintain Non-Medicare primary status for Members over 65 who are not eligible for Medicare.
- v. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. - iv., above.

j. The Plan requires a Vendor that can enroll Split Contracts.

The Vendor shall confirm and describe each of the following:

- i. Contract will support enrollments where the family members are split between the Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by the Vendor).
- ii. Vendor will support enrollments where one or more family members are enrolled in one Plan Design as Medicare primary and other family member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements j.i. - ii., above.

k. The Plan requires a Vendor that will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections.

The Vendor shall confirm and describe each of the following requirements:

- i. Vendor will provide a single web-based PCP selection tool that can be integrated with the Plan's EES vendor's enrollment site.
- ii. Vendor will develop workflows that support the maintenance of the PCPs which may require that the Vendor notify Members if their elected PCP is no longer in the network, or to notify the EES vendor if any PCP code information has changed. The Member communication should include instructions for electing a new PCP. The final workflows will be defined during Contract implementation.
- iii. Vendor will send any updated PCP information back to the EES vendor. For example, if the Member does not update their PCP with a PCP that is in the Vendor's network, the Member's PCP selection should be updated to "none selected".
- iv. Vendor's systems will store a PCP election for each enrolled Member.
- v. Vendor's systems will store a PCP election date at the Member level.
- vi. Vendor will notify providers that they have been selected as a Member's primary care provider.
- vii. Vendor shall describe any limitations and/or issues with meeting requirements k.i. - vi., above.

The Vendor shall describe the following:

- viii. The proposed process for updating the EES vendor when the identifying PCP codes have changed.
- ix. The proposed process for updating the EES vendor when the PCP no longer participates in the network.

l. The Plan requires a Vendor that can support the production of custom Member-level ID cards.

The Vendor shall confirm and describe each of the following ID card requirements:

- i. Vendor will produce individual ID cards for each enrolled Member.

- ii. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 9 for sample of the Plan's current ID card.)
 - 1) Plan's logo.
 - 2) Plan's messaging.
 - 3) Plan's network.
 - 4) Out-of-NC network.
 - 5) Plan's Rx BIN and PBM information.
 - 6) Group Name (e.g. Wake County Schools, University of North Carolina, Department of Transportation).
 - 7) Member's selected PCP.
- iii. Members can request new ID cards online.
- iv. Members can print a temporary ID card that includes the Plan's PBM information and custom network information.
- v. Vendor will produce new ID cards when the Member's PCP changes.
- vi. Vendor will mail all ID cards the latter of five (5) days from receiving enrollment data or five (5) days before the effective date.
- vii. Vendor offers a virtual ID card for Members who prefer to use mobile technology.
- viii. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. - vii., above.

The Vendor shall describe each of the following ID card requirements:

- ix. Events that trigger production of new Member ID cards.
 - x. Any other unique Member ID card innovations that may be of interest to the Plan.
- m. **The Plan requires a Vendor that understands the importance of a successful Open Enrollment and has the resources required to support the Plan's Open Enrollment. While it is the Plan's goal to offer only one Open Enrollment per year, multiple Open Enrollments may be required.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will participate in end-to-end Vendor testing prior to Open Enrollment, including mock premium bills to the Employing Units.
- ii. Vendor will support an Open Enrollment period that generally lasts two (2) to four (4) weeks and during a time period chosen by the Plan.
- iii. Vendor will support multiple Open Enrollments in one Plan year, if requested by the Plan.
- iv. Vendor will vary the Open Enrollment periods by Group and/or Product, if requested by the Plan.
- v. Vendor will receive Member enrollments from the Plan's EES vendor prior to Open Enrollment that have been "mapped" to a specific Plan Design for the next Plan year. The "mapping" of Members will occur over several weeks prior to the beginning of Open Enrollment. These "mapped" Members may be included in the daily EDI Change Files received from the Plan's EES vendor or in a full file, if chosen by the Plan.
- vi. Vendor will receive and process Member elections from the Plan's EES vendor after Open Enrollment using a full file or via daily change files. The type of file will be determined by the Plan during the initial implementation and will be re-evaluated annually as part of OE planning.

- vii. Vendors will produce and distribute ID cards for over 500,000 Members after Open Enrollment so that Members receive their ID cards prior to the new Plan Year.
- viii. Vendor will have all Open Enrollment enrollments processed in time to produce group premium bills in early December for January coverage.
- ix. The Vendor shall describe any limitations and/or issues with meeting requirements m.i. - viii., above.

The Vendor shall describe each of the following:

- x. Process for receiving Open Enrollment elections, including number of elections that can be received and processed in a single day.
 - xi. Process and timing for working open enrollment elections that do not process electronically.
- n. The Plan requires a Vendor that will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of Certificates of Creditable Coverage (CCC) and reporting needs under sections 6055 and 6056 of the IRS code.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will produce and mail CCCs to Members whose coverage terminates, as required by law.
 - ii. Vendor will produce CCCs for Members who reside in states that require annual CCCs.
 - iii. Vendor will produce and mail or email CCCs on demand, for Members who request new copies of CCCs.
 - iv. Vendor will customize any Member letters and/or notices that are available to Members online or by mail. Customization includes, but is not limited to, the ability to include the Plan's branding.
 - v. Vendor will create new, ongoing, or as needed letters to Plan Members, as requested by the Plan.
 - vi. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPCA.
 - vii. Vendor will produce the 1094-C and 1095-C forms.
 - viii. Vendor will produce the 1095-B form.
 - ix. Vendor will provide call center support to respond to both HBR and Member inquiries about 1094-C and 1095-B forms.
 - x. Vendor will file IRS forms electronically.
 - xi. Vendor will continue filing corrections to the IRS throughout the year.
 - xii. The Vendor shall describe any limitations and/or issues with meeting requirements n.i. - xi., above.
- o. The Plan requires a Vendor that will support the receipt of Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 11 for the Vendor Audit Process.**

The Vendor shall confirm that it will perform the following services:

- i. Monthly audit of the Plan's active membership with the EES vendor which includes monthly correction of any indicated mismatches to align the Vendor and EES vendor records.
- ii. Monthly audit of the Retirement Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group with the EES vendor which includes monthly correction of any indicated mismatches to align the Vendor and EES vendor records.
- iii. Vendor will implement other audits with any other Plan vendor, as requested by the Plan.
- iv. The Vendor shall describe any limitations and/or issues with meeting requirements o.i. - iii., above.

5.2.8 Group Billing and Collection**5.2.8.1 Overview and Expectations**

The Plan seeks a Vendor that can provide a full range of best in class Group billing and collection services. These services include, but are not limited to, Group premium billing, collection, and reconciliation for each of the Groups and reporting at the Plan, Group, and Entity level. The Vendor shall produce a Group Premium Invoice for each Employing Unit for both the Employer and Subscriber premiums for Active Employees and the Employer Share for the premium for 12-month RIF Members, Leave of Absence (LOA) Members, and Members enrolled in the HDHP offered to non-permanent full time Employees. While the Vendor will not be responsible for premium collection for the Retirement Group, the Vendor will be required to produce a monthly Group Premium Invoice for the Retirement Group that will be used for reconciliation purposes. The Vendor shall accept electronic fund transfers (EFTs), checks, and funds transferred through the State banking system. The Vendor must also provide services that assure the highest levels of quality, accuracy, efficiency and timeliness. The Vendor shall implement processes for all financial transactions that are compliant with state banking guidelines, including the policies and regulations of the Office of State Controller and the Department of State Treasurer. As such, the Plan may have unique limitations or special requirements around deposits and collections.

- State banking: <https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf>
- Cash management: <https://www.osc.nc.gov/state-employees/statewide-policies/Section-300>

Objectives

- a. Ensure accurate and timely premium billing, premium collection, premium deposit, reconciliation, and reporting.
- b. Promote efficiency, accuracy, and a superior customer experience for the Plan and its Employing Units by selecting a Vendor with state-of-the-art business tools, processes, and services.
- c. Ensure Employing Units have appropriate resources and tools to reconcile and process the monthly invoices.
- d. Ensure all applicable policies and regulations of the Office of State Controller and the Department of State Treasurer, including state banking requirements, are supported.
- e. Ensure a seamless transition of invoicing and collection services.

5.2.8.2 Services

- a. **The Plan prefers a Vendor with a premium billing system that is fully integrated with the Vendor's enrollment and claims administration systems.**

The Vendor shall describe each of the following:

- i. The group premium and billing platform, including development (i.e., purchased or developed internally), recent enhancements, planned enhancements, and operating requirements.
- ii. The integration between the premium billing system, enrollment system, claim system, and, if offered, the employer portal.

- iii. The workflow that outlines the process between enrollment coverage changes and Group premium billing changes (i.e., single Subscriber adds a Dependent. Is the coverage change automatic in the group premium billing system or is a process step required?).

b. The Plan requires a Vendor that can support the Plan's premium rate structure which differs by Plan Design, Medicare and Non-Medicare primary status, tier, premium wellness credits earned, years of service, and eligibility type. The Plan's current Group Billing Rate Structure can be found in Exhibit 13,.

The Vendor shall confirm and describe each of the following:

- i. Vendor will support the Plan's Group billing premium rate structure as shown in Exhibit 13, Group Billing Rate Structure.
- ii. Vendor will apply the appropriate premium rate to the Member's enrollment based on the enrollment attributes provide by the EES vendor. Attributes may include:
 - 1) Tier Code (the Plan currently has a four (4) tier structure).
 - 2) Plan Design Elected by each family member (In a Split-Contract scenario, family members can be loaded in different Plan Designs).
 - 3) Medicare Primary, Non-Primary Status for each family member.
 - 4) Premium Wellness Credits earned.
 - 5) 12-Month RIF indicator.
 - 6) Leave of Absence (LOA) indicator.
 - 7) Part time status.
 - 8) Cost Factor (Defines Retiree contribution level).
 - 9) Employment status code.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan requires a Vendor that can meet the Plan's unique Group premium billing requirements which includes the ability to ensure all financial transactions are compliant with state banking guidelines, including the policies and regulations of the Office of State Controller (OSC) and the Department of State Treasurer which can be found at the following links:

- State banking: <https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf>
- Cash management: <https://www.osc.nc.gov/state-employees/statewide-policies/Section-300>

The Vendor shall confirm and describe each of the following:

- i. Vendor will comply with all policies and regulations of the OSC and the Department of State Treasurer, as outlined in the Finance and Banking Section of this RFP (Section 5.2.3) and as may be amended from time to time, when managing the Group Billing and Collections for the Plan.
- ii. Vendor will provide a consolidated electronic Group Premium Invoice to each Employing Unit, via a web-based electronic billing tool with both summary and detailed data. The Group Premium Invoice shall include coverage period, group/account number, product and coverage tier, employer and Employee amounts, Member and employer identifiers and Subscriber name (aka List Bill). The Group Billing Rate Structure is outlined in Exhibit 13.
- iii. Vendor will provide all the reports and tools necessary for the Employing Units or Entity to reconcile their invoices on a monthly basis.
- iv. Vendor will aggregate the Group Premium Invoices for Employing Units that are paid and reconciled by a centralized unit while maintaining the ability to recognize the Employing Unit the Member is tied to (i.e. State agencies that are all handled centrally by OSC).

- v. Vendor will calculate, and display interest owed on late premium payments for certain Employing Units in electronic billing tool. Currently the Plan charges interest for premiums due for Charter Schools and Local Governments per N.C.G.S. § 135-48.55.
 - vi. Vendor will vary the invoicing schedule by Employing Unit and month to align with individual Employing Units payroll timelines.
 - vii. Vendor will adjust the monthly Group Premiums Invoices with retroactive adjustments received since the last Group Premium Invoice was produced.
 - viii. Vendor will set the premium due date at the 1st of each month.
 - ix. Vendor will accept premium payments by check.
 - x. Vendor will accept premium by ACH.
 - xi. Vendor will accept premium payments transferred through the State Banking System.
 - xii. Vendor will deposit payments received within twenty-four (24) hours of receipt to comply with the State's banking and cash management requirements.
 - xiii. Vendor will accept and apply electronic Data Files containing multiple Group premium payments from the State or another vendor and upload into the premium billing system within twenty-four (24) hours of receipt (i.e., One vendor or Entity submits premium payments on one file for multiple state agencies).
 - xiv. Vendor will track and report premium receipts.
 - xv. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – xiv. above.
- d. **The Plan prefers a Vendor that will hold claims for individual Groups that do not pay their full premiums by the due date.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will hold claims for individual Groups that do not pay in full, or do not pay up to a certain percentage (threshold) of the amount due, by the due date.
- ii. Vendor can vary the premium threshold by Group. For example, the Retirement System must pay 100% or the premiums due to advance the hold, but the Department of State Treasurer's threshold may only be 99% to advance the hold date.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – ii. above.

The Vendor shall provide the following:

- iv. A description of the premium billing and collection process, including a sample monthly billing timeline. The timeline should include the "cut-off" time for receiving eligibility changes that would be reflected on the Group Premium Invoice.
- v. A description of the premium receipt posting and reconciliation process.
- vi. A definition of delinquent premium.
- vii. A description of the claims-hold process for Members with an Employing Unit that does not remit payment by the due date.

- viii. A description of the Employing Unit notification process when the premium is delinquent.
 - ix. A sample of the reports available to the Plan to track premium receipts.
 - x. A sample premium bill, at the Employing Unit level. (If premium bill format varies by delivery method, provide sample of each type.)
 - xi. A description of the team that will support Group premium billing and collection.
- e. The Plan requires a Vendor that will support the Plan's premium billing rules for Members who enroll through their Employing Unit but whose Employee premiums are billed by the Plan's billing vendor which makes these Members Direct Bill members because only the Employer Share of their premium is billed to the Employing Unit. Refer to N.C.G.S. §§ 135-48.40, 134-48.41, and 135 48.40(e) for more information on these Plan Members. The Vendor must also be able to accommodate any Employees who are 100% contributory and are therefore required to pay the full premium. No portion of their premium shall be billed to the Employing Unit, but they must appear on the invoice.

The Vendor shall confirm and describe each of the following:

- i. Vendor will bill the Employing Unit for only the employer portion of the premium for Members who are invoiced for the Employee share of the premium by the Plan's billing vendor. Members who are invoiced for the Employee premium will be flagged in the enrollment Data Files from the EES vendor.
 - ii. If requested by the Plan, Vendor will display the 100% contributory Employees in the monthly Group Premium Invoice as covered, but not to invoice the Employing Units for their premiums. These Members will be flagged in the enrollment Data Files from the EES vendor.
 - iii. Vendor shall describe any limitations and/or issues with meeting requirements e.i. – ii. above.
- f. **The Plan requires a Vendor that will, upon request, support the Plan, the Employing Units, and/or the Office of State Controller with invoice reconciliation. While it is a requirement that the Vendor provide the necessary tools for entities to complete their own reconciliation, there are instances where additional research and information is required to resolve outstanding discrepancies.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will produce a monthly Group Premium Invoice and corresponding reports for the Retirement System Group. The Retirement System Group includes both direct-bill Members where only the employer share of the premium is invoiced and full-bill Members where both the employer and Subscriber share of the premium are invoiced.
 - ii. Vendor will assist the Plan and the Plan's billing vendor with Retirement System reconciliation on an as needed basis.
 - iii. Vendor will assist the Plan and the Plan's billing vendor with Employing Unit reconciliation on an as needed basis.
 - iv. Vendor shall describe any limitations and/or issues with meeting requirements f.i. – iii. above.
- g. **The Plan prefers a Vendor who will ensure that all Group Premium Invoices are accurate and that proper financial controls are in place.**

The Vendor shall confirm and describe the following:

- i. The existence of an internal quality control program and audits that will ensure accuracy of the billing and collection process.

- ii. The types and frequency of standard reconciliation process, including, but not limited to, reconciliation of billed in comparison with paid amounts and reconciliation of bill generation and presentment.
- iii. The performance standards for Group billing and collection accuracy. Provide results for each of the last two (2) years.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements g.i. – iii. above.

5.2.9 Data and Technology

5.2.9.1 Overview and Expectations

Aligned with the Plan's vision and mission to be an innovative, data driven organization, the Plan seeks a Vendor that utilizes the latest advances in health information technology to support the Plan's volume, complexity, and unique requirements, and that maintains best-practices in all areas of technology, including infrastructure, data management, data security, reporting, and analytics. The Plan seeks to partner with a Vendor with best-in-class infrastructure and systems capable of meeting the Plan's current and future requirements. This includes the ability to meet the Plan's initial and ongoing testing needs which requires dedicated testing environments and resources. The Plan also seeks a Vendor that will dedicate resources with the appropriate subject matter expertise in these critical functions.

Consistent with the Plan's mission of operating a data-driven organization, the Plan seeks a Vendor that has the tools, technologies, strategies, and thought leadership that will allow for cutting-edge, advanced level reporting, data analytics, and modeling that provides valuable insights for better decision making in support of the operational and strategic priorities of the Plan.

Objectives

- a. Partner with a Vendor that has the technology, infrastructure, and subject matter expertise to support the Plan.
- b. Ensure Vendor has the system flexibility and resources to meet the Plan's custom Data File and Plan vendor integration requirements.
- c. Partner with a Vendor that places a high value on data security and constantly and consistently strives to improve data security and data management.
- d. Engage a Vendor that will support customized Data Files to and from multiple Plan vendors, the Plan, and/or Plan Partners and will work with the Plan to establish Data File schedules that meet the Plan's requirements.
- e. Partner with a Vendor that has the expertise, resources, and technology to meet the ad hoc and ongoing data reporting and analysis needs.

5.2.9.2 Thought Leadership

- a. **The Plan requires a Vendor that can provide strategy and thought leadership regarding health care data processing, data management, and data reporting and associated disciplines.**

The Vendor shall provide copies of the strategy, planning, and process and procedure documents for each of the following:

- i. Project management.
- ii. IT infrastructure.
- iii. Backup and recovery.
- iv. Development/Testing/ Production environments.
- v. Implementation testing.
- vi. Regression testing.
- vii. Break/ fix testing.
- viii. Data management.
- ix. Data governance.
- x. Data quality.
- xi. Data security.
- xii. Data integration.
- xiii. Data transmission.

- xiv. Data reporting.
- xv. Data analytics.
- xvi. Data standards.
- xvii. Reference data.

The Vendor shall provide the following:

- xviii. A list of training and certifications required for Vendor's project management staff.

5.2.9.3 Technology Services

- a. **The Plan requires a Vendor that will provide state-of-the-art Data Centers that will be secure 24/7/365 with an uptime of 99.9%. This includes having the tools, technology, and protocols to ensure the confidentiality, integrity, and availability of the Plan's data, to prevent unauthorized access, and to prevent data corruption.**

The Vendor shall confirm and describe the following:

- i. Existence of U.S. based Data Centers and whether they are operated internally or outsourced/sub-contracted.
- ii. Plan data will not be "co-mingled" with data from the rest of Vendor's book of business.
- iii. Existence of a U.S. based primary and disaster recovery Data Centers.
- iv. Existence of automated fail-over processes, technology, organization, and infrastructure.
- v. Existence of 24/7/365 security monitoring and reporting for the Data Centers, application systems and sub-contracted technology.
- vi. Existence of processes to ensure only appropriate personnel have access to Data Centers, application codes and systems, and the Plan's data.
- vii. Mission critical equipment and systems are in a restricted area. Include in the description the level and roles of employees who have access to these restricted areas and the Plan's data.
- viii. Existence of security systems such as, but not limited to, key cards, badges, and PINs to ensure access to the Data Centers is restricted to appropriate personnel.
- ix. Existence of layered security controls to protect the Plan's data, servers, applications, and network.
- x. Existence of security provisions in the systems and Data Centers to protect the Plan's data.
- xi. Adherence to National Institute of Standards and Technology (NIST) data security standards appropriate for moderate information system(s).
- xii. How data is being disposed/archived on schedule using NIST standards.
- xiii. Existence of system and network redundancy and failover provisions (LAN and WAN, Telcom, Power) that will ensure 99.9 percent uptime.
- xiv. Vendor has data security policies and procedures that are reviewed and updated quarterly.
- xv. Vendor will share all data security policies and procedures annually or as requested by the Plan and revise them as needed within a 6-month timeline.
- xvi. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xv. above.

The Vendor shall provide:

- xvii. Copies of the Vendor's data security policies and procedures.
- xviii. The name and credentials of the Vendor's Chief Data Security Officer or equivalent position.
- xix. The schedule for backed-up data and the rotation of backed-up media (e.g., Daily back up kept for sixty (60) days, plus monthly backups for twenty-four (24) months and yearly backup for the last five (5) years); and how often the backups are successfully restored and tested to validate data and media has not been corrupted.
- xx. The security strategy for data at rest, data in use, and data in motion.
- xxi. The secure process that is used to ensure the receipt of timely, accurate, traceable data for the data storage.
- xxii. The protocols for management of a PII/PHI security breach.
- xxiii. Technology services organization chart with roles and responsibilities.

The Vendor shall describe each of the following:

- xxiv. How data shared with the Plan, Plan vendors, and Plan Partners is securely maintained and managed during and after transmission of Data Files.
- xxv. How security risks are identified, escalated, and documented. Include any mitigating tactics.
- xxvi. Overall Data Center architecture. Include documentation to support the design.
- xxvii. Systems and applications that will be used to support EDI transaction management and other B2B services.
- xxviii. Number of outages that occurred in the past 24 months.
- xxix. Total amount of time clients experienced a planned and unplanned outage for the same 24-month period.
- xxx. Whether or not security has ever been breached and if so, the nature of the security breach, and the actions taken and/or procedures introduced post security breach.

b. The Plan prefers a Vendor that will work with the Plan to ensure scheduled down time does not impact Plan deliverables.**The Vendor shall confirm the following:**

- i. Clients are notified at least (60) sixty days prior to any planned system downtime.
- ii. Client preferences about down time are taken into consideration.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan prefers a Vendor with a Data Warehouse that can meet all the Plan's data needs.**The Vendor shall confirm:**

- i. The existence of a Data Warehouse.
- ii. Vendor shall describe any limitations and/or issues with meeting requirement c.i. above.

The Vendor shall describe each of the following:

- iii. Product and version.
- iv. Architecture and data model.
- v. All tools used and what tools are available to access the data in the Data Warehouse.
- vi. Any recent or planned enhancements to the Data Warehouse.
- vii. Policies and processes in place to manage any changes to the Data Warehouse environment that will be used for the Plan.

d. The Plan requires a Vendor that will provide a production environment that can dynamically allocate additional resources when demand exceeds the current production configuration.

The Vendor shall confirm and describe the following:

- i. How performance of servers and/or processors are monitored.
- ii. How EDI demand is dynamically supported.
- iii. Configuration of the production environment, including but not limited to:
 - 1) The platform and database used.
 - 2) Number of servers.
 - 3) Processors.
 - 4) Memory.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iii. above.

The Vendor shall provide each of the following:

- v. A detailed list and description of any outsourced/sub-contracted technology, infrastructure, and services or capabilities.
- vi. A list of the products used to support EDI transaction management. Include an overview of each product's architecture which should include each of the following:
 - 1) Current version.
 - 2) Next scheduled update/release and version.
 - 3) Product(s) are supported by third party vendor until 'month/year'.

e. The Plan requires a Vendor to have a Business Continuity/Disaster Recovery plan.

The Vendor shall confirm and describe the following:

- i. The Vendor will update and test the Business Continuity/Disaster Recovery plan annually.
- ii. The Vendor will report on whether or not the Business Continuity/Disaster Recovery plans were invoked over the past seven (7) years and, to provide explanation of when and why they were invoked, their effectiveness and the repercussions, including financial or legal penalties, loss of business, etc.
- iii. The Vendor will provide guidelines that have been established to review and update the Business Continuity/Disaster Recovery plan and targeted recovery time, including the date when the last Business Continuity/Disaster Recovery was updated.

- iv. The Vendor will perform nightly backup of the Plan's data.
- v. The Vendor shall describe any limitations and/or issues meeting requirements e.i. – iv., above.

The Vendor shall provide each of the following:

- vi. Standard Operation Procedures (SOP) for all EDI activity.
- vii. Process and turnaround time for completing new data requests.
- viii. Process for escalating data error issues as well as the chain of command for reporting and managing escalations to the Plan.
- ix. Description of the tools and processes for monitoring and measuring service quality.

5.2.9.4 Testing Services

a. The Plan requires a Vendor with sufficient test regions to support the Plan.

The Vendor shall confirm and describe the following:

- i. Vendor will provide dedicated End-to-End testing environment(s) that can be refreshed with production data to support the Plan during the initial implementation and any ongoing implementations such as the annual open enrollment testing or any new Plan vendor implementations which may require both Vendor unit testing and End-to-End Testing with Plan vendors.
- ii. When requested by the Plan, Vendor will provide multiple testing environments using virtual servers or partitioned systems to successfully complete concurrent projects initiated by the Plan.
- iii. Vendor will provide a test environment and test data that is an exact replica of the production environment for regression testing. Include in the description how test data is populated.
- iv. The Vendor shall describe any limitations and/or issues meeting requirement a.i.-iii. above.

The Vendor shall describe the following:

- v. The Plan's testing support organization chart with roles and responsibilities and how they are aligned to the Plan's dedicated Data Manager and Implementation Manager.
- vi. The configuration of the testing environment, including the platform and database used, number of services, processors, memory, etc.
- vii. Methodology and approach to testing quality assurance of products and processes.
- viii. Methodology and approach to performance testing.
- ix. How regression testing will be performed, what data will be used, and what automation tools and support services will be provided.
- x. What testing automation software is provided, what training will be offered to the Plan for its use, and how it will be used for implementations and for Open Enrollment.

5.2.9.5 Data Warehouse Support Services

- a. The Plan requires a Vendor that ensures the data provided to the Plan for use in the Plan's Data Warehouse is accurate, reliable, and timely, and matches the cycles of reporting provided to the Plan so that data reporting is reliable by time period to provide consistent results across reports and data files.**

The Vendor shall confirm and describe the following:

- i. Data will be delivered at least once a month, by the 15th of the month following the processing period.
 - ii. Data records will be delivered as incremental additions or adjustments, or full files as requested by the Plan.
 - iii. Data will be delivered with a mechanism to identify unique records across months.
 - iv. Data delivered will be accompanied by reference tables, updated on a regular basis.
 - v. Data delivered will be cross referenceable by unique keys across all datasets provided by the Vendor to the Plan.
 - vi. The Vendor shall describe any limitations and/or issues to meeting the requirements listed in Section a.i. – v.
- b. The Plan requires a Vendor that will assist the Plan in understanding any custom data provided for the Plan's Data Warehouse outside of industry standards.**

The Vendor shall confirm and describe the following:

- i. Vendor will participate in knowledge transfer work sessions as requested by the Plan.
- ii. Vendor will participate in report validation sessions, as requested by the Plan.
- iii. The Vendor shall describe any limitations and/or issues to meeting the requirements listed in Section b.i. – ii., above.

The Vendor shall describe the following:

- iv. Other activities, reports, etc., that the Vendor will provide to ensure the Plan and the Vendor can reconcile the metrics being managed and reported by the Vendor and can reproduce matching results from the data provided to the Plan, for the Data Warehouse.

5.2.9.6 Data Governance

- a. The Plan requires a Vendor with a strong focus on data governance.**

The Vendor shall confirm and describe the following:

- i. Vendor's existing data governance program and detailed description of the overall availability, usability, integrity, and security of data used. Include in the description an organization chart with roles and responsibilities for the data support organization that will support the Plan.
- ii. Existence of data governance policies and procedures. Include in the description how often these policies and procedures are reviewed.
- iii. Existence of quality control around all processes and procedures related to data. Include in the description the process, policy, methodology, use of any industry standards and tools and best practices for data file extracts and reports including ad hoc reports.
- iv. Governance program for both inbound and outbound file transmissions.
- v. Vendor shall describe any limitations and/or issues meeting requirements a.i. – iv.

The Vendor shall describe each of the following:

- vi. How the success of governance is measured.
- vii. How the governance process is invoked in the event of an issue or question.
- viii. Process to resolve any data quality issues, questions, or inconsistencies.
- ix. Tools, technology, and service used to validate inbound and outbound edits and business rules, specify proprietary versus outsourced/sub-contracted vendors.
- x. Transformation and business rules available to meet the Plan's specialized business needs and provide the best data consumption both for inbound and outbound processing.
 - 1) Eligibility configurations.
 - 2) Claims configurations.
 - 3) Configurations.
- xi. Process for correcting historical errors in Vendor's data, Data Warehouse, or data management processes.
- xii. Process for resolving quality issues identified by the Plan (i.e. response/resolution time, proactive prevention of recurrence).

5.2.9.7 Data Quality**a. The Plan requires a Vendor with a strong focus and commitment to data quality.****The Vendor shall confirm and describe the following:**

- i. Data quality repairs are made at transaction record level in the appropriate source system. Include in the description the typical turnaround time for making any corrections.
- ii. Data is accurate and consistent across Vendor's platform(s).
- iii. Vendor will meet weekly to discuss data quality and address ongoing data issues. The meeting shall be attended by the Vendor's Data Manager that will be 100% dedicated to the Plan.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i.-iii., above.

The Vendor shall describe the following:

- v. Standards used to ensure data is accurate and consistent over the life span of the data.
- vi. Tools, technology, and service used to validate inbound and outbound edits and business rules, specify proprietary versus outsourced/sub-contracted vendors.
- vii. Vendor will re-use business rules for processing files being sent to the Plan or Plan vendors for consistent data quality.

5.2.9.8 Data Management**a. The Plan requires the Vendor to have the tools, technology, and protocols to provide for continual operations and maintenance of the metadata used in conjunction with the master and transactional data.**

The Vendor shall confirm and describe the following:

- i. The Vendor makes continuous and consistent updates to the metadata (information that provides information about other data, e.g., fully descriptive data dictionaries, reference data, field formats, field characteristics, field usage, etc.) which will be shared with the Plan on an ongoing basis.
- ii. The Vendor makes continuous and consistent updates to the reference data (value sets for identifiers and codes) used to perform data analysis which will be shared with the Plan on an ongoing basis.
- iii. Vendor will share the methodology and data logic used to produce the standard reports that will be provided to the Plan and how that logic corresponds to the Data Files that the Vendor will provide to the Plan on an ongoing basis.
- iv. Transformation and business rules available to meet the Plan's specialized business needs and provide the best data consumption both for inbound and outbound processing.
- v. Vendor will maintain at least ten (10) years of Plan data, all of which can be reported on upon request by the Plan.
- vi. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-v., above.

5.2.9.9 Data Interchange

- a. **The Plan requires a Vendor with the capability to process and accurately load daily custom and ASC x12 EDI transmission sets from Plan vendors and/or Plan Partners to support the ongoing operations of the Plan.**

The Vendor shall confirm and describe the following:

- i. Vendor will accept industry standard and/or custom Data Files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:
 - 1) ASC X12 EDI transaction sets.
 - 2) XML files.
 - 3) Flat/ Fixed Files.
- ii. Vendor will accept and process multiple files within the same day.
- iii. Vendor will accept and process multiple concurrent file transmissions.
- iv. Vendor will accept and exchange unique Member ID's generated from Plan vendors through EDI files.
- v. Vendor will accept daily Data Files, seven (7) days a week.
- vi. Vendor will have the capability to accept and load no less than 250,000 transactions in a single file transmission within a four (4) hour window.
- vii. Vendor will process "change" records as either dropped or added records.
- viii. Vendor will load and process "drop" and "add" files for same Members within the same day.
- ix. Vendor will use current, most advanced data quality tools or system configuration to ensure the accuracy of inbound and outbound transactions.

- x. Vendor will manually handle and track exceptions, for instance, discrepancies, or enrollments that error out or do not otherwise process and require manual intervention. Include in the description the workflow for handling enrollments that do not automatically process and how each one is tracked to completion.
- xi. Vendor will exchange the enrollment and eligibility data using SFTP and HTTPS secure protocols with PGP encryption.
- xii. Vendor will generate and send Vendor's unique Member ID through acknowledgment EDI files.
- xiii. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.
- xiv. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits.
- xv. Vendor will itemize information considered "trade secret" or proprietary.
- xvi. Vendor will extract and/or load daily EDI files containing 50,000 transactions within a 4-hour window.
- xvii. Vendor will, at a minimum, have the capability to extract and/or load data files containing the Plan's full membership within a 24-hour window.

b. The Plan requires a Vendor that has the capability to accurately produce recurring outbound Data Files for Plan vendors and upon request, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 15, Vendor Data Feeds for 2019.

The Vendor shall confirm and describe the following in regard to operational data:

- i. Vendor will provide ASC X12 transaction sets that include, but are not limited to:
 - 1) 275 Patient Information. This transaction set is used to communicate individual patient information requests and patient information (either solicited or unsolicited) between separate health care entities in a variety of settings to be consistent with confidentiality and use requirements. Patient information consists of demographic, clinical, and other supporting data.
 - 2) 276 Health Care Claim Status report. This transaction set is used by a provider, recipient of health care products or services, or their authorized agent to request the status of a health care claim or encounter from a health care payer. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.
 - 3) 277 Health Care Information Status Notification. This transaction set is used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter, health care services review, or transactions related to the provisions of health care. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.
 - 4) 278 Health Care Services Review Information. This transaction set is used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review. Users of this transaction set are payors, plan sponsors, providers, utilization management and other entities involved in health care services review.
 - 5) 834 Benefit Enrollment and Maintenance. This transaction set is used to establish communication between the sponsor of the insurance product and the payer. Such transaction(s) may or may not take place through a third-party administrator (TPA). For the purpose of this standard, the sponsor is the party or

entity that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association, or insurance agency. The payer refers to an entity that pays claims, administers the insurance product or benefit, or both. A payer can be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Champus, etc.), or an entity that may be contracted by one of these former groups. For the purpose of the 834-transaction set, a third-party administrator (TPA) can be contracted by a sponsor to handle data gathering from those covered by the sponsor if the sponsor does not elect to perform this function itself.

- 6) 835 Health Care Claim Payment/Advice. This transaction set is used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.
- 7) 837 Health Care Claim. This transaction set is used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third-party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third-party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

c. The Vendor shall describe any limitations and/or issues meeting requirements a. – b., above.

d. The Plan requires a Vendor that will release data to the Plan as described in N.C.G.S. § 135-48.32(b). Any limitations on the Plan's use of data shall be no more restrictive than as described in N.C.G.S. § 135-48.32.

The Vendor shall confirm each of the following:

- i. Vendor will release data to the Plan as described in N.C.G.S. § 135-48.32(b).
- ii. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in N.C.G.S. § 135-48.32.
- iii. The Vendor shall describe any limitations and/or issues with meeting requirements in Section d.i.-ii., above.

The Vendor shall describe each of the following.

- iv. Any limitations that may be placed on the Plan, Plan vendors, and Partners or Employing Units, as far as access to systems or data.
- v. Information considered "trade secret" or proprietary, itemized by categories.

5.2.9.10 EDI Monitoring Services

a. The Plan prefers a Vendor that has the capability to review the status of EDI files in real-time and provide automated notifications and alerts.

The Vendor shall confirm and describe each of the following:

- i. Vendor's capability to view EDI file status through a portal.
- ii. Existence of a portal or other user interface that will display for external users (Plan staff or the Plan vendors) the real-time status of file(s) and data exceptions.
- iii. Vendor will provide the Plan or Plan vendors access to review specific EDI transactions and actual raw data.
- iv. Vendor will provide an automated capability to monitor business processing. Services including, but not limited to:
 - 1) Files processing.
 - 2) Files delivered.
 - 3) Files received.
 - 4) Files processed.
 - 5) Files percent completed.
 - 6) Discrepancies found.
 - 7) EDI throughput percentage.
- v. Vendor will send notifications or alerts to one or more recipients of either the Plan, Plan vendors, and Partners, as directed by the Plan.
- vi. Vendor will support an optimized schedule for sending and receiving files to and from the Plan or Plan vendors, as requested by the Plan and agreed upon during implementation planning.
- vii. Vendor will provide a copy of all files sent to Plan vendors to the Plan via SFTP.
- viii. The Vendor shall describe any limitations and/or issues meeting requirements in sections a.i. – vii., above.

5.2.9.11 Data Audit and Reconciliation Services

- a. **To ensure the accuracy of the enrollment data in the Vendor's system, the Plan requires a Vendor that can accept and process Full Files, or Audit Files, from the Plan's EES vendor for the purposes of both auditing and reconciling enrollment and financial data.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will perform enrollment and eligibility audits and reconciliations, on a schedule requested by the Plan.
- ii. Vendor will use automated processes to ensure the appropriate fields are audited.
- iii. Vendor will use automated processes to ensure the appropriate amounts are reconciled.
- iv. The Vendor shall describe any limitations and/or issues meeting requirements a.i. – iii., above.

The Vendor shall complete Table 4 below to identify which data elements are and are not currently part of an automated audit process and shall describe the following:

- v. Vendor's current process for automatically updating any discrepancies to match the Enrollment and Eligibility System (EES).
- vi. Vendor's process for automating updates based on audit findings to complete reconciliation.
- vii. Vendor's process for prioritizing and implementing enhancements that may be required to meet the Plan's, or other vendor's, reconciliation needs.

Table 4			
Data Element	Y/N	Data Element	Y/N
Member Demographics			
Full Name		Relationship	
Multiple Addresses		Multiple Member IDs	
Multiple Phone Numbers		Multiple Email Addresses	
SSN		Gender	
Date of Birth (DOB)		Date of Death	
Elections			
Original Effective Date		Termination Date	
Current Plan Effective Date		Current Plan Termination Date	
Benefits Level		Family Coverage Level	
Multiple Spans of Coverage		Current Span of Coverage	
Terminated Coverage		Future Coverage	
Coordination of Benefits			
Medicare Part A eligibility date		Medicare Part B eligibility date	
Medicare Part A enrollment date		Medicare Part A termination date	
Medicare Part B enrollment date		Medicare Part B termination date	
Medicare Primary Date(s)		Medicare Secondary Date(s)	
Plan Primary Date(s)		Plan Secondary Date(s)	
Medicare Beneficiary Identifier		Medicare Entitlement Reason(s)	
Plan Specific Offerings			
PCP Name		PCP Location	
PCP Effective Date		PCP Termination Date	
Premium Credits		Employee job status	

b. The Plan requires a Vendor that has advanced data integration capabilities to support Plan programs.

The Vendor shall confirm and describe the following:

- i. Vendor will integrate with Plan vendors and/or Plan Partners to support Plan programs, if requested by the Plan. For example, if the Plan wants to share data about what incentives a Member may have earned via Vendor's platform.
- ii. The Vendor shall describe any limitations and/or issues meeting requirement b.i., above.

5.2.10 Customer Experience

5.2.10.1 Overview and Expectation

A top priority for the Plan is ensuring a superior customer experience with all customer-facing resources and tools. The Plan seeks a Vendor who has similar priorities and who will strive to excel in this area. Every process and procedure and customer touch point should be designed to provide the best customer experience possible. Customers include Plan Members, Health Benefit Representatives (HBRs), and the Plan. Communications must be written clearly and simply for all customers to easily understand them.

There must be a variety of options, including robust web tools and customer call centers, for customers to interact with the Vendor. The Vendor must show a dedication to constant customer experience improvements and be an innovator in online Member engagement. Online engagement includes transparency tools and provider search functions that clearly identify low cost, high quality providers by specialty. If Plan-specific networks are utilized, these tools must display the Plan-specific information.

Objectives

- Provide a superior customer experience for Plan Members and HBRs.
- Provide state of the art web tools for Plan Members and HBRs.
- Support single sign-on from the EES vendor for Members to view claims and out-of-pocket accumulations.
- Contract with a Vendor that is willing to partner with the Plan on initiatives and enhancements that will improve Member and HBR satisfaction through enhanced processes, services, and online tools.
- Contract with a Vendor that is willing to customize its communication materials and online tools to meet the Plan's needs.
- Contract with a Vendor that has a track record of going above and beyond the call of duty to exceed customer expectations.

5.2.10.2 Services

- a. **The Plan requires a Vendor with a Member call center to have hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to all Member inquiries. The call center should be dedicated to the Plan with a Plan-specific phone number and greeting.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide a dedicated Member call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member Inquiries. Include in the description the anticipated number of call center resources that will be dedicated to the Plan.
- ii. Vendor will add additional resources to the call center at no additional cost to the Plan as required to meet increased demand during peak call periods, such as during Open Enrollment.
- iii. Vendor will have a dedicated toll-free number for Plan Members.
- iv. Vendor will answer the phones with a greeting that identifies the call center as a representative for the State Health Plan.
- v. Availability of a 24/7 interactive voice response (IVR) system with basic eligibility, benefit, and claims status information for Members.
- vi. Vendor will customize the IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
- vii. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.

- viii. Vendor will receive emails from Plan Members and respond to their inquiries.
- ix. Upon request, Vendor will provide expanded hours of operation during the Open Enrollment period at no additional cost to the Plan. Include in the description the proposed hours. The Plan's enrollment and eligibility call center is generally open on Saturdays during Open Enrollment.
- x. Vendor will provide non-English speaking services for callers who may need assistance in other languages. Include in the description what languages are available.
- xi. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them. Include in the description other services the Vendor may offer for this population.
- xii. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xi. above.

The Vendor shall describe each of the following:

- xiii. Any other non-web-based services provided to Members by the Vendor's Customer Call Center.
- xiv. The Plan and Member customer service model for Vendor's current largest group.
- xv. The method for handling complaints, for developing and implementing action plans to resolve complaints, and for reporting complaints and follow-up actions to the Plan.
- xvi. The training that will be provided to Vendor's Call Center resources, to educate them on Plan enrollment rules, plan designs, incentives, and Plan vendor integration requirements.
- xvii. Vendor's experience managing both Medicare Primary and Non-Medicare primary populations within one Group. Include detailed information about how Call Center representatives assigned to the Plan will be trained on Medicare rules and the Plan's specific Medicare primary product enrollment rules.
- xviii. The key performance indicator (KPI) targets and results for the Vendor's Member Call Centers for each of the last two (2) calendar years.

b. The Plan prefers a Vendor with integrated call tracking and recording systems that enable the Vendor or the Plan to easily track, pull, audit, and report on Member and HBR calls.

The Vendor shall confirm and describe each of the following:

- i. Vendor will record and track **all** Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
- ii. Vendor will record and track **all** HBR calls including call reason and call resolution.
- iii. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.
- iv. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.
- v. Vendor will provide copies of call notes to Members upon request.
- vi. Vendor will provide reports, based on call reason type, to the Plan upon request.
- vii. The existence of a call audit program to measure the accuracy of the information provided to Members and HBRs who call the Vendor.
- viii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – vii., above.

- c. The Plan requires a Vendor with an Escalation Team and single point of contact to work with the Plan to resolve any escalated issues.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide an Escalation Team to respond to and resolve inquiries from the Plan.
- ii. Vendor will have a single point of contact and a back-up contact for Plan leaders to contact to resolve any escalated Member issues that may arise.
- iii. Vendor will designate team members to be given access to the Plan's PBM's systems to make emergency pharmacy updates, when requested by the Plan.
- iv. Vendor will process benefit and enrollment exceptions within twenty-four (24) hours, or as requested by the Plan.
- v. Describe any limitations and/or issues with meeting requirements c.i.-iv. above.

- d. The Plan requires a Vendor with an HBR call center to have hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to all HBRs for premium billing, eBilling, and enrollment inquiries. The call center should be dedicated to the Plan with a Plan-specific phone number and greeting.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide a dedicated HBR call center for enrollment, premium billing, and eBilling questions with a dedicated toll-free number with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to HBR inquiries. Include the description of the anticipated number of resources that will be assigned to Employing Unit call center.
- ii. Vendor will accept and respond to Employing Unit emails.
- iii. Vendor will answer the phones with a greeting that identifies the Vendor's representative as a member of the State Health Plan.
- iv. Vendor will provide reporting to the Plan around HBR users' most recent login history to the billing platform.
- v. Describe any limitations and/or issues with meeting requirements d.i.-iv. above.

The Vendor shall describe the following:

- vi. The service model most frequently used by the Vendor to support groups with a similar number of HR resources as the Plan (there are currently over 1,000 HBRs supporting more than 400 groups).

- e. The Plan requires a Vendor that offers a robust, secure Member portal for Plan Members which can be customized to meet the Plan's needs. Members should have access to view and print their claims and benefit information, order ID cards and print temporary ID cards, search for providers, and shop for services. The portal should also include wellness tools and other health care support tools. If the Plan chooses to offer applicable plan designs, Members should also be able to view their Health Reimbursement Account (HRA) and/or Health Savings Account (HSA) information and engage in other activities that increase their health literacy.**

The Vendor shall confirm and describe each of the following services:

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

- ii. Vendor will support single sign-on to and from the Plan's PBM Customer portal, the Plan's EES vendor and other Plan vendor sites, as requested by the Plan.
- iii. Vendor will customize the portal with the Plan's branding.
- iv. In addition to displaying the Plan's branding, the Vendor will display the name of the Member's Employing Unit (e.g., Department of State Treasurer, Retirement System, Wake County Schools, etc.) once the Member has logged into the secure member site.
- v. A Subscriber has access to his/her own data as well as his/her own Dependent's data via the Member portal as allowed by law.
- vi. A Dependent only has online access to his/her own data via the Member portal.
- vii. Vendor will, upon request, segregate and provide secure Member portal access to a Dependent, or a Dependent's designee, in a court-ordered scenario such as a Medical Support Notice.
- viii. Member portal will capture Plan Members' preferences for communication and appointment reminders including, but not limited to, frequency, topics, mode (text, email, mail).
- ix. Member portal will provide a personal portal calendar with the ability to set appointments with case and disease management counselors, active life coaches and other program consultants including the ability to enable text message reminders.
- x. Member portal will push appointments to personal calendars, allow a Member's health team to have access to Member's personal portal calendar, and will add appointments with set reminders.
- xi. Member portal will provide health/condition-specific resources to Members, such as educational videos, recipes, digital coaching modules, webinars, links to Plan approved/promoted websites, evidenced-based articles, and tools for self-management.
- xii. Member portal will provide and moderate online forums and live chat groups. Include in the description how the forums will be managed and whether the Plan or Employing Units will have access to run and or manage their own topics.
- xiii. Member portal will receive and display timely data from various providers such as, but not limited to, lab results from large independent labs, prescriptions from pharmacies, and other data from physicians' offices. This information could be used by Plan Members to gather information necessary to complete annual health assessment or validate Member actions to earn incentives.
- xiv. Member portal will allow Members to:
 - 1) View claims and claim payment status.
 - 2) View and print EOBs.
 - 3) View deductible and out-of-pocket (OOP) accumulations.
 - 4) SSO to the HSA vendor, if applicable.
 - 5) View HRA claims, if applicable.
 - 6) View HRA Balances, if applicable, including, but not limited to:
 - a) Initial HRA Funding.
 - b) Rollover Funds.
 - c) Incentive Funds.
 - 7) Order ID Cards.
 - 8) Print temporary ID cards.
 - 9) Order new HRA or HSA debit cards, if applicable.

- 10) Track incentive programs and benefit designs (e.g., cash rewards, health reimbursement account contributions) and administer the reward for participation, as defined by the Plan.
 - 11) Complete a health assessment that could be customized by the Plan.
- xv. Member portal will accept and display Member-specific information from other systems and Vendor's health team, including:
- 1) Electronic medical and health records.
 - 2) Disease Management Nurse notes.
 - 3) Case Management notes.
 - 4) Health Coach notes.
 - 5) Vendor analytical system alerts, such as gaps in care.
 - 6) Progress towards Incentives earned, if applicable.
- xvi. Vendor will provide the following services whether the Member is logged into the secure site or accessing these tools on the unsecured site:
- 1) Search for providers by specialty.
 - 2) Search for procedure/service cost.
- xvii. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-xvi. above.

The Vendor shall provide each of the following:

- xviii. Description of all the services, including any clinical information, available to Members via the secure Member portal.
 - xix. Description of the mobile technology available to Plan Members and the types of services offered through this technology including, but not limited to, virtual ID card that will display the Plan's custom ID, mobile care programs, customized alerts.
 - xx. Copy of the 2019 scheduled down time for the Member and employer portals.
 - xxi. Results of system availability for Members and employers, excluding scheduled down time for each of the last two (2) years.
- f. The Plan prefers a Vendor with the flexibility to support the Plan's initiatives by providing customized web solutions.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will customize the materials available to Plan Members via the secure Member portal.
- ii. Vendor shall describe any limitations and/or issues with meeting requirement f.i. above.

The Vendor shall describe the following:

- iii. Any other web services included by the Vendor that will provide value to the Plan and Plan Members.
- g. The Plan requires a Vendor with online billing functionality that shall be used to provide monthly Employing Unit premium invoices, including summary and detail invoice reports, to each Employing Unit and/or Entity.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide an online, web based, billing tool with role-based security at the Employing Unit, Entity and Plan level. The Plan should have “super-user” access at the Plan level to view data at the Employing Unit level. The Employing Units should only have access to see data related to their Employing Unit. Within the Employing Unit, users should be able to have both update and view-only access. Additionally, an aggregate user role will be necessary for specific multi-group management.
 - ii. HBRs will have access and ability to export to a spreadsheet and print electronic billing documents from the online billing tool.
 - iii. The online billing tool will maintain historical invoices for at least 10 years, with the most recent 3 years available online for users.
 - iv. The online billing tools will offer resources to support monthly billing reconciliation by the Employing Units.
 - v. Employing Units will be able to pay the invoice online, via ACH.
 - vi. Employing Units will also be able to pay by check and that payment will display in the online billing tool.
 - vii. Vendor will include multiple Member IDs including, but not limited to, a SSN and/or an employer assigned ID on the invoice presented by the online billing tool.
 - viii. Vendor will provide tools to the Employing Unit that allows them to run mock bills prior to the production of the monthly invoice.
 - ix. Vendor shall describe any limitations and/or issues with meeting requirements g.i. – viii. above.
- h. The Plan prefers a Vendor that has a secure employer web portal accessible to the Plan to view Plan Member claims and enrollment data. Approved Plan staff should be able to view individual Member and claims data and run reports at the aggregate Plan level and Employing Unit level.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment information.
- ii. Vendor will provide an online portal that Plan Staff can use to view individual Member claims. The claims view access in the portal should be similar to the view access a Member has via the secure member portal.
- iii. Vendor will provide an online portal that provides ad hoc reporting capabilities that will allow the Plan to run reports at the aggregate Plan level, Entity level, and the Employing Unit level.
- iv. Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iii. above.

The Vendor shall describe the following:

- v. Any other functionality available via the online portal.
- i. The Plan prefers a Vendor that will participate in and support the Plan’s customer experience initiatives including, but not limited to, surveying Members and HBRs.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiatives, upcoming Plan mailers and/or events, and develop and implement process improvements between Plan vendors and Partners.
- ii. Vendor, if instructed by the Plan, will conduct an annual Member Satisfaction Survey for all Plan Members, including Members who are not enrolled in plans administered by the Vendor. The Plan will be responsible for communicating the survey to Plan Members and may provide a link to the survey on the Plan's website. The Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.
- iii. Vendor will conduct other surveys, as requested by the Plan.
- iv. Vendor will conduct HBR satisfaction surveys. The Plan will be responsible for communicating the survey to HBRs and may provide a link to the survey on the Plan's web site. The Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.
- v. Vendor will attend Plan-hosted Open Enrollment events to educate members on Plan options. The Plan representatives are generally on the road across the state during most of September and October promoting Open Enrollment. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.
- vi. Vendor will provide both web-based and regional on-site HBR billing training to HBRs. Currently, the Plan conducts quarterly regional events for HBRs to educate them on premium billing and enrollment. Representatives from the TPA and EES vendor are required. Other events are scheduled as needed.
- vii. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.
- viii. Vendor will attend Wellness Fairs and other promotional events around the state, as requested by the Plan.
- ix. Upon request, Vendor will provide resources to conduct biometric screening at wellness events, as requested by the Plan. If requested, Vendor shall have the ability to send the biometric results to the Members' primary care providers.
- x. Vendors will provide language interpreters, including sign language, at events as requested by the Plan.
- xi. The Vendor should describe any limitation to meeting requirements i.i. - x., above.

The Vendor shall describe the following:

- xii. Any other resources or services included by the Vendor to support Member and HBR outreach and educational events.
- j. **The Plan requires a Vendor that will support the Plan's custom benefit books and will work with the Plan to customize Member and HBR communication materials. The Vendor must also develop and implement new communication materials to support any programs implemented for the Plan.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will assist with the Plan's Benefit Booklet review and/or provide guidance regarding the Plan's Benefit Booklets which includes individual books for each plan offered.

- ii. Vendor will co-brand letters or other materials the Vendor will send to Members and HBRs.
- iii. Vendor will customize the content of any letters or other materials the Vendor will send and/or display to Members and HBRs.
- iv. Vendor will develop and disseminate appropriate Member communication for each Medical Management program.
- v. Vendor will develop and implement new communication materials for Members, HBRs, and/or Providers to support any programs implemented for the Plan.
- vi. Vendor will suppress specific Member communications, upon request.
- vii. Vendor will develop and disseminate appropriate Provider communications, as requested by the Plan.
- viii. The Vendor shall describe any limitation and/or issues meeting requirements j.i. – vii., above.

The Vendor shall provide each of the following:

- ix. Samples of communication developed for targeted populations for specific medical management interventions.
- x. Samples of member-directed communications that can be shared with the Members' primary care provider (PCP).
- xi. Samples of innovative communication methods that are currently used or are in development for future use.

k. The Plan prefers a Vendor that has expertise in Member Communications.

The Vendor shall confirm and describe the following:

- i. The availability of Marketing and Communication resources for the Plan.
- ii. Vendor will mail direct communications pieces to Members.
- iii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. In the description Vendor should include customization possibilities of both items. Refer to Exhibits 9 and 14 for sample ID Cards and EOB.
- iv. The Vendor shall describe any limitation and/or issues meeting requirements k.i. – iii., above.

5.2.11 Product Management

5.2.11.1 Overview and Expectations

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

The Plan currently offers three (3) Preferred Provider Organization (PPO) plans to Members, including approximately 25,000 Medicare primary Members who have not elected a Medicare Advantage Plan. Two of these plan designs, the 80/20 Plan and the 70/30 Plan, include copay incentives for electing a primary care provider (PCP). The third plan, a High Deductible Health Plan, is for non-permanent full time Employees. The health benefit plans currently offered can be found at the following links:

- 80/20 Plan: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_80-20_benefit_booklet.pdf
- 70/30 Plan: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_70-30_benefit_booklet.pdf
- HDHP: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_hdhp_benefit_booklet.pdf

Objectives:

- a. Engage a progressive Vendor with a proven track record for delivering plan design innovation, speed to market, and an aptitude for “bending the trend” of health care costs.
- b. Promote Member engagement by selecting a Vendor with state-of-the-art web tools, communication strategies, and programs that support consumer driven health care.
- c. Improve the Customer experience by selecting a Vendor with the breadth and depth of resources to provide fully integrated Products.
- d. Ensure quality care and maximize savings.

5.2.11.2 Product Services

- a. **The Plan requires a Vendor that can not only support the Plan’s current PPO Plans but has the flexibility to support any requested changes. The Vendor shall also be able to ensure that all Products and Plan Designs are compliant with federal regulations including the Patient Protection and Affordable Care Act (PPACA).**

The Vendor shall confirm and describe:

- i. Vendor will administer the 2020 PPO offerings which include the 80/20 PPO Plan, the 70/30 PPO Plan and the HDHP Plan which are described in detail on the Plan’s web site: <https://www.shpnc.org/2019-employee-benefits>. These plan designs include, but are not limited to, the following requirements:
 - 1) Ability to apply a copay and a deductible to the same service.
 - 2) Ability to reduce a copay when the Member visits the Primary Care Provider (PCP) listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 16, Primary Care Provider Incentive Program for more information on PCP copay reductions.
 - 3) Ability to integrate deductible and/or out-of-pocket (OOP) accumulators with the Plan’s PBM to support a combined Medical/Rx deductible and OOP maximums.
 - 4) Ability to waive the ER copay when the Member is admitted for an inpatient stay and/or an observation stay.
 - 5) Ability to apply a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
 - a) PCP.
 - b) Specialist.
 - c) Urgent Care.
 - d) Emergency Room (ER).
 - e) Physical Therapy.
 - f) Occupational Therapy.
 - g) Speech and Hearing Therapy.
 - h) Acupuncture.
 - i) Outpatient Behavioral Health.
 - j) Per Inpatient Confinement.
- ii. Vendor will ensure all Products and Plan Designs are compliant with all federal regulations, including the PPACA.
- iii. Vendor will administer all benefits as required by Article 3B of Chapter 135 of the North Carolina General Statutes and as may be amended from time to time.

- iv. Vendor will administer benefits in accordance with all Federal and State requirements.
- v. Vendor will partner with the Plan to design custom benefits and/or plan design features, as requested by the Plan and provide associated financial/actuarial impact analysis.
- vi. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.
- vii. The Vendor shall describe any limitations or issues with meeting the requirements described in a.i.- vi. above.

b. The Plan prefers a Vendor that can configure up to four benefit (coinsurance) levels per PPO Plan as follows:

- **Tier 1 network benefit: Highest coinsurance level for preferred in-network providers.**
- **Tier 2 network benefit: Second highest coinsurance level for non-preferred in-network providers.**
- **Out-of-Area (OOA) provider benefit: Third highest coinsurance level for areas where there is no network provider available to the Member for the particular service.**
- **Non-network provider benefit: Lowest benefits for non-network providers.**

Example:

Tier 1 Provider: No deductible / 100% coinsurance

Tier 2 Provider: \$500 deductible / 80% coinsurance

OOA Provider: \$500 deductible / 70% coinsurance

Non-network Provider: \$1000 deductible / 50% coinsurance

The Vendor shall confirm that it will, upon request, support the following:

- i. A four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an OOA benefit, and a non-network benefit.
- ii. A three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.
- iii. A three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.
- iv. The Vendor shall describe any limitations or issues with meeting the requirements described in b.i -iii. above.

c. The Plan requires a Vendor that will provide innovative Plan Designs and programs including Plan Designs integrated with incentives.

The Vendor shall confirm and describe that it will, upon request, support each of the following plan design features:

- i. Set cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.
- ii. Customize Vendor's current value-based and incentive Plan Design features and/or implement new, customized ones for the Plan.
- iii. Integrate with other Plan vendors to deliver value-based and/or incentive benefits.
- iv. Set benefit limits by any age.
- v. Set benefit limits by place of service.
- vi. Set benefit limits by frequency of service.

- vii. Set benefit limits by facility type.
- viii. Set benefit limits by per-diem maximums.
- ix. Set benefit limits by confinement.
- x. Set benefit limits by episode of care.
- xi. Set benefit limits by DRG.
- xii. Set provider copay by specialty type.
- xiii. Apply different coinsurance and/or deductible for specialty pharmacy claims.
- xiv. Apply a copay on a service with a coinsurance other than 100%.
- xv. Include or exclude copays in the out-of-pocket calculation.
- xvi. Track an individual and family OOP maximum.
- xvii. Include deductible carry-forward.
- xviii. Exclude deductible carry-forward.
- xix. Set non-network coinsurance at any percentage.
- xx. Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.
- xxi. The Vendor shall describe any limitations and/or issues with meeting requirements c.i. – xx. above.

The Vendor shall describe each of the following:

- xxii. Current value-based plan design elements available in Vendor's current product suite with projected or actual cost/savings on a PMPY basis. Include in the description willingness to put performance guarantees around these elements.
- xxiii. How incentives have been successfully woven into current products and/or plan designs with projected or actual cost/savings on PMPY basis. Include in the description the willingness to put performance guarantees around these elements.
- xxiv. Any reference-based pricing initiatives in North Carolina and nationally that could or would be in place during the term of the Contract.

d. The Plan prefers a Vendor that offers a full-service health reimbursement account (HRA).

The Vendor shall confirm and describe that, upon request, it will implement an HRA for Plan Members with the following features:

- i. HRA annual balances based on the number of family members enrolled. Example:
 - 1) Subscriber only = \$600 starting balance.
 - 2) Subscriber + one (1) dependent = \$1200 starting balance.
 - 3) Subscriber + two (2) or more dependents = \$1800 starting balance.
- ii. Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.3 Include in the description a copy of the integration workflow between the medical claims processing systems and the HRA processing system.

- iii. Proration that reduces the starting HRA amount for Members who enroll after the beginning of the benefit year.
 - iv. Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.
 - v. Ability to accept and appropriately apply HRA rollover funds from the prior TPA into Members' HRAs.
 - vi. Automatic claims reimbursement functionality from the HRA.
 - vii. Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.
 - viii. Annual HRA rollover functionality.
 - ix. Ability to customize the HRA Member portal, as requested by the Plan.
 - x. Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.
 - xi. HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.
 - xii. Ability to support "split-families" where one or more of the family members are not eligible for the HRA because he or she is Medicare Primary. Example: Medicare Primary Subscriber is enrolled in the 70/30 Plan and the spouse and Dependent Child are enrolled in the HRA PPO.
 - xiii. HRA Debit Card.
 - xiv. Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.
 - xv. Ability to provide an HRA on a copay based plan like the 80/20 PPO.
 - xvi. Ability to customize HRA reports, as requested by the Plan.
 - xvii. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. - xvi. above.
- e. **The Plan prefers a Vendor that offers Health Savings Accounts (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.**

The Vendor shall confirm and describe that it will, upon request:

- i. Provide HSAs for Members enrolled in an HDHP.
- ii. Provide HSA banking services to support funding by the Plan.
- iii. Support custom funding reconciliation services, as requested by the Plan.
- iv. Support integration with an HSA administrator other than the one offered by the Vendor.
- v. Customize the HSA Member portal, as requested by the Plan.
- vi. Customize any HSA Member materials, including letters, as requested by the Plan.
- vii. Provide HSA debit cards that can be customized with the Plan's logo.

- viii. Provide HSA checking accounts.
- ix. Provide welcome kits to Members when they initially enroll in an HSA.
- x. Describe any limitations and/or issues with meeting requirements e.i.-ix. above.

The Vendor shall provide each of the following:

- xi. Description of all the services provided under HSA banking.
- xii. List of banks available to Members for HSA accounts.
- xiii. Process flow for initial Member HSA bank account set-up.
- xiv. Process flow for updating banks with ongoing Member enrollment and demographic changes.
- xv. Process flow for Plan deposits into Members' HSA bank accounts.
- xvi. Sample reports available to the Plan to manage banking services.
- xvii. Timeline for implementing HSA banking services.
- xviii. Resources available to the Members to help set up HSA bank accounts if the Plan does not fund the HSA account.

f. The Plan prefers a Vendor who integrates Telehealth into the standard plan designs.

The Vendor shall describe the following:

- i. Telehealth benefit options available to the Plan.

g. The Plan prefers a Vendor that can offer unique products for Medicare Primary Members.

The Vendor shall confirm and describe the following:

- i. Vendor will provide a self-funded Group Medicare Supplement Plan as requested by the Plan.
- ii. The Vendor shall describe any limitations and/or issues with meeting requirement g.i. above.

h. The Plan requires a Vendor that can partner with the Plan on benefit development that includes an annual benefit development life cycle that begins about eighteen (18) to twenty-four (24) months prior to the effective date but may not be finalized until close to the effective date.

The Vendor shall confirm and describe:

- i. The Vendor will partner with the Plan as early as twenty-four (24) months prior to the effective date to develop new benefits.
- ii. The Vendor will preview Vendor's new benefit features, plan design features, and/or products at least nine (9) months prior to rollout.
- iii. The Vendor will work with the Plan to implement benefits that may not be finalized and/or approved until close to the effective date. While it is the Plan's preference to have all benefits approved by the Board more than six (6) months in advance, there are dependencies, such as final budget approval by the NC General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.
- iv. The Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iii. above.

5.2.12 Claims Processing and Appeals

5.2.12.1 Overview and Expectations

The Plan seeks a Vendor with an efficient business rules-based claims system that can support required state, federal, and other custom benefits. The Vendor shall also provide tools that detect and prevent the payment of duplicate, excluded, and/or fraudulent claims as well as identify and properly bundle claims that should be included with other services. The Plan requires a Vendor with strong performance measures and operational teams that consistently strive to achieve superior results. The Vendor must be able to administer medical and pharmacy claims appeals as required by Chapters 58 and 135 of the North Carolina General Statutes and federal law. The Vendor should be able to implement processes for all financial transactions that are compliant with State banking requirements and provide timely documentation and reporting to support the Plan's financial reporting. As such, the Plan may have unique limitations or special requirements around funding claims and adjustments.

[Note: See Section 5.2.3 "Finance and Banking" for more details].

Objectives

- a. Ensure claims are processed in accordance with federal and state regulations as well as the Plan's specific benefit rules. Refer to benefit summaries and benefit booklets available at the following link: <https://www.shpnc.org/2020-benefit-information>.
- b. Partner with a Vendor that can configure and, if necessary, enhance its claims system to support innovative plan designs and benefits.
- c. Minimize "pay and pursue" claims recovery by selecting a Vendor that strives to prevent erroneous claims payment by focusing on robust pre-edits that seek to prevent duplicate, excluded, fraudulent, and improperly bundled claims payment.
- d. Ensure the Plan's Medicare eligible claims are processed in accordance with Plan rules and federal requirements.
- e. Promote efficiency by selecting a Vendor with state-of-the-art business tools, processes, and Services.
- f. Ensure all applicable policies and regulations of the Office of State Controller and Department of State Treasurer are supported.

5.2.12.2 Services

- a. **The Plan requires a Vendor that can provide the following claims services.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will administer claims in accordance with the terms outlined in the 70/30 PPO Plan, 80/20 PPO Plan, and HDHP PPO Plan Benefit Booklets found at the following link: <https://www.shpnc.org/2020-benefit-information>.
- ii. Vendor will configure and, if necessary, enhance its claims system to support innovative plan designs and benefits.
- iii. As required by N.C.G.S. § 90-414.4, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. Vendor must deny any claims received from providers that are not in compliance on the date of service.
- iv. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
- v. Vendor will process claims according to restrictions in age, diagnosis, procedure code, revenue code, modifier, provider classification, provider network restriction, or place of service.
- vi. Vendor will maintain and make accessible to the Plan at least ten (10) years of claims history.

- vii. Vendor will generate appropriate letters and notifications, and will customize them as requested by the Plan.
- viii. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add additional edits at the Plan's request.
- ix. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – viii. above.

b. The Plan prefers a Vendor that can perform the following claims services.

The Vendor shall confirm and describe each of the following:

- i. Upon request, Vendor will pay all claims, including non-network claims based on assignment of benefits.
- ii. Vendor will provide a weekly summary of any claims totaling $\geq \$100,000.00$ to the Plan's Contract Administrator for day to day activities. The summary shall include the total charge, total allowed amount, Member cost share, and a short description of circumstance of the claim, including a status of the Member's condition.
- iii. Vendor will attempt to negotiate a lower rate for any out-of-network claims $\geq \$5,000$, even in scenarios where the Plan allows for the payment of billed charges for emergent, medically necessary care.
- iv. Describe any limitations and/or issues with meeting requirements b.i. – iii. above.

The Vendor shall describe each of the following:

- v. The claims processing platform, including development (i.e., purchased or developed internally), recent enhancements, planned enhancements, and operating requirements. Include any planned platform change and timeline for implementation.
- vi. The claims workflow from receipt to final processing.
- vii. The methodology and tools used to support pre-edits or pre-release claims reviews that avoid "pay and chase" and the savings associated with these edits or processes.

c. The Plan requires a Vendor that can support the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM.

The Vendor shall confirm and describe each of the following:

- i. Vendor will support the Plan's appeals process required by Chapters 58 and 135 of the North Carolina General Statutes. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.
- ii. Vendor will support the Plan's pharmacy appeals with customized reporting.
- iii. Vendor will produce custom appeals letters.
- iv. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's office, as appropriate, throughout the appeals process. When necessary, Vendor's subject matter experts will be required to testify during hearings.
- v. Describe any limitations and/or issues with meeting requirements c.i. – iv. above.

The Vendor shall describe each of the following:

- vi. Appeals process for Vendor's current book of business.

vii. Changes that will be required to meet the Plan's statutory requirements.

The Vendor shall provide the following:

viii. A sample of a level one and level two claims appeal letter for the Vendor's current book of business.

d. The Plan requires a Vendor that can provide the following Medicare claims services.

The Vendor shall confirm and describe each of the following:

- i. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.
- ii. Vendor will process claims when Medicare is primary. Include in the description the process the Vendor will use to ensure that Medicare primary Members' claims are not inappropriately paid as State Health Plan primary.
- iii. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 17, Claims Processing Phantom Plan - Medicare Part B for more information on Phantom Processing.
- iv. Vendor will accurately display the processing of these claims on an EOB. Provide a sample of an EOB with claims that have been coordinated with Medicare.
- v. Vendor will support the Plan's PBM by sharing information about Members with Phantom B processing.
- vi. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – v. above.

The Vendor shall provide each of the following:

- vii. The top five (5) clients, by size (total Members), currently utilizing Medicare direct services and the number of Medicare primary members in each client's plan.
- viii. Auto-adjudication rate of Medicare crossover claims.
- ix. Current process for confirming Medicare primary status.

e. The Plan requires a Vendor that can perform coordination of benefits (COB) services.

The Vendor shall confirm each of the following:

- i. Vendor will support the Plan's COB rules as outlined in the Plan's Benefit Booklets found at the following link: <https://www.shpnc.org/2020-benefit-information>.
- ii. Vendor will coordinate benefits without credit reserve.
- iii. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-ii. above.

f. The Plan requires a Vendor that will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, disclosures, reporting, etc.).

The Vendor shall confirm each of the following:

- i. Vendor will support all applicable state laws including, but not limited to, those listed in N.C.G.S. § 135-48.51.

- ii. Vendor will support all applicable federal regulations, including, but not limited to, 42 CFR Part 2.
- iii. Vendor will support all future state and federal requirements.
- iv. Vendor shall describe any limitations and/or issues meeting requirements f.i.-iii. above.

The Vendor shall describe the following:

- v. The process for monitoring regulations that may impact claims administration.
 - vi. Any subsequent implementation approach for new regulations.
- g. The Plan requires a Vendor that will ensure the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of the Vendor's action, inaction, or system failure.**

The Vendor shall confirm the following:

- i. The Plan will not be responsible for prompt-pay interest as a result of the Vendor's action, inaction, or system failure.
 - ii. Vendor shall describe any limitations and/or issues with meeting requirement g.i. above.
- h. The Plan seeks a Vendor that will provide EOBs to Members that meet Plan and Federal requirements and are presented in an easy to read and understandable format.**

Vendor shall confirm each of the following:

- i. Vendor will produce EOBs that meet all Federal requirements.
 - ii. Vendor will mail EOBs to Members.
 - iii. Vendor will prevent Subscribers from having access to dependent EOBs when the Subscriber does not have custodial rights.
 - iv. Vendor will customize EOBs with the Plan's logo and custom network and other information as illustrated in attached Sample EOB, Exhibit 14.
 - v. Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iv., above.
- i. The Plan prefers a Vendor that can perform the following EOB services.**

Vendor shall confirm each of the following:

- i. Vendor will mail EOBs to directly to Dependents eighteen years of age or older without a copy to the Subscriber.
- ii. Vendor will mail a Dependent's EOB to a different address, if a different address exists in the Dependent's demographic record.
- iii. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.
- iv. Vendor will provide an EOB via the secure Member portal.
- v. If applicable, Vendor will provide a single, combined Medical and Health Reimbursement Account (HRA) EOB. If available, provide sample.

- vi. Vendor will include communications developed by the Plan as “inserts” in the EOB envelop.
- vii. Vendor will display claim descriptions and details on EOBs using the level of detail, labels, and descriptions requested by the Plan.
- viii. Vendor shall describe any limitations and/or issues with meeting requirements i.i. – vii., above.

j. The Plan requires a Vendor that can support the Plan’s eighteen (18) month timely filing rules set forth in N.C.G.S. § 135-48.52(6).

The Vendor shall confirm each of the following:

- i. Vendor will support an eighteen (18) month claims run-out.
- ii. Vendor will recognize a new claims submission and reject it after the eighteen (18) month timely filing period.
- iii. Vendor shall describe any limitations and/or issues meeting requirements j.i. - ii., above.

The Vendor shall describe the following:

- iv. Time period allowed to providers, per the Vendor’s provider contracts, to submit initial claims and claims corrections.

k. The Plan seeks a Vendor with claims systems that can support primary care provider (PCP) “gate-keeper” rules, if requested.

The Vendor shall confirm and describe the following:

- i. Options available to apply PCP gate-keeper logic to claims.
- ii. Vendor shall describe any limitations and/or issues with meeting requirement k.i., above.

5.2.13 Audit

5.2.13.1 Overview and Expectations

The Plan seeks a Vendor that places great value on the accuracy of its deliverables. This Vendor must demonstrate a dedication to quality in all aspects of its operation, be willing to share internal and external accuracy and audit results, and collaborate with the Plan on quality initiatives. Furthermore, the Vendor must be open to audits by the Plan’s auditors as well as audits performed by and for the North Carolina Office of the State Auditor. The Plan expects the Vendor to be time sensitive to all audit requests and be prepared to support multiple audits simultaneously.

Audit Types

- Standard Audits are performed on an ongoing quarterly basis by the Plan’s auditors. These standard audits are used to measure claims accuracy, generally and associated with the Performance Guarantees (Section 6.3), and in preparing the State’s Comprehensive Annual Financial Report (CAFR). Note: Certain audits are conducted by a Certified Public Accountant firm and relied upon by the North Carolina Office of the State Auditor.
- Focused Audits and Comprehensive Electronic Audits are also performed on an as-needed basis at the Plan’s discretion throughout the Plan Year.
- State Audits. The North Carolina Office of the State Auditor may initiate an audit at any time pursuant to statutory authority (N.C.G.S. Chapter 147, Article 5A).