

3.5 PERFORMANCE OUTSIDE THE UNITED STATES

Vendor shall complete ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR. In addition to any other evaluation criteria identified in this RFP, the State may also consider, for purposes of evaluating proposed or actual contract performance outside of the United States, how that performance may affect the following factors to ensure that any award will be in the best interest of the State:

- a) Total cost to the State
- b) Level of quality provided by the Vendor
- c) Process and performance capability across multiple jurisdictions
- d) Protection of the State's information and intellectual property
- e) Availability of pertinent skills
- f) Ability to understand the State's business requirements and internal operational culture
- g) Particular risk factors such as the security of the State's information technology
- h) Relations with citizens and employees
- i) Contract enforcement jurisdictional issues

3.6 INTERPRETATION OF TERMS AND PHRASES

This Request for Proposal serves two functions: (1) to advise potential Vendors of the parameters of the solution being sought by the State; and (2) to provide (together with other specified documents) the terms of the Contract resulting from this procurement. As such, all terms in the Request for Proposal shall be enforceable as contract terms in accordance with Attachment C: North Carolina General Contract Terms and Conditions. The use of phrases "shall" and "must" create enforceable contract obligations. In determining whether proposals should be evaluated or rejected, the State will take into consideration the degree to which Vendors have proposed or failed to propose solutions that will satisfy the State's needs as described in the Request for Proposal. Except as specifically stated in the Request for Proposal, no one requirement shall automatically disqualify a Vendor from consideration. However, failure to comply with any single requirement may result in the State exercising its discretion to reject a proposal in its entirety.

4.0 REQUIREMENTS

This Section lists the requirements related to this RFP. By submitting a proposal, the Vendor agrees to meet all stated requirements in this Section as well as any other specifications, requirements, and terms and conditions stated in this RFP. If a Vendor is unclear about a requirement or specification or believes a change to a requirement would allow for the State to receive a better proposal, the Vendor is urged and cautioned to submit these items in the form of a question during the question and answer period in accordance with Section 2.5. Vendors must provide a response to Sections 4.6 and 4.10 in accordance with Section 2.7.2.b).

4.1 CONTRACT TERM

The Contract shall have an initial term of fifty-eight (58) months, including twenty-two (22) months for implementation, beginning March 1, 2020 through December 31, 2024. The Vendor shall begin providing services on January 1, 2022.

At the end of the Contract's current term, the State shall have the option, in its sole discretion, to extend the Contract on the same terms and conditions for up to two additional one-year terms beginning January 1, 2025 through December 31, 2025 and January 1, 2026 through December 31, 2026. The State will give the Vendor written notice of its intent to exercise each extension option no later than thirty (30) days before the end of the Contract's then-current term. In addition, the State reserves the right to extend a contract term for a period of up to 180 days in 90-day-or-less increments.

4.2 PRICING

Proposal price shall constitute the total cost to the State for complete performance in accordance with the requirements and specifications herein. Vendor shall not invoice for any amounts not specifically allowed for in this RFP. Vendor shall be responsible for all travel expenses, including travel mileage, meals, lodging, and other travel expenses incurred in the performance of this Contract. Complete ATTACHMENT A: PRICING FORM and include in Proposal.

4.3 INVOICES

4.3.1 Administrative Fees

- a) The Vendor shall submit a completed and signed "STATE OF NORTH CAROLINA SUBSTITUTE W-9 FORM, Request for Taxpayer Identification Number" to the Plan's Contracting Section within fifteen (15) days of execution of the Contract. This form can be accessed at the following link: <https://www.osc.nc.gov/vendor-resources>.
- b) The Vendor shall invoice the Plan for administrative fees for services rendered in accordance with the Scope of Work and provisions of this contract, and in compliance with the cost proposed in Attachment A.
- c) All invoices shall be submitted electronically to SHPNCFinance@nctreasurer.com to ensure timely receipt and payment.
- d) All invoices shall include an authorized signature and a certification stating "As an authorized representative of the Vendor, I hereby certify that the units and amounts billed to the North Carolina State Health Plan (Plan) on this invoice are accurate and true and comply with all laws, regulations, and contractual provisions that are conditions of payment pursuant to the relationship between the Vendor and the Plan."
- e) The Vendor shall submit an invoice by the 20th day of each month, unless another date is approved by the Plan, reflecting all billable administrative activity for the previous month.
- f) Any services invoiced on a Per Member Per Month (PMPM) or Per Subscriber Per Month (PSPM) basis shall be based on actual membership provided by the Plan's EES vendor. The membership report will be provided electronically to the Vendor by the Plan or the Plan's EES vendor by the 10th State Business day of the month. The Vendor agrees that membership is to be based on this membership report without exception.
- g) The Parties shall mutually agree to an invoicing and reimbursement schedule for any one-time fees charged in accordance with Attachment A, except the Plan shall not make payment for any one-time fees prior to the date services for the applicable component of the Scope of Work are fully implemented.
- h) The Plan, at its sole discretion, shall determine if the services on each invoice have been satisfactorily completed. The Plan may withhold payment for incomplete, unsatisfactory, or untimely deliverables.
- i) The Plan reserves the right to validate any invoice submitted for payment and shall have access to Vendor's or Subcontractors' supporting documentation necessary to validate the invoice.
- j) Payment of fees will be made within thirty (30) calendar days of receipt of the invoice, provided that the Plan has determined satisfactory completion of a particular service or deliverable. If the Plan determines an invoice contains an error, the Vendor shall be required to submit a corrected invoice, in which case payment shall be made within thirty (30) calendar days of receipt of the corrected invoice.
- k) The Vendor is responsible for any and all payments to Subcontractors.
- l) Payment of the invoice by the Plan does not constitute a waiver or otherwise prejudice the Plan's right to object to or question any invoice or matter in relation thereto. Such payment shall not be construed as acceptance of any party of the work or service provided or as an approval of any of the amount invoiced therein.

4.3.2 Claims and other Disbursements:

- a) The Vendor shall batch claims and/or other disbursements for payment from the Plan's bank account on a weekly basis according to the disbursement schedule established by the Plan.
- b) The Vendor shall submit a weekly reporting package of disbursements as required in Section 5.2.3 et seq., no later than 9:30 a.m. ET on the first State Business day of each week.
- c) The Vendor shall hold checks and processing of electronic funds transfers (EFTs) for all disbursements until funding is authorized and requisitioned by the Plan. The Plan shall notify the Vendor of funding availability no later than noon on the second State Business day of each week.

- d) The Plan reserves the right to validate any reporting package of disbursements submitted for funding and shall have access to the Vendor's or Subcontractors' supporting documentation as necessary to validate the funding request.
- e) Funding of weekly disbursements by the Plan shall not constitute a waiver or otherwise prejudice the Plan's right to object to or question any disbursement or matter in relation thereto. Such funding shall not be construed as acceptance of any part of the work or service provided or as an approval of any of the amount funded therein.

4.4 PAYMENT TERMS

The Vendor will be compensated at the rates quoted in the Vendor's Cost Proposal.

4.5 FINANCIAL STABILITY

Each Vendor shall certify it is financially stable by completing ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION. The State is requiring this certification to minimize potential issues from Contracting with a Vendor that is financially unstable. From the date of the Certification to the expiration of the Contract, the Vendor shall notify the State within thirty (30) days of any occurrence or condition that materially alters the truth of any statement made in this Certification.

4.6 REFERENCES

Vendors shall provide at least three (3) references for which they have provided Services of similar size and scope to those proposed herein. The State may contact these users to determine whether the Services provided were substantially similar in scope to those proposed herein and whether the Vendor's performance has been satisfactory. The information obtained may be considered in the evaluation of the proposal.

COMPANY NAME	CONTACT NAME	TELEPHONE NUMBER

4.7 BACKGROUND CHECKS

Vendor and its personnel are required to provide or undergo background checks at Vendor's expense prior to beginning work with the State. As part of this process, the details below must be provided to the State:

- a) Any **criminal felony conviction**, or conviction of any crime involving moral turpitude, including, but not limited to fraud, misappropriation or deception, of Vendor, its officers or directors, or any of its employees or other personnel to provide Services on this project, of which Vendor has knowledge or a statement that it is aware of none;
- b) Any **criminal investigation** for any felony or offense involving moral turpitude, including, but not limited to fraud, misappropriation, falsification or deception pending against Vendor, its officers or directors, or any of its employees or other personnel to provide Services on this project, of which Vendor has knowledge or a statement it is aware of none;
- c) Any **regulatory sanctions** levied against Vendor or any of its officers, directors or its professional employees expected to provide Services on this project by any state or federal regulatory agencies within the past three years or a statement that there are none. As used herein, the term "regulatory sanctions" includes the revocation or suspension of any license or certification, the levying of any monetary penalties or fines, and the issuance of any written warnings;

- d) Any **regulatory investigations** pending against Vendor or any of its officers, directors or its professional employees expected to provide Services on this project by any state or federal regulatory agencies of which Vendor has knowledge or a statement that there are none.
- e) Any **civil litigation**, arbitration, proceeding, or judgments pending against Vendor during the three (3) years preceding submission of its proposal herein or a statement that there are none.

Vendor's responses to these requests shall be considered to be continuing representations, and Vendor's failure to notify the State within thirty (30) days of any criminal litigation, investigation, or proceeding involving Vendor or its then current officers, directors, or persons providing Services under this Contract during its term shall constitute a material breach of contract. The provisions of this paragraph shall also apply to any Subcontractor utilized by Vendor to perform Services under this Contract.

4.8 PERSONNEL

Vendor shall not substitute key personnel assigned to the performance of this Contract without prior written approval by the Plan's Contract Administrator regarding day-to-day activities. Vendor shall notify the Plan's Contract Administrator regarding day-to-day activities of any desired substitution, including the name(s) and references of Vendor's recommended substitute personnel. The State will approve or disapprove the requested substitution in a timely manner. The State may, in its sole discretion, terminate the services of any person providing services under this Contract. Upon such termination, the State may request acceptable substitute personnel or terminate the contract services provided by such personnel.

4.9 VENDOR'S REPRESENTATIONS

- a) Vendor warrants that qualified personnel shall provide Services under this Contract in a professional manner. "Professional manner" means that the personnel performing the Services will possess the skill and competence consistent with the prevailing business standards in the industry. Vendor agrees that it will not enter any agreement with a third party that may abridge any rights of the State under this Contract. Vendor will serve as the prime vendor under this Contract and shall be responsible for the performance and payment of all Subcontractor(s) that may be approved by the State. Names of any third-party vendors or Subcontractors of Vendor may appear for purposes of convenience in Contract documents; and shall not limit Vendor's obligations hereunder. Vendor will retain executive representation for functional and technical expertise as needed in order to incorporate any work by third party Subcontractor(s).
- b) If any Services, deliverables, functions, or responsibilities not specifically described in this Contract are required for Vendor's proper performance, provision and delivery of the service and deliverables under this Contract, or are an inherent part of or necessary sub-task included within such service, they will be deemed to be implied by and included within the scope of the Contract to the same extent and in the same manner as if specifically described in the Contract. Unless otherwise expressly provided herein, Vendor will furnish all of its own necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies, and materials necessary for the Vendor to provide and deliver the Services and Deliverables.
- c) Vendor warrants that it has the financial capacity to perform and to continue perform its obligations under the Contract; that Vendor has no constructive or actual knowledge of an actual or potential legal proceeding being brought against Vendor that could materially adversely affect performance of this Contract; and that entering into this Contract is not prohibited by any contract, or order by any court of competent jurisdiction.

Continued on next page.

4.10 ADMINISTRATORS FOR THE CONTRACT AND HIPAA PRIVACY OFFICER

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

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

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

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

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

Sharon Smith
Manager of Contracting and Compliance
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, NC 27604
Phone (919) 814-4432
Email: Sharon.Smith@nctreasurer.com

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

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

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

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

Name: _____
 Title: _____
 Agency: _____
 Address: _____

 Phone: _____
 Email: _____

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

Name: _____
 Title: _____
 Agency: _____
 Address: _____

 Phone: _____
 Email: _____

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

Name: _____
 Title: _____
 Agency: _____
 Address: _____

 Phone: _____
 Email: _____

4.11 CONFIDENTIALITY AND PROTECTION OF PROPRIETARY INFORMATION

Pursuant to N.C.G.S. §§ 135-48.10, 132-1.2, 132-1.10, and 75-65 and in accordance with other applicable state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), the Vendor shall maintain the confidentiality of all Plan Member information, in whatever form, and however it is obtained. The Vendor further agrees that if it receives, stores, processes, has access to, maintains, or otherwise deals with "patient identifying information" or "records" as defined in 42 C.F.R. § 2.11 from a substance use disorder "program," as defined in 42 C.F.R. § 2.11, that is federally assisted in a manner described in 42 C.F.R. § 2.12(b), then it is fully bound by the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, with respect to such information and records, including but not limited to the provisions related to use, disclosure and re-disclosure thereof. For any security breach by the Vendor or its Subcontractors or agents as described in Article 2A of Chapter 75 of the North Carolina General Statutes, the Plan has a right to require the Vendor to provide notice required by N.C.G.S. § 75-65 and to offer credit monitoring for affected Members, all at Vendor's sole expense.

a) Confidentiality Agreements

Within ten (10) calendar days of the Contract execution date, the Vendor must begin the process of executing Confidentiality Agreements with Plan vendors as determined by the Plan. The Vendor must complete the execution of Confidentiality Agreements within forty-five (45) calendar days of the Contract execution date. The Plan will provide the Vendor with contact information for these Plan vendors upon announcement of the winning Vendor.

4.12 ADMINISTRATIVE DECISION MEMOS (ADM)

Administrative Decision Memos (ADM) will be used to document processes or initiate changes related to the performance of this Contract. The Plan will initiate the ADM for response by the Vendor. If requested by the Plan, the Vendor shall submit an ADM after consulting with the Plan for approval. Upon written approval by the Plan's Contract Administrator regarding day-to-day activities, the ADM will be incorporated into the Contract. Updates and revisions to an ADM shall follow this procedure.

4.13 CONTRACT DOCUMENTS

The Contract consists of the following documents, incorporated herein by reference:

- a) The Addenda to this RFP, if any; and
- b) This RFP, which includes all Exhibits, Attachments, and Appendices; and
- c) The Vendor's Minimum Requirements Proposal including clarifications and supplemental documentation;
- d) The Vendor's Technical and Cost Proposal including clarifications, supplemental documentation, and written information from oral presentations; and,
- e) Any ADM, Business Requirements Document (BRD), or Implementation Plans (developed or modified as described in Attachment C. 24. Amendments).

4.14 DATA OWNERSHIP

The Vendor understands and agrees that all data and documents provided by the Plan or by Plan vendors are and shall be owned by the Plan or its vendors and shall be used by the Vendor solely for the purposes described in this Contract. Under no circumstances shall the Vendor share the data with any other entity without the Plan's prior written authorization except as otherwise authorized by this Contract.

4.15 CONFLICT OF INTEREST

By signing the Execution Page, Vendor certifies that it shall not take any action or acquire any interest, either directly or indirectly, that will conflict in any manner or degree with the performance of its services during the term of the Contract.

The Vendor shall:

- a) Disclose any relationship to any business or associate with whom the Vendor is currently doing business that creates or may give the appearance of a Conflict of Interest related to this RFP.
- b) Disclose prior to employment or engagement by the Vendor, any firm principal, staff member or subcontractor, known by the Vendor to have a Conflict of Interest or potential Conflict of Interest related to this RFP.
- c) Disclose any affiliation, business relationship or other association with any Plan vendor. A full list of Plan vendors is available at https://shp.nctreasurer.com/AboutSHP/oversight/Pages/SHP_contracted_vendors.aspx.
- d) Provide written notice to the Plan of any actual or imminent legal matters or regulatory compliance actions involving the Vendor and federal, state, or local government entities. Without limitation, notice shall be provided for investigations and legal actions or matters subject to arbitration involving the Vendor and/or its subcontractors, including key management or executive staff, or any major stakeholder (five percent (5%) or more), brought by a

government agency (federal or state) on matters relating to payments from government entities. In providing the notice, the Vendor shall provide the date of initiation, the subject matter, and the parties to the matter, and the resolution if resolved at the time of the notice. Notice must include settlement agreements or corporate integrity agreements, unless otherwise confidential.

- e) Specify any lawsuits or regulatory compliance actions with which the Vendor has been involved within the past five (5) years. If any, please provide a detailed explanation.
- f) Notify the Plan in writing within fifteen (15) calendar days of any material changes in disclosures or certifications made under this section for the duration of the contract.

4.16 VENDOR'S REPRESENTATIVE

The Vendor shall:

- a) Provide to the Plan in Attachment J: Minimum Requirements Submission Information a list of individuals with authority to bind the firm in connection with this Contract, including answering questions, providing clarifications concerning the Vendor's proposal, and executing future contractual documents.
- b) Notify the Plan in writing within fifteen (15) calendar days of any changes in those individuals identified as having authority to bind the firm.

4.17 DEBARRED, SUSPENDED OR EXCLUDED VENDORS

The Vendor shall:

- a) Notify the Plan in writing within fifteen (15) calendar days if any of its principals, Subcontractors or Subcontractors' principals become debarred, suspended, or in any way excluded from State or Federal procurements as reported to the System for Award Management (SAM) or appears as an excluded provider on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
- b) If information contrary to this certification or notification subsequently becomes available, such evidence may be grounds for non-award, or breach of contract should the Vendor be a recipient of the contract award.

4.18 REGISTRATION AND CERTIFICATION

The Vendor shall comply with the following:

- a) As a condition of contract award, any Vendor that is a corporation, limited-liability company, or limited-liability partnership shall have received, and shall maintain throughout the term of the Contract, a Certificate of Authority to Transact Business in North Carolina from the North Carolina Secretary of State, as required by North Carolina law.
- b) Vendor shall notify the Plan in writing within fifteen (15) calendar days of any changes in certifications made in response to this RFP for the duration of the Contract.

4.19 TRANSITION OF CONTRACT SERVICES AND RELATED ACTIVITIES

The Vendor shall:

- a) Upon award of the Contract, cooperate fully with the incumbent, as required by the Plan, in the transition of contract services and related activities.
- b) Upon expiration or termination of the Contract, cooperate fully in the transition of contract services and related activities to the successor TPA vendor or other vendors for a period up to eighteen (18) months which includes, but is not limited to sending Data Files during the testing and transition phase, as requested by the Plan and formalized in the Implementation Plan with the new TPA vendor.
- c) During the 18-month runout of the Contract, continue the services required to support claims processing which include, but are not limited to claims processing, eligibility, customer service, appeals and grievances, Medical Management, escheats, and recoveries.

4.20 PERFORMANCE GUARANTEES

By signing the Execution Page, Vendor certifies its agreement to adhere to the Performance Guarantees in Section 6.3.

5.0 TECHNICAL & COST PROPOSAL REQUIREMENTS & SPECIFICATIONS

5.1 MINIMUM REQUIREMENTS:

This procurement is open to qualifying Vendors that satisfy the Minimum Requirements described in this section. Vendors must meet all Minimum Requirements for technical responses to be evaluated for possible Contract award. The Plan reserves the right to reject proposals deemed incomplete or non-compliant with these Minimum Requirements.

Vendors shall duplicate the Minimum Requirements Table below and provide the page number reference to the location within the Vendor's proposal where the minimum requirement has been satisfied.

Vendors shall respond to all questions and confirmation/certification/description requests that are described herein in their Minimum Requirements response using the same RFP numbering sequence. Vendors are cautioned to provide sufficient detail for the Plan to validate their responses.

TPA MINIMUM REQUIREMENTS TABLE

	Requirement	RFP Section Number and Page Number of Response
1	Vendor must agree to a carve-out of Pharmacy Benefit Manager (PBM) services.	
2	Vendor must have worked with at least one (1) public or private client with more than one hundred thousand (100,000) covered lives for whom the Vendor provided services. Provide documentation to support experience requirement.	
3	Vendor must have experience managing split contracts where members of the same family (contract) can be enrolled in different Products or Plan designs. (Example: one (1) or more member(s) of the family is enrolled in a Medicare Primary 70/30 Plan and other family members are enrolled in the 80/20 Plan.) Provide documentation to support experience requirement.	
4	Vendor must exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and Board of Trustees.	
5	Vendor must comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan, and confirm agreement that all premium receipts and other moneys belonging to the Plan that are collected or received by the Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan. Provide documentation that supports the Vendor's understanding of the requirement and ability to comply.	
6	Vendor must comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website: https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf . Vendor shall provide documentation that supports the Vendor's understanding of the requirement and ability to comply.	
7	If Vendor will be disbursing funds from Plan bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and electronic funds transfers (EFT) for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least thirty (30) days prior to January 1, 2022.	

	If Vendor will not be disbursing funds from the Plan bank accounts, the Vendor should insert N/A in the last column.	
8	Vendor must agree to manage the part of the network that is "owned" by the Plan. Management may include handling provider credentialing, provider maintenance, and providing a provider search tool that integrates the Plan's network with the Vendor's network, needed to support Plan Members that reside in North Carolina and throughout the United States.	
9	Vendor must be able to support the Plan's Group Billing requirements as described in Section 5.2.8. Vendor shall provide documentation that supports the Vendor's understanding of the requirement and the ability to comply.	
10	<p>Vendor must demonstrate financial stability. Vendor shall provide audited or reviewed financial statements prepared by an independent Certified Public Accountant (CPA) for the two (2) most recent fiscal years that shall include, at a minimum, a balance sheet, income statement (i.e., profit/loss statement), and cash flow statement and, if the most recent audited or reviewed financial statement was prepared more than six (6) months prior to the issuance of this RFP, the Vendor shall also submit its most recent internal financial statements (balance sheet, income statement, and cash flow statement or budget), with entries reflecting revenues and expenditures from the date of the audited or reviewed financial statement, to the end of the most recent financial reporting period (i.e., the quarter or month preceding the issuance date of this RFP). Vendor is encouraged to explain any negative financial information in its financial statement and is encouraged to provide documentation supporting those explanations.</p> <p>Consolidated financial statement of the Vendor's parent or related corporation/business entity shall not be considered, unless: 1) the Vendor's actual financial performance for the designated period is separately identified in and/or attached to the consolidated statements; 2) the parent or related corporation/business entity provides the State with a document wherein the parent or related corporation/business entity will be financially responsible for the Vendor's performance of the contract and the consolidated statement demonstrates the parent or related corporation's/business entity's financial ability to perform the contract, financial stability, and/or such other financial considerations identified in the evaluation criteria; and/or 3) Vendor provides its own internally prepared financial statements and such other evidence of its own financial stability identified above.</p>	
11	<p>Vendor shall certify, without exception:</p> <ol style="list-style-type: none"> The sufficiency of its security standards, tools, technologies, and procedures in providing Services under this Contract. That any Cloud Infrastructure as Service (IaaS), Platform as a Service (PaaS), and Software as a Service (SaaS) solutions system(s) used to provide the Services under this Contract and that contain Plan Data has, and will maintain, a third party security assertion with a favorable opinion for the proposed system that is consistent with the data classification level and security controls appropriate for moderate information system(s) per the National Institute of Standards and Technology NIST 800-53 revision 4. The current and favorable third-party security assertions will be verified yearly, and the Vendor will be required to provide an updated report or a bridge letter verifying that the system environment and functions have not changed since the last Security Assertion report was produced (bridge letter option only valid for two years after full third-party assessment). It is the Plan's preference for the Vendor to provide a full SOC2, Type 2 security assessment report. If the Vendor maintains that any information contained in such report is proprietary or otherwise confidential, the Vendor shall redact these portions of the report, and supply the un-redacted portions for review. Alternatively, the Vendor may submit any of the following for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). All component names and types shall be clearly defined and outlined. 	

	<ol style="list-style-type: none"> 1. The Opinion Letter from the third party that performed the assessment stating that the SOC2, Type 2 report shows a favorable opinion; or 2. A signed letter from the Vendor's highest ranking officer attesting that the Vendor has passed as SOC2, Type 2 security assessment within the last year with a favorable opinion; or 3. A SOC3 showing that the Vendor maintained effective controls over its systems for the last year. <p>iv. A third-party SOC2, Type 2 security assessment report is preferred, but assessment reports performed under other security frameworks will be considered as a substitute as long as the security controls can be cross-walked to the appropriate NIST-800-53 security control requirements (e.g. ISO 27001, HITRUST). The State reserves the right to independently evaluate, audit, and verify such requirements, including requesting the performance of a penetration test with satisfactory results. The Vendor shall include the full version of any substitute third party assessment report(s) as part of its submission. If the Vendor maintains that any information contained in such report(s) is proprietary or otherwise confidential, the Vendor shall redact these portions of the report, and supply the un-redacted portions for review. The Vendor shall supply a third-party security assertion for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). The report shall clearly define the service type(s) included in the assertion.</p> <p>v. If the Vendor submits a substitute security framework, the State reserves the right to, based upon its evaluation, request that the Vendor provide a suitable amount of cyber breach liability insurance coverage and/or commit to obtaining a favorable SOC2, Type 2 security assessment within a specified time period as a condition of Contract award. The Vendor shall list the amount of cyber breach liability insurance that it currently carries for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). If the Vendor is currently undergoing a SOC2, Type 2 assessment, the Vendor shall list the expected date for completion.</p>	
12	Vendor must agree to Attachment C: North Carolina General Terms and Conditions without exception. Refer to Section 2.3.	
13	Vendor shall complete and submit, without exception, Attachment D: Location of Workers Utilized by Vendor.	
14	Vendor shall complete, sign and submit, without exception, Attachment E: Certification of Financial Condition	
15	Vendor shall complete, sign, and submit Attachment G: Business Associate Agreement (BAA).	
16	Vendor shall be HIPAA compliant; and shall complete, sign, and submit Attachment H: HIPAA Questionnaire and supply copies of and sign the Vendor's HIPAA privacy and security policies. If the Vendor maintains that any information contained in the HIPAA privacy and security policies is proprietary or otherwise confidential, the Vendor may redact these portions and supply the un-redacted portions for review.	
17	Vendor shall complete, sign and submit Attachment I: Nondisclosure Agreement.	
18	Vendor must complete, sign and submit Attachment J: Minimum Requirements Submission Information	

5.2 TECHNICAL PROPOSAL REQUIREMENTS AND SPECIFICATIONS

5.2.1 General

The Plan requires a Vendor with a robust suite of services, a dedication to quality, a commitment to providing a superior Customer Experience, and staff with the expertise to support the Plan's strategic goals. For consideration, each proposal must clearly demonstrate **all of the requirements** in this section. The Plan reserves the right to reject proposals deemed incomplete, non-responsive, or non-compliant with RFP requirements.

The Vendor shall respond to all questions and confirmation/certification/description requests that are described herein in its proposal response using the same RFP numbering sequence. The Plan is not interested in generalized responses. The nature of this RFP is detailed, and the Plan's expectation is to receive detailed and direct responses to all questions and confirmation/certification/description requests. The following directives are used throughout this RFP:

- **Provide** – The Plan's expectation is that the Vendor will provide a sample or copy of the requested material or information.
- **Describe** – The Plan's expectation is that the Vendor will provide a detailed narrative description of the requested information.
- **Confirm** – The Plan's expectation is that the Vendor will affirm a requirement by, at a minimum, inserting the word CONFIRM.
- **Limitations** – The Plan's expectation is that the Vendor will describe in detail any limitations impacting its ability to perform the applicable requirement(s) or specification(s). If limitations are not requested regarding a specific requirement or specification, or if the Vendor does not identify any limitations in response to a request, then the Vendor shall perform as described in the requirement or specification. Any limitations identified by the Vendor will be considered during scoring of the Vendor's proposal. Failure to agree to any requirement may result in disqualification of the Vendor's proposal.

5.2.2 Account Management

5.2.2.1 Overview and Expectations

The Plan seeks to partner with a Vendor that has the experience, knowledge, and resources to support all the services outlined in this RFP. The Vendor must be transparent when partnering with the Plan on initiatives or providing internal processes, data, or other information, as requested by the Plan. The Vendor must also show a willingness to develop custom networks, products, or processes to support the Plan. Finally, the Vendor must be responsive and have the resources to support Plan operations, implementations, and ongoing data needs. The Plan prefers a Vendor with resources in North Carolina. In this section, the Plan seeks to determine the level of experience, expertise, transparency, and in some cases, the specific resources, and the location of the resources, that will be utilized to support this Contract.

Objectives

- a. Ensure the Vendor will dedicate the appropriate leadership resources to support the Plan during implementation and on an ongoing basis.
- b. Partner with a Vendor that shares the Plan's desire to be transparent when it comes to provider contracting and provider data.
- c. Ensure the Vendor has the experience and systems required to support the Plan.

5.2.2.2 Experience

The Plan requires a Vendor with a history of providing third party administrative (TPA) services for claims processing and related services and custom client networks.

The Vendor shall provide each of the following:

- i. Description of the company, its operations and ownership.
 - ii. Description of any specific expertise in TPA services and how long the company has been providing TPA services.
 - iii. Description of the types of custom networks the Vendor has built for other clients.
 - iv. Description of the Vendor's experience administering plans which utilize networks built by an entity other than the Vendor (e.g., a custom network built by an employer).
 - v. Description of all processes and protocols involved with loading/building the custom network in the Vendor's claims system.
- a. The Plan requires a Vendor with a proven track record of providing TPA services to clients of similar size and complexity to the Plan.**

The Vendor shall confirm and describe each of the following:

- i. The existence of one or more current or former administrative services only (ASO) clients with more than 100,000 members.
 - ii. The existence of one or more current or former ASO clients with more than 25,000 Medicare Primary members.
 - iii. The existence of one or more current or former ASO clients with more than 100,000 lives for which Vendor has managed the client's custom network.
 - iv. The Vendor shall describe any limitations and/or issues with meeting requirements b.i. - iii., above.
- c. The Plan prefers a Vendor with a proven track record of supporting at least two (2) clients with more than 500,000 members.**
- i. The Vendor shall provide the number of ASO clients in each size category and the name of the two (2) largest clients in each category in the table provided below:

Table 1 ASO/TPA Clients

Number of Members	Number of Clients	Largest clients for this Size Category (complete box with names of at least two (2) clients and number of current members for these clients).
100,000 – 250,000		
250,001 – 500,000		
> 500,000		

5.2.2.3 Resources

- a. **The Plan requires a Vendor that is willing to dedicate resources to the Plan during implementation and on an ongoing basis.**

The Vendor shall provide each of the following:

- i. Organizational chart of key executives, operational leaders, and technical leaders who will support the Plan during implementation and on an on-going basis.
- ii. Short biography for each of the staff listed in the chart; clearly note the frequency the Plan will interact with each staff member.

- b. **The Plan requires certain resources be dedicated to the Plan and available to support the Plan on an ongoing basis.**

The Vendor shall confirm it will provide a dedicated resource for each of the following roles. If the staff member assigned to fill the role is already known, Vendor shall include a brief biography of the specific resource:

- i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.
- ii. **Member Services Manager** – Responsible for all customer service functions and reporting.
- iii. **Claims Services Manager** – Responsible for claims payments and recoveries.
- iv. **Enrollment, Group Set-Up, and Premium Billing Manager** – Responsible for all enrollment, enrollment files, premium billing, and reconciliation services.
- v. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment, Group Set-Up, and Premium Billing Manager.
- vi. **Data Manager** – Responsible for providing expertise in data analytics and modeling as well as coordinating data requests, data testing, and data exchanges, including any Data Files to Plan vendors, Plan Partners, and the Plan. If a different resource is needed to manage data exchanges than is needed to manage data analytics, modeling, and data requests, the Vendor shall provide information on both resources.
- vii. **Network Operations Manager** – Provides oversight and leadership of the implementation and maintenance of the Plan's custom network, the North Carolina State Health Plan Network. This includes implementing and updating the tools required to maintain the reimbursement rates and methodologies outlined in Exhibit 1, North Carolina State Health Plan Network Participation Agreement; Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, and any current or future alternative payment arrangements.
- viii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process.

While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed.

The Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:

- i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure

clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic objectives.

- ii. **Actuary** - Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating ROI in order to measure financial effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) as well as alternate payment models (Accountable Care Organizations, Clinically Integrated Networks, etc.). Will be required, upon request, to provide sufficient data and documentation to the Plan to independently verify calculations. The Actuary shall be a Fellow of the Society of Actuaries with a primary focus in Health Benefit Systems.
- iii. **Privacy Officer** - Responsible for ensuring compliance with all applicable laws and regulations, including, but not limited to, HIPAA, Patient Protection and Affordable Care Act (PPACA), and ERISA. Responsible for maintaining internal controls to protect PHI and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.
- iv. **Attorney** - Responsible for communicating program and policy updates to the Plan and coordinating as necessary with the Plan's internal counsel and staff. Responsible for promptly reviewing materials for the Vendor and providing appropriate, legally justifiable, feedback to the Plan. This person must be well-versed in Chapter 135 of the North Carolina General Statutes and the extent to which North Carolina Department of Insurance ("DOI") regulations apply to the Plan.

b. The Vendor shall describe any limitations and/or issues with meeting requirements b.- c. above.

c. The Plan prefers a Vendor with the resources named in 5.2.2.3.b. located in North Carolina.

The Vendor shall provide the following:

- i. City and state for each office where resources named in 5.2.2.3.b. will be primarily located.
- ii. City and state for each location that will provide support for the services included in this RFP (i.e., claims processing, customer services, medical management, data management, and implementation).
- iii. Approximate number and type of staff for each location.

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

The Vendor shall confirm and describe each of the following:

- i. Vendor will meet with the Plan within two (2) weeks of a new request or initiative and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan. Meeting topics could include, but would not be limited to, data requests, network and/or product development, pilots, and other initiatives.
- ii. Once a project or initiative is underway, Vendor will meet with the Plan within one (1) week of the request and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan.
- iii. Vendor will respond to Plan inquiries regarding legal, financial, or operational matters within forty-eight (48) hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.
- iv. Vendor will respond to Plan inquiries regarding customer and provider matters within twenty-four (24) hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.
- v. Upon request, Vendor will provide written documents outlining internal processes and procedures and, when requested by the Plan, agree to alter internal processes to meet the needs of the Plan.

- vi. Vendor will provide the Plan detailed information, including direct access to contracts, relating to current and proposed provider payment arrangements. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules.
- vii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.
- viii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. - vii., above.

5.2.3 Finance and Banking

5.2.3.1 Overview and Expectations

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

It is important to understand the billing and payment hierarchy of the Plan.

- **Premium billing** – Billed to and paid by the Employing Units with oversight from the Plan
- **Claims funding** – Billed to and funded by the Plan
- **Administrative Services Fees** – Billed to and paid by the Plan

Objectives

- a. 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.
- b. Ensure accurate and timely processing and reporting of premium collections and deposits and related transactions.
- c. Ensure accurate and timely processing and reporting of disbursements, including claims payments and related transactions.
- 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 and followed.

5.2.3.2 Services

- a. **The Plan requires a Vendor that can support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:**
 - State banking: <https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf>
 - Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
 - Escheats: <https://www.nccash.com/holder-information-and-reporting>
 - High level daily deposits and disbursements of state funds workflows: Exhibit 2

The Vendor shall confirm and describe each of the following:

- i. Vendor will comply with all State banking requirements, cash management policies, escheat regulations and any other related requirements for handling the Plan's financial transactions.
- ii. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.
- iii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer, if required.
- iv. Vendor will complete bank reconciliations for all disbursing accounts, if required.
- v. Vendor will complete the escheat process for warrants/checks generated by the Vendor and issued against the Plan's bank account(s) or against the Vendor's bank accounts as prescribed by State guidelines and regulations. Refer to Exhibit 3 for TPA Escheats Process.
- vi. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.
- vii. Vendor will provide access to up to three (3) years of historical premium billing and receipts and claims funding data.
- viii. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-vii., above.

The Vendor shall describe the process for each of the following:

- ix. Receiving and depositing, on a daily basis, premiums, refunds, and other receipts in the form of checks, automatic clearing house (ACH) drafts and wires in the Plan's bank account with the State Treasurer in accordance with N.C.G.S. § 147-77.
- x. Determining and notifying the Plan of funding requirements for claims and other disbursements and the submission of backup documentation.
- xi. Reviewing and issuing refunds as appropriate. Include turn-around time.
- xii. Handling and reporting of any type of returns on deposited receipts.
- xiii. Detecting, correcting, and reporting misapplied deposits and collections.
- xiv. Tracking, reporting, and collecting receivables including delinquent accounts.
- xv. Determining uncollectible accounts for debt write-off, including criteria.
- xvi. Tracking and reporting prepaid premiums.
- xvii. Tracking, handling, and reporting recoveries.
- xviii. Handling returned provider payments.

b. The Plan requires a Vendor with state-of-the-art business software and processes to conduct the activities and services within the scope of the Contract.**The Vendor shall confirm and describe each of the following:**

- i. The Vendor will provide electronic submission of deposit reports, disbursement funding requirements, and detailed back up documentation in support of all financial transactions.

- ii. The Vendor will provide electronic submission of invoices and back up documentation for administrative fees.
- iii. The 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. (e.g., One vendor submits premium payments on one file for multiple state agencies.)
- iv. The Vendor will provide historical check register detail and premium billing and receipts as well as claims funding data at the Plan level.
- v. The Vendor shall describe any limitations and/or issues with meeting requirements b.i. – iv., above.

The Vendor shall describe each of the following:

- vi. The integration between the premium billing, collection, claims processing, auditing, and recovery systems and financial reporting systems.
- vii. Number of years beyond three (3) years for which historical data is available, the level of detail, and reporting capabilities.

c. The Plan requires a Vendor that will ensure that all deposits and disbursements are accurate and that proper financial controls are in place.

The Vendor shall confirm and describe each of the following:

- i. The existence of an internal quality control program and audits that will ensure the accuracy of all financial reporting to the Plan.
- ii. The existence of a monthly reconciliation process for medical claims; all receipts including but not limited to regular deposits, ACHs/drafts, claims refunds, and recoveries; bank accounts including returned payments and nonsufficient funds (NSF).
- iii. The Vendor shall describe any limitations and/or issues with meeting requirement c.i.-ii., above.

The Vendor shall provide each of the following:

- iv. Accuracy standards and internal audit results relative to processing deposits and disbursements on behalf of ASO clients from each of the last two (2) years.
- v. A description of the internal quality control program and audits.
- vi. A description of the process for reconciling bank accounts.
- vii. A description of the process for reconciling claims payments and claims refunds.
- viii. A description of the process for reconciling premium receipts.
- ix. A description of the process for reconciling all deposits including regular deposits, ACHs/drafts, benefit/claim refunds, recoveries, etc.

d. The Plan requires a Vendor that can adhere to the requirements regarding weekly claims and other disbursements, daily deposits, and related financial processing and reporting. Refer to Exhibit 2 for Daily Deposits and Disbursements of State Funds Workflows.

The Vendor shall confirm and describe each of the following:

- i. For Vendors disbursing funds from Plan bank accounts, or requesting reimbursement from the Plan for checks and ACH transactions from the Vendor's bank accounts that have been cashed or accepted, the Vendor will batch claims for payment from the Plan's bank account on a weekly basis as determined by the Plan.
- ii. For Vendors disbursing funds from Plan bank accounts or requesting reimbursement from the Plan for checks and ACH transactions from the Vendor's bank accounts that have been cashed or accepted, the Vendor will issue any other disbursements, including refunds from the Plan's bank account on a weekly basis as determined by the Plan.
- iii. The Vendor will hold payment of weekly claims and other disbursements until funding is authorized and requisitioned by the Plan.
- iv. The Vendor will limit the aggregate dollar amount of claims paid each week if requested by the Plan to manage cash flow.
- v. The Vendor will deposit checks received into the Plan's bank account within twenty-four (24) hours of receipt to comply with the State's banking and cash management requirements.
- vi. The Vendor will provide a daily reporting package of deposited premiums and other receipts as required by the Plan (see reporting Section 5.2.16).
- vii. The Vendor will provide a weekly reporting package of claims and other disbursements as required by the Plan (see reporting Section 5.2.16).
- viii. The Vendor will customize the reporting of any deposits, disbursements, or other financial transactions as required by the Plan.
- ix. The Vendor will notify and report on all warrants/checks to be escheated prior to submitting state filings, and if required by the Plan, adhere to a prior approval process for escheats.
- x. The Vendor will recommend uncollectible accounts for write-off and adhere to a prior approval process.
- xi. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. – x., above.

The Vendor shall provide the following:

- xii. The Vendor's claims batching workflow.

e. The Plan requires a Vendor that will ensure financial and banking processes and reporting remain compliant over the term of the Contract.**The Vendor shall confirm and describe the following:**

- i. The Vendor will notify and consult with the Plan at least sixty (60) days in advance, or as soon as practicable, of any system or business process or system change as it relates to the handling, processing, or reporting of the Plan's financial transactions.
- ii. The Vendor will notify the Plan when any system outage, defect, or other issue impacts the ability to meet any of the requirements in this section of the RFP.
- iii. The Vendor shall describe any limitations and/or issues with meeting requirements e.i. – ii., above.

The Vendor shall provide:

- iii. A SOC 1, Type II, which reports on controls at the service organization relevant to user entities financial statements including the design and operating effectiveness of controls (testing of controls and results). If applicable, a bridge letter should be provided to attest that to the best of management's knowledge, controls have not materially changed since the last audit opinion.

The Vendor shall confirm the following:

- iv. The Vendor will provide an annual SOC 1, Type II report upon request by the Plan.
 - v. The Vendor shall describe any limitations and/or issues with meeting requirements e.iv., above.
- f. The Plan requires a Vendor that will process ad hoc checks, such as settlement checks to Members, as requested by the Plan. The funding of these checks will be included as part of the weekly disbursement.**

The Vendor shall confirm and describe the following:

- i. The Vendor will process ad hoc checks to Plan Members and other entities, as requested by the Plan.
- ii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i., above.

5.2.4 Network Management**5.2.4.1 Overview and Expectations**

The Plan seeks a Vendor that will support its provider reimbursement strategy which is the focal point of the Clear Pricing Project. This project has been designed to provide affordable, quality care and increase transparency, predictability, and value for Plan Members. To accomplish these goals, the Plan has begun to build its own network of North Carolina providers, the North Carolina State Health Plan Network ("custom network"), with reimbursement rates that are referenced to Medicare rates. The Vendor must load the Plan's custom network in the Vendor's system(s), and process claims based on the reimbursement methodology developed by the Plan. See Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy. While the Plan will contract directly with some providers, the Vendor must be able to supplement the Plan's custom network with other providers to ensure access to care standards are met throughout the state and provide supplemental contracts for services such as reference labs, durable medical equipment, and other commodity services. The Vendor must be flexible in this regard, including being able to accommodate the transition of more providers to the custom network in the future.

The Vendor also must be able to supplement the Plan's custom network with a national wrap-around network of providers located outside of North Carolina, as the Plan has Members in every state. During the initial phase of the Clear Pricing Project, providers outside of North Carolina will not be required to accept the Medicare-based reimbursement methodology.

The Plan shall partner with a Vendor that will work with the Plan during the implementation of the custom network to develop processes, payment policies, and ongoing network maintenance, to ensure that the integrity and ongoing viability of the custom network is maintained.

While phase one of the Clear Pricing Project is the establishment of a provider network whose reimbursement rate is referenced to Traditional Medicare, it is the Plan's intent in the next phase to strategically layer alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation, into the provider contracts where appropriate. The Plan shall partner with a Vendor with a shared vision to customize and implement these strategies, as needed, to meet the Plan's goals. A 'one size fits all' methodology will not meet the needs of a state so geographically diverse as North Carolina.

Finally, the Plan recognizes that the health care landscape is constantly changing; therefore, the Plan also seeks to partner with a Vendor that has the flexibility to meet changing needs which may include a full-service network offered

by the Vendor or a narrow network offered by the Vendor or designed specifically for the Plan. The Plan intends to evaluate the full breadth of provider services offered by the Vendor.

Objectives:

- a. Partner with a Vendor who will support and supplement the Plan's custom network.
- b. Engage a Vendor that has systems and processes that will easily administer and maintain the Plan's reference-based reimbursement methodology.
- c. Provide a quality network to support Plan Members who reside in all one hundred (100) counties of North Carolina and throughout the United States.
- d. Ensure that Plan Members living and traveling outside of North Carolina have access to a strong network.
- e. Engage with a Vendor that will provide a full-service network or a narrow-network, if requested by the Plan.
- f. Partner with a Vendor that has thought leadership around developing and implementing custom provider reimbursement strategies to meet the future needs of the Clear Pricing Project.
- g. Partner with a Vendor that has demonstrated experience implementing alternative payment models such as, but not limited to, Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), and two-sided risk.
- h. Partner with a Vendor that will work with the Plan and other Plan vendors to develop and implement new alternative payment models such as bundled payment arrangements, risk sharing, and capitation.

5.2.4.2 Custom Network Services

- a. **The Plan requires a Vendor that will provide claims processing and related services utilizing a custom network that includes providers contracted by the Plan. While the Plan intends to contract directly with service providers in North Carolina, the Vendor will need to supplement the network with a national wrap-around network of providers located outside of North Carolina. The Vendor will also be asked to supplement the network with contracts for services such as reference labs, durable medical equipment, or other commodity services and other North Carolina providers, as needed, to ensure access to care standards are met.**

The Vendor shall confirm and describe each of the following:

- i. Vendor acknowledges that the Plan is a governmental payor.
- ii. Vendor will accept and load a network of North Carolina providers contracted directly by the Plan. This includes loading the providers to facilitate claims processing and provider look-up via a provider search tool for Plan Members.
- iii. Vendor will provide a portal for Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.
- iv. Vendor will maintain an accurate and functional provider directory for the Plan, including providing a function in the portal through which providers can update their demographic information at regular intervals specified by the Plan.
- v. Vendor will administer all provisions of the current North Carolina State Health Plan Network Participation Agreement ("NPA"), Exhibit 1 and Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy.
- vi. Vendor will administer any future iterations of and changes to the NPA with the understanding that these are not subject to review by the North Carolina Department of Insurance ("DOI") since the Plan is self-funded and not subject to DOI regulations except for those specifically listed in N.C.G.S. § 135-48.51.

- vii. Vendor will supplement the Plan's custom network with other providers contracted directly by the Vendor to ensure access to care standards are met in North Carolina.
 - viii. Vendor will supplement the Plan's custom network with other providers contracted directly by the Vendor for services such as, but not limited to, durable medical equipment, reference labs, or other commodity services. Vendor will allow the Plan will view these contracts upon request.
 - ix. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for services such as, but not limited to, specialty pharmacy.
 - x. Vendor will provide a national wrap-around network of providers located outside of North Carolina to support Members living and traveling around the country. The Plan has Members residing in all fifty states.
 - xi. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-x., above.
- b. The Plan requires a Vendor that will administer the Plan's Medicare-based reimbursement methodology for in-network providers in the custom network that includes different reimbursement rates for professional, inpatient, and outpatient services. See Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy. There is also a delineation between rural, non-rural, and other facilities:**
- **Non-Rural Inpatient – 175% of Medicare**
 - **Non-Rural Outpatient – 225% of Medicare**
 - **Professional – 160% of Medicare**
 - **Rural Inpatient– 200% of Medicare**
 - **Rural Outpatient – 235% of Medicare**

The Vendor shall confirm and describe each of the following:

- i. Vendor will load, maintain, and adjudicate claims for in-network services rendered by providers contracted by the Plan in the custom network according to the Plan's Medicare-based reimbursement methodology at the in-network rates outlined above. Include in the description the specific repricing/pricing tools that will be used.
 - ii. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if desired by the Plan.
- c. The Plan requires a Vendor that will administer the Plan's Medicare-based reimbursement methodology for out-of-network providers as follows:**
- **Non-Rural Inpatient – 125% of Medicare**
 - **Non-Rural Outpatient – 150% of Medicare**
 - **Professional – 130% of Medicare**
 - **Rural Inpatient – 150% of Medicare**
 - **Rural Outpatient – 180% of Medicare**

The Vendor shall confirm and describe each of the following:

- i. Vendor will load, maintain, and adjudicate claims for non-network services according to the Plan's Medicare-based reimbursement methodology at the non-network rates outlined above.
 - ii. Vendor will reimburse Members, not providers, when services are rendered by an out-of-network provider.
- d. While the Plan may contract directly with North Carolina providers in the custom network, the Plan requires a Vendor that will be responsible for the development, maintenance, and administration of medical and payment policies. In addition, the Vendor must be able to administer any Medicare medical and payment policies adopted by the Plan. Because the Plan's reimbursement methodology is indexed to**

Medicare, some policies may need to be adjusted to better align with Medicare guidelines. In the future, the Plan may require the administration of medical or payment policies developed by other Plan vendors.

The Vendor shall confirm and describe:

- i. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support the Plan's custom network.
 - ii. Vendor will administer any Medicare medical and payment policies adopted by the Plan.
 - iii. If necessary, Vendor will adjust its medical and payment policies to align with a Medicare-based reimbursement methodology and utilize these policies when administering benefits for the Plan.
 - iv. Vendor will administer any medical or payment policies developed by other Plan vendors in the future.
- e. The Vendor shall describe any limitations and/or issues with meeting requirements b. – d. above.**
- f. While the Plan may contract directly with North Carolina providers, the Plan requires a Vendor that will be responsible for credentialing new providers that join the custom network.**

The Vendor shall confirm and describe:

- i. Vendor will evaluate and credential any new providers that wish to join the Plan's custom network.
 - ii. Vendor will reevaluate current Plan providers' credentials at the appropriate intervals.
 - iii. Vendor has a robust credentialing process in place to ensure timely completion of this function. Include in the description the Vendor's standard turnaround time for completing the credentialing process and the frequency with which the Vendor recredentials providers.
 - iv. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. – iii., above.
- g. The Plan requires a Vendor that can follow access to care standards when there is not a specific provider available in a geographic area.**

The Vendor shall provide the following:

- i. Vendor's current access to care standards for North Carolina.
- h. The Plan requires a Vendor that is flexible in its approach to handling "hidden providers" (e.g. an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon).**

The Vendor shall confirm and describe each of the following:

- i. How "hidden providers" are addressed in the Vendor's provider contracts and/or payment policies.
- ii. How "hidden providers" allowed amounts are determined by the Vendor.
- iii. Whether "hidden providers" are paid at the in-network or out-of-network cost-shares.
- iv. Vendor will customize "hidden provider" payment policies, as requested by the Plan.
- v. Vendor will apply "hidden provider" rules as required by the Plan.
- vi. The Vendor shall describe any limitations and/or issues with meeting requirements h.i. – v., above.

- i. **The Plan requires a Vendor that has demonstrated the ability and experience to design and implement transparent alternative payment and/or care delivery models. The Vendor must also integrate with other Plan vendors to support these arrangements.**

The Vendor shall confirm and describe each of the following:

- i. Experience and ability in designing or contributing to the design of each of the following alternative models of care or clinically integrated systems. Include details about the scale of each initiative, the population and the provider network involved.
 - 1) Bundled/Episodic Payments.
 - 2) Clinically Integrated Networks.
 - 3) Patient-Centered Medical Homes.
 - 4) Accountable Care Organizations.
 - 5) Community Care Organizations.
 - 6) Integrated Delivery Networks.
 - 7) Physician-Hospital Organizations.
 - 8) Shared Risk/Savings.
 - 9) Pay-for-Performance.
 - 10) Global Payment/Capitation.
 - 11) Primary Care Incentives.
- ii. Vendor will support the integration and ongoing operations of any of the aforementioned alternative payment models or clinically integrated systems that may be designed and managed by other Plan vendors.
- iii. Vendor has the system capability to support capitated payments.
- iv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.
- v. Vendor has the tools to initiate a new clinical partnership, assign payment, and achieve physician engagement in new models of payment and care.
- vi. The Vendor shall describe any limitations and/or issues with meeting requirements in i.i. – v., above.

The Vendor shall provide each of the following as examples of leadership, expertise, and capability to implement innovative provider payment models:

- vii. Example of an implementation of an innovative engagement strategy that resulted in an increase in provider/patient engagement. Include details on the scale of the initiative and describe the population and the provider network involved.
 - viii. Description and examples of tools and actionable reports used for provider/network-level viewing of progress reports, such as dashboards.
 - ix. Description of the type of innovative alternative provider payment model(s) the Vendor would recommend be implemented for Plan Members inside and outside of North Carolina.
- j. **The Plan requires a Vendor with a provider call center to have hours of operation from at least 8:00 a.m. ET to 5:00 p.m. ET, each State Business Day, to respond to all provider inquiries, whether for the custom network or Vendor's supplemental network. The call center should be dedicated to the Plan with Plan-specific phone number and greeting.**

The Vendor shall confirm and describe each of the following:

- i. Vendor will provide a dedicated provider call center for network and claims 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 provider inquiries. Include the description of the anticipated number of resources that will be assigned to this call center.

- ii. Vendor will accept and respond to provider 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. The Vendor shall describe any limitations and/or issues with meeting requirements in j.i. – iii., above.

The Vendor shall describe each of the following:

- v. Any other non-web-based services provided to providers by the Vendor's Call Center.
- vi. 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.
- vii. The training that will be provided to Vendor's Call Center resources, to educate them on the custom network.

5.2.4.3 Traditional Network Services

- a. **As stated throughout this RFP, one of the key principles for the Plan is to provide transparent pricing and high-quality care. This principle applies whether the Plan utilizes its own custom network, or a network provided by the Vendor. Therefore, the Plan requires a Vendor that offers traditional TPA services that include providing network solutions that are contracted and managed by the Vendor. In this regard, the Plan requires a Vendor that will provide a strong network in all one hundred (100) counties of North Carolina and throughout the United States. The Vendor's North Carolina network will be used, at the Plan's discretion, to supplement the Plan's custom network or as a stand-alone network.**

The Vendor shall confirm and describe how it will:

- i. Provide a network that will support the Plan's current Plan Designs for Members residing in all one hundred (100) counties in North Carolina and throughout the United States.
- ii. Provide a network that will support the Plan's current Plan Designs for Members who live in or travel to one of the other forty-nine (49) states.
- iii. Provide services to Members who travel outside the United States and have an urgent medical need.
- iv. Support transparency by allowing the Plan, at its request, to directly view any contracts associated with this network.
- v. The Vendor shall describe any limitations and/or issues with meeting requirements in a.i. – iv.

- b. **The Plan requires a Vendor with a robust provider management component.**

The Vendor shall describe each of the following:

- i. Organizational structure of the network management and/or provider development team(s). Include the names and job descriptions of the network management team members that will interact with the Plan to support ongoing network initiatives.
- ii. Primary functions for network management/provider relations team(s).
- iii. Network growth and development plans including how network gaps and deficiencies are evaluated and addressed.
- iv. Approach for recruiting and selecting providers to participate in Vendor's network(s).

- v. Process for collaborating with providers to address issues that may develop over time.
- vi. Process for initiating and monitoring provider quality improvements.
- vii. Process for collaborating with providers on new initiatives, models, or demonstrations. Provide a recent example.
- viii. Frequency of provider office site visits.
- ix. Provider education and retention activities and the frequency of each.
- x. Process for responding to and investigating Member reported provider deficiencies.
- xi. Process for responding to and investigating Member complaints about providers.
- xii. Process for responding to and investigating Member reported provider fraud.
- xiii. Payment models, other than fee for service, currently in use in North Carolina and nationally.
- xiv. Basis for determining non-network claim allowed amounts when services required by Members are available in-network. (i.e. usual & customary, average contracted rate, percent of Medicare, billed charges).
- xv. Basis for determining non-network claim allowed amounts when services required by Members are not available in-network. (i.e. usual & customary, average contracted rate, percent of Medicare, billed charges).
- xvi. Criteria used to tier networks and to include/exclude providers, as well as a go forward strategy to move to risk-based reimbursements and how that will impact provider access.
- xvii. How Centers of Excellence and transplant network services are developed. Include in the description the process for selection, evaluation, and ongoing performance measurement.
- xviii. Strategy to reduce the cost variance on commodity services such as those listed below. Include in your description any cost variance opportunities based on site of service and/or reference based pricing.
 - 1) Radiology.
 - 2) Lab Services.
 - 3) Durable Medical Equipment.
 - 4) In office specialty medications.
- xix. How the Plan will be informed of major contract disputes or potential network disruption to its Members.
- xx. How the Vendor is moving towards transparency in provider contracting.

Continues on next page.

c. The Plan requires a Vendor that maintains high quality networks.**The Vendor shall complete:**

- i. The table below regarding physician credentialing for the Vendor's proposed network. Verified does not mean self-reported by the physician. It means the status is confirmed by the Vendor through some other data source.

Table 2. - Network Quality			
Vendor's Proposed Network	Verified	Data Source Utilized?	Frequency of Re-credentialing?
State License	<input type="checkbox"/> Yes		Every ____ years
Medical School Grad	<input type="checkbox"/> Yes		Every ____ years
DEA Current	<input type="checkbox"/> Yes		Every ____ years
Residency Training Grad	<input type="checkbox"/> Yes		Every ____ years
Board Certification	<input type="checkbox"/> Yes		Every ____ years
Proof of Malpractice Insurance	<input type="checkbox"/> Yes		Every ____ years
Malpractice History	<input type="checkbox"/> Yes		Every ____ years
Hospital Standing	<input type="checkbox"/> Yes		Every ____ years
Hospital Privileges	<input type="checkbox"/> Yes		Every ____ years
National Databank Registration	<input type="checkbox"/> Yes		Every ____ years
Federation of State Boards	<input type="checkbox"/> Yes		Every ____ years
Review of Consumer Complaints	<input type="checkbox"/> Yes		Every ____ years

- ii. The table below that identifies the NCQA and/or URAC accreditation achieved by Vendor's commercial PPO business. Be specific about the accreditation status and corresponding dates.

Table 3. - Accreditation				
Type of Accreditation	Date of Accreditation	Renewal Date	Date of last review	Outcome of Review

- iii. For Table 3 above, provide the following:

- 1) If accreditation was denied or highest accreditation available not received, provide the rationale.
- 2) If no review was held or scheduled, note the reason.
- 3) If Vendor's accreditation status changed between the initial review date and current status, indicate each status change and date of the change.

The Vendor shall provide each of the following:

- iv. A GeoAccess report for Vendor's proposed network using the zip code census data for Plan membership. See Exhibit 8 for the State Health Plan for Teachers and State Employees 5 Digit ZIPcode report.
- v. Based upon the data provided, identify any counties in North Carolina or in other states where the provider network may not have adequate capacity to meet potential Plan demand.

- vi. Access to care standards.
 - vii. Description of how network adequacy, or access to care, is determined and monitored.
 - viii. Description of expansion plans in areas that do not meet access to care standards.
 - ix. For the state of North Carolina, provide a listing of all acute care North Carolina hospitals that are considered out-of-network hospitals in Vendor's proposed network.
 - x. A network directory for the Vendor's proposed network for all of North Carolina.
 - xi. A North Carolina map indicating participating counties and the process for enhancing networks as needed.
 - xii. Maps of Florida, South Carolina, Virginia, Georgia, and Tennessee indicating participating counties and the process for enhancing networks as needed.
 - xiii. Process for accessing care outside of the United States.
- d. The Plan requires a Vendor that, upon request, will offer a "narrow" network of lower cost, high quality providers for the Plan's Members located in all 100 counties in North Carolina.**

The Vendor shall confirm and describe how it will:

- i. Offer a statewide "narrow" network of lower cost, high quality providers to be paired with a custom plan design, as requested by the Plan. This offering may be a full replacement or offered alongside other plan design options. Vendor should describe in which counties and/or cities the network is "narrowed" and which systems and large providers are in and out of the narrow network. Provide, along with the description, a GeoAccess report for Vendor's proposed narrow network using the zip code census data for Plan membership. See Exhibit 8, State Health Plan for Teachers and State Employees 5 Digit ZIPcode report.
- ii. Build a custom narrow network at the regional or state level for the Plan. Include in the description the timeline to develop and deploy a custom network.
- iii. Provide a strategy to ensure Plan Members have access to primary care providers, behavioral health providers, and specialists based on the size of the "narrow" network proposed.
- iv. Support transparency by allowing the Plan, at its request, to view any contracts associated with this network.
- v. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iv., above.

The Vendor shall describe the following:

- vi. Custom network reimbursement options for Members who live and/or seek care outside of North Carolina.

The Vendor shall provide each of the following:

- vii. Description of the types of "narrow network" products or Plan Designs currently available.
- viii. Description of metrics utilized to qualify physicians and facilities for the "narrow network."
- ix. Description of any other Network Specific Products or Plan Designs not already described that are available to the Plan.
- x. All current network offerings available in North Carolina.

- e. **The Plan requires a Vendor that has strong transition of care policies to assist Members when their provider is no longer in the network or if they are admitted to a non-network facility.**

The Vendor shall describe each of the following:

- i. Process for notifying Members when their selected PCP is no longer in the network.
- ii. The transition of care process and overall Member impact when a Member is admitted to a non-network facility on an emergency basis (i.e. admitted through the emergency room).

- f. **The Plan prefers a Vendor that supports the Plan's need to communicate Plan specific benefits, Plan Design, and programs to Providers.**

The Vendor shall confirm and describe each of the following:

- i. Availability of a provider portal and how Vendor will share Plan specific information with network providers via the portal.
- ii. Other tools and resources available to the Plan to communicate directly with network providers about Plan specific benefits, Plan Designs, programs or other initiatives, as requested by the Plan.
- iii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. – ii., above.

5.2.5 Medical Management & Health Care Support Programs

5.2.5.1 Overview and Expectations

Medical Management - The Plan seeks a Vendor that demonstrates versatility and innovation in managing the complex medical environment. The Vendor should provide high quality, evidence-based, member centric, cost-efficient clinical management programs that support Members with the most appropriate, effective and high-value benefits to improve their health while fostering an optimum Member experience. The Vendor must provide Medical Management services for physical and behavioral health diagnoses, including substance abuse diagnoses, highly acute and prevalent diagnoses, as well as new diagnoses or conditions that become of interest to the Plan in the future. The Vendor must be able to support the Plan in providing the right care, at the right time, delivered within the right place of service by the right provider at the right price to all Members in need of medical care.

Health Care Support Programs is the approach the Plan has adopted for supporting Members and managing all aspects of health, across the spectrum of wellness to chronic disease and end of life support. The Plan focuses on engaging Members in their own health and simultaneously improving the quality and coordination of care within the health care system. The goal has been and continues to be to maintain or improve the Member's health by providing them with benefits and a variety of resources that meet the Members where they are in their journey to better health and wellbeing.

Objectives

- a. Ensure high quality, comprehensive, holistic Medical Management and Health Care Support Programs for Members' physical health, behavioral health, and substance abuse/misuse care, with the goal of reducing the overuse/ underuse of medical services and maximizing cost-effective options that result in optimal Member outcomes.
- b. Partner with a Vendor that utilizes clinical quality indicators, including Healthcare Effectiveness Data and Information Set (HEDIS) and other national quality standards to monitor appropriateness, quality, effectiveness, and accessibility of care to minimize variations between practices and provider networks across the State.
- c. Provide new and innovative Medical and Health Care Support Programs and initiatives to address needs and opportunities identified to meet the Plan's strategic priorities.
- d. Identify Members that need assistance with the day to day management of their chronic conditions and provide the resources and support necessary to manage them.

5.2.5.2 Services

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

The Vendor shall confirm and describe each of the following:

- i. The Vendor will provide Member-appropriate, cost efficient, and effective services for each of the following:
 - 1) Prior-authorization (PA) programs.
 - 2) Post-service medical reviews.
 - 3) Utilization management programs.
 - 4) Concurrent review programs.
 - 5) Transition of care programs.
 - 6) Service denial appeals.
 - 7) Targeted case management (in-patient, transplant, extended length of stay, hip and knee replacements).
 - 8) Benefit exception process.
- ii. The Vendor will customize any of the Medical Management programs or policies, as requested by the Plan.
- iii. Describe any limitations and/or issues with meeting requirements in a.i.-ii. above.

The Vendor shall provide each of the following:

- iv. Process for evidence-based medical policy development and review schedule including process of offering coverage for new technologies and/or services.
- v. Processes used to identify, propose, implement, and evaluate interventions to address Member patterns of overutilization or ineffective utilization of controlled substances, emergency department (ED), inpatient utilization, poly-pharmacy, and other high cost, inefficient, or ineffective services.
- vi. A description of the online capacity for pre-certification submission and adjudication available to Providers, as well as any other electronic tools available to support Medical Management

- b. **The Plan requires a Vendor that will offer new and innovative Medical Management programs for Plan Members, and support the Plan's strategic interests.**

The Vendor shall confirm and describe each of the following:

- i. The Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation.
- ii. The Vendor will serve as a thought leader around Medical Management initiatives to specifically address Plan Members' current and anticipated health care needs.
- iii. The Vendor will compare related cost and outcomes across specific diagnosis categories and provide solutions to address any discrepancies identified among providers.
- iv. The Vendor will provide solutions to address significant and unfavorable medical diagnoses and care gap closure trends specific to Plan Members.
- v. Describe any limitations and/or issues with meeting requirements in b.i.-iv. above.

The Vendor shall provide details on the following, including actual impact achieved on reducing costs and improving outcomes / health status:

- vi. Sample innovative Medical Management pilot programs currently in place as well as any planned or in development.

- vii. Examples of innovative models of care programs/pilots planned, in development, retired, or currently in place, including solutions to challenges and outcomes as applicable.
- viii. Examples of thought leadership provided to clients and if implemented, detail the process, timeline, intervention(s), strategies to solve challenges, and outcomes, as applicable.
- ix. Examples of practice and/or provider level quality improvement interventions, including solutions to challenges and outcomes.

c. The Plan requires a Vendor that can identify Plan Members that require specialized care.

The Vendor shall confirm it will appropriately identify and engage Members in each of the following programs. Include in the description the algorithms used to identify Members for the program as well as any limitations to delivering the programs:

- i. Transition of Care (TOC) Programs.
- ii. High utilizer outreach and management programs.
- iii. Complex case management programs.
- iv. Describe any limitations and/or issues with meeting requirements in c.i.-iii. above.

d. The Plan requires a Vendor that will work with the Plan to develop and implement new targeted care management programs, as requested by the Plan. Some programs may require integration with other Plan vendors or Plan Partners. The Vendor may also propose new care management programs for Plan Members.

The Vendor shall confirm and describe each of the following:

- i. Upon request, the Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members.
- ii. The Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, the Vendor, and any other Plan vendors or Plan Partners involved in the program administration.
- iii. Describe any limitations and/or issues with meeting requirements in d.i. - ii., above.

The Vendor shall describe each of the following:

- iv. All targeted and special care management programs available to the Plan.
- v. Process to research, define strategy, develop, and implement a targeted or special care management program.

The Vendor shall provide:

- vi. Examples of any targeted programs developed and implemented, include any barriers experienced and outcomes as a result of the program.

e. The Plan requires a Vendor that will conduct risk stratification for identifying and targeting Plan Members who could benefit from disease management, case management, and health coaching services.

The Vendor shall confirm that it will stratify and perform targeted outreach based on the following:

- i. Current health status.

- ii. Functional status.
- iii. Risk of disease/disease progression.
- iv. Risk of hospitalization or recent hospitalization.
- v. Hospital readmissions.
- vi. Risk identified by Wellness Review completion, medical claims, and Rx drug claims.
- vii. Enrollment in special programs (e.g., lower or waived co-pays for drugs related to a chronic condition, waived co-pay) that require engagement with a nurse or health coach.
- viii. High utilization of services (e.g., non-emergent/emergent related to chronic illness, ambulance, hospitalization, pharmacy, hospital re-admissions). High utilization will be determined by the Vendor as approved by the Plan.
- ix. Low or poor utilization of services (e.g., absence of a PCP visit or an annual preventive exam for a 45-year-old with a diagnosis of asthma).
- x. High claim amount.
- xi. History of high cost claims over a specified period of time.
- xii. Situations where a Member did not receive appropriate care based on accepted standards of care (gaps in care).
- xiii. Special populations identified for high intensity case management, such as Members with renal disease or mental health issues, or other conditions to be agreed upon between the Plan and the Vendor.
- xiv. Other criteria requested by the Plan.
- xv. Describe any limitations and/or issues with meeting requirements in e.i.-xiv. above.

The Vendor shall describe each of the following:

- xvi. Programs of disease management, case management, and care coordination that are currently provided to clients. Description should include details on number of required sessions, core components, and any national models that are followed in these programs. Indicate which programs will be available to the Plan on January 1, 2022.
- xvii. Process of outreach and intervention to Members identified as requiring disease management or case management that will incorporate the Member's lifestyle, education level, socioeconomic factors, health and wellness behaviors, attitudes/readiness to change, and values. This should include but is not limited to:
 - 1) Triage, assessment, and intervention following clinical protocols.
 - 2) Education about treatment options.
 - 3) Appropriate referrals for medical management (e.g., case management and disease management or other available resources (weight loss programs, diabetes prevention programs, tobacco and vaping cessation programs, etc.).
- xviii. Ability to propose innovative benefit design around long-term care including transition support from the hospital to the community (community would encompass home, nursing home, retirement home, hospice, skilled nursing facility, etc.).

- xix. Ability to perform specialty case management and care coordination for high cost specialty conditions such as oncology, multiple sclerosis, or rheumatoid arthritis.
- xx. Alternative methods for reaching “unable to reach” Members and Members that opt to be added to do not call lists.
- xxi. Capability to securely store and update Member contact information.

The Vendor shall provide the approach, process, and tools used to:

- xxii. Conduct the risk stratification.
- xxiii. Collect Member contact information.
- xxiv. Members for outreach.
- xxv. Conduct outreach to Members.
- xxvi. Address “unable to reach” Members.
- xxvii. Communication for items (i) through (v) listed above, including modes of communication other than telephonic.
- xxviii. Work with Members and providers to achieve closure of “gaps in care.”
- xxix. Collaborate with providers and hospitals to provide support services and coordinate patient care.
- xxx. Perform disease management, including the specific diseases or conditions targeted for intervention.
- xxxi. Perform case management, including the specific diseases or conditions targeted for intervention.
- xxxii. Provide end of life supports.

- f. **The Plan prefers a Vendor that will work with other Plan vendors and/or Plan Partners to provide the appropriate care and support for Plan Members.**

The Vendor shall confirm and describe the following:

- i. Vendor’s ability to perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.
- ii. Describe any limitations and/or issues with meeting requirement in f.i. above.

The Vendor shall describe the following:

- iii. Vendor’s process to identify and report on outcomes following referral to Plan vendors and Partners.

- g. **The Plan prefers a Vendor that provides strong health coaching services.**

The Vendor shall confirm and describe the availability of each of the following. Include in the description the educational requirements and professional certifications of the staff providing the services along with the training provided to prepare them to work with Plan Members.

- i. Disease Management Health Coaching Services, including specialized health coaches such as Certified Diabetes Educators (CDE), Registered Dietitians, Pharmacists, Exercise Physiologists, etc., in addition to Registered Nurses.
- ii. Active Lifestyle Health Coaching Services, including nutritionists, behavioral therapists, exercise physiologists/personal trainers, etc.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements g.i. – ii., above.

h. The Plan requires a Vendor that incorporates the latest technology when managing Plan Members' health.

The Vendor shall confirm and describe the following:

- i. Vendor incorporates the use of use of mHealth products to collect member-level data, such as glucometers, scales, blood pressure monitoring systems used by home-based monitoring, mobile applications, or wearables.
- ii. The Vendor shall describe any limitations and/or issues with meeting requirement h.i., above.

i. The Plan requires a Vendor that can support the Plan in its estimation of ROI for Medical Management programs provided and can provide the ROI methodology of Medical Management programs for the current book of business.

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

- i. Necessary data and participate fully in the calculation of ROI by the Plan and its actuary in consultation with the TPA.
- ii. The ROI calculation methodology used by the Vendor for its current BOB for the overall Medical Management program, as well as for each component of service described above.
- iii. Any tools that the Vendor has access to that will assist the Plan in assessing financial impact and/or return on investment of the Plan's current plan designs.
- iv. Any strategies to assess financial impact and/or return on investment for proposed plan design changes.
- v. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. – iv., above.

5.2.6 Pharmacy Management

5.2.6.1 Overview and Expectations

The Plan seeks a Vendor that will partner with the Plan to meet its strategic priorities. The Vendor must be willing to collaborate with the Plan and the Plan's PBM and other Plan vendors to support aggressive management of the pharmacy and medical benefits. The Vendor must also value strong specialty pharmacy Medical Management programs that seek to improve quality of care and reduce associated costs. The Vendor must partner with the Plan on new and innovative specialty pharmacy initiatives. If requested, the Vendor must be willing to transition some or all specialty pharmacy claims to the PBM.

Objectives

- a. Ensure quality care and maximize savings through strong specialty pharmacy Medical Management programs with the goal of reducing costs and improving quality.
- b. If requested, implement pharmacy plan design elements that provide value to the Plan and Plan Members.
- c. Engage as a strategic partner on specialty pharmacy Medical Management initiatives.
- d. Maintain a seamless integration with the Plan's PBM.
- e. Utilize an aggressive pharmacy management approach with respect to pharmacy and medical benefits.

5.2.6.2 Services

- a. **The Plan requires a Vendor that maintains strong specialty pharmacy Medical Management programs that improve the quality of care and reduce associated costs.**