

EXHIBIT E

(Part 2)

- iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
 - v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.
 - vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
 - vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."
 - viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.
 - ix. Vendor will co-brand letters or other materials Vendor sends to Members.
 - x. Vendor will customize the portal with the Plan's branding (logo).
 - xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will receive emails from Plan Members and respond to their inquiries.
Confirm ☒ Does Not Confirm ☐
 - ii. Upon request, Vendor will provide expanded hours of operation during the OE period at no additional cost to the Plan. The Plan's enrollment and eligibility call center is generally open on Saturdays during OE.
Confirm ☒ Does Not Confirm ☐
 - iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.
Confirm ☒ Does Not Confirm ☐
 - iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.
Confirm ☒ Does Not Confirm ☐
 - v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.
Confirm ☒ Does Not Confirm ☐
 - vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.
Confirm ☒ Does Not Confirm ☐
 - vii. Vendor will provide copies of call notes to Members upon request.
Confirm ☒ Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

- 1) View claims and claim payment status.

Confirm ☒Does Not Confirm ☐

- 2) View and print EOBs.

Confirm ☒Does Not Confirm ☐

- 3) View deductible and OOP accumulations.

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

- 5) View HRA claims, if applicable.

Confirm ☒Does Not Confirm ☐

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

- a) Initial HRA Funding.

- b) Rollover Funds.

- c) Incentive Funds.

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

- 9) Complete a Health Assessment that could be customized by the Plan.
Confirm ☒ Does Not Confirm ☐
- xxiv. Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:
- 1) Electronic medical and health records.
Confirm ☒ Does Not Confirm ☐
- 2) Disease Management Nurse notes.
Confirm ☒ Does Not Confirm ☐
- 3) Case Management notes.
Confirm ☒ Does Not Confirm ☐
- 4) Health Coach notes.
Confirm ☒ Does Not Confirm ☐
- 5) Vendor analytical system alerts, such as gaps in care.
Confirm ☒ Does Not Confirm ☐
- 6) Progress towards Incentives earned, if applicable.
Confirm ☒ Does Not Confirm ☐
- xxv. Vendor will provide the following services whether the Member is logged into the secure member portal or accessing Vendor's external site:
- 1) Search for providers by specialty.
Confirm ☒ Does Not Confirm ☐
- 2) Search for procedure/service cost.
Confirm ☒ Does Not Confirm ☐
- xxvi. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiative, upcoming Plan mailers and/or events, and develop and implement process improvements between the Plan vendors and Partners.
Confirm ☒ Does Not Confirm ☐
- xxvii. Vendor, if instructed by the Plan, will conduct an annual Member Satisfaction Survey for all Plan Members, including Members who are not enrolled in plans administered by Vendor. The Plan will be responsible for communicating the survey to Plan Members and may provide a link to the survey on the Plan's website. Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.
Confirm ☒ Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

5.2.8 Claims Processing and Appeals Management

5.2.8.1 Overview and Expectations

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

5.2.8.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
- i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.
 - ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
 - iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.
 - iv. Vendor will customize any appeals letters, as requested by the Plan.
 - v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.
 - vi. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan – Medicare Part B."
 - vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.
 - viii. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.
Confirm ☒ Does Not Confirm ☐
 - ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.
Confirm ☒ Does Not Confirm ☐
 - iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).
Confirm ☒ Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

- viii. Vendor will coordinate benefits with other commercial payors.

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

5.2.9 Claims Audit, Recovery, and Investigation

5.2.9.1 Overview and Expectations

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

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

5.2.9.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

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

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

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

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

- iii. Vendor's recovery processes will follow all deposit and financial reporting requirements outlined in Section 5.2.2, Finance and Banking.
 - iv. Vendor will recover any overpayments to Providers by offsetting future payments or by demand without any limitation as to time since the Plan as a government payor is not subject to the two-year limitation established in N.C.G.S. § 58-3-225(h).
 - v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (North Carolina General Statutes Chapter 105A, Article 1), the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29), Wage Garnishment (N.C.G.S. § 135-48.37A), and Credit Card Intercepts (N.C.G.S. § 1-359) and implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 10, "State Health Plan Recovery Workflows."
 - vi. Vendor will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, mental health parity, disclosures, reporting, etc.).
 - vii. Vendor has an investigation or similar unit to investigate possible fraud and abuse and will share details about specific investigations that impact the Plan, including the names of the providers involved.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support any other audit requested by the NC OSA.
Confirm ☒ Does Not Confirm ☐
 - ii. Vendor will support multiple audits simultaneously. Although the Plan will work with Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.
Confirm ☒ Does Not Confirm ☐
 - iii. Vendor will provide the Plan's Auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits including remote, view only access to view the claims adjudication system used by Vendor to process the Plan's claims.
Confirm ☒ Does Not Confirm ☐
 - iv. Vendor will provide on-site office space at Vendor's facilities that are actually processing Plan claims, including system access for the Plan's Auditors, the Plan, or the NC OSA.
Confirm ☒ Does Not Confirm ☐
 - v. Vendor will customize any standard audit reports to meet the Plan's specific audit needs.
Confirm ☒ Does Not Confirm ☐
 - vi. Vendor will provide claims files to the Plan's Auditors on a monthly basis.
Confirm ☒ Does Not Confirm ☐
 - vii. Vendor will provide feedback on all site visit claims within two (2) weeks of the end of the on-site visit. Vendor will also respond to any findings in the draft audit report within two (2) weeks of receipt.
Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

5.2.10 Initial Implementation and Ongoing Testing

5.2.10.1 Overview and Expectations

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

5.2.10.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

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

Other workstreams will kick-off throughout 2023.

- ii. Vendor will have the depository bank account(s) setup and tested at least 45 days prior to January 1, 2025.
- iii. If applicable, Vendor will have the disbursement account(s) setup and tested at least 30 days prior to January 1, 2025.
- iv. Vendor will have all services, including custom programs, operational by January 1, 2025.
- v. Vendor will work with the Plan to document in an ADM all custom processes developed to meet the Plan's unique requirements. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
- vi. Vendor will work with the Plan to finalize Vendor Audit Schedule for 2025 and subsequent years. The Audit Schedule will be updated via ADM. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
- vii. For all technical components of the initial implementation as well as any implementations throughout the lifetime of the Contract, Vendor will develop functional requirements documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation derived from the Plan's Business Requirements. These documents must be mutually agreed upon by Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.
- viii. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live of any initiative. To support testing, Vendor must not only have the resources, but also the test environments, necessary to support multiple work streams at one time. As mentioned above, the Test Plan will be mutually agreed upon by Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.
- ix. Vendor will support the 2025 Open Enrollment, which is currently scheduled for October 2024, but may be rescheduled to a different time at the Plan's sole discretion. Vendor must have the group set-up complete, the call center open, any required SSOs in place, the PCP selection tool integrated with the Plan's EES vendor and be able to accept EDI from Plan vendors during the month Open Enrollment occurs.

b. Vendor shall additionally confirm each of the following:

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

5.2.11 Reporting

5.2.11.1 Overview and Expectations

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

5.2.11.2 Services

a. Vendor confirmed the following Minimum Requirement:

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

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

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

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒ Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

1) Demographics.

a) Gender.

b) Age.

c) Race.

2) Employing unit, work location.

3) Geography.

a) Zip Code.

b) County.

c) Hospital Service Area.

d) Healthcare Referral Region (HRR).

e) Out-Of-State.

4) Subscriber versus Member.

5) Active and Retiree (Pre and Post-65).

6) Plan Type.

7) Time period.

a) Calendar Year (CY).

b) Year-to-Date (YTD).

c) Month-to-Month.

d) Fiscal Year.

e) Quarterly.

f) Ad-hoc.

8) Paid, incurred, capitated claims.

9) Provider Level.

- a) By NPI, DEA #, In/Out-of-Network, Vendor's unique provider number.
 - b) PCP, Specialist, Hospital.
- 10) Network.
- a) In/Out-of-Network.
 - b) Quality Outcomes.
- 11) Utilization Trends.
- a) High Cost Claimants.
 - b) High Volume Claims Utilizers.
- 12) Disease Categories via ICD-10, DRG, MDC, or ad hoc criteria.
- a) Chronic conditions.
 - b) Acute conditions.
 - c) Catastrophic (cost-driving outliers).

Confirm ☒Does Not Confirm ☐

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

- 1) Weekly membership reports that include, but are not limited to, the following information:
- a) Group Number.
 - b) All internal and external member Identification numbers (i.e., EES assigned ID, SSN, MBI, Employer ID, etc.).
 - c) Subscriber number.
 - d) Hire date.
 - e) Coverage effective date.
 - f) Coverage expiration date.
 - g) Current benefit effective date.
 - h) Current benefit expiration date.
 - i) Member First Name.
 - j) Member Last Name.
 - k) Member SSN.
 - l) Member date of birth.
 - m) Member tier.
 - n) Member benefit identifier code(s).
 - o) Medicare primary flag.
 - p) Medicare Coverage.
 - Medicare A effective date
 - Medicare B effective date.
 - q) Medicare effective date.

r) Medicare expiration date.

Confirm ☒

Does Not Confirm ☐

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

- a) Enrollment by Plan Design, Entity, Group, Tier, and Medicare Status.
- b) In-state Member counts by county broken down by Plan Design, then totaled.
- c) Out-of-state Member counts by state or country broken down by Plan Design, then totaled.
- d) Enrollment by Group number broken down by Subscriber and Dependent, then totaled.
- e) Graphs (pie charts) that include:
 - All Members by Plan Design.
 - In-state Members by Plan Design.
 - Out-of-state Members by Plan Design.
 - All Members by Coverage Tier.
 - Top 10 Counties.

Confirm ☒

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

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

Confirm ☒

Does Not Confirm ☐

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

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

- a) The amount of recoveries due, but not received.
- b) The amount of any unapplied receipts.
- c) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days; and over 120 days.
- d) Supporting documentation from which these amounts are derived.

Confirm ☒

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2) Quarterly report of any uncollectible accounts:

- a) Recommended for debt write-off which includes, but is not limited to:
 - Account name.
 - Subscriber number, if applicable.

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

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

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

Confirm ☒Does Not Confirm ☐

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

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

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

Confirm ☒Does Not Confirm ☐

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

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

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

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

Confirm ☒ Does Not Confirm ☐

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

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

- a) Subscriber number, if applicable.
- b) Provider information, if applicable.
- c) Date returned.
- d) Dollar amount.

Confirm ☒ Does Not Confirm ☐

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

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

- a) Number of checks processed weekly.
- b) Number of EFTs processed weekly.
- c) Payment amount(s) by type e.g., claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.
- d) Weekly total by type.
- e) Month to date total by type.
- f) Supporting documentation of all disbursements and an explanation of any adjustments and/or miscellaneous payments, e.g., check register, any system generated reports of check writes, etc.

Confirm ☒ Does Not Confirm ☐

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

- a) Date of each daily deposit.
- b) Total amount of deposit for each day.
- c) Breakdown of amount by type of deposit, i.e., checks, wires, ACH (drafts).
- d) Monthly total of each type.

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- 8) Monthly reconciliation of claims and other disbursements which includes, but is not limited to:
- a) Daily transactions listed individually with a daily total as well as a summary total.
 - b) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds, and other disbursements.
- Confirm ☒ Does Not Confirm ☐
- 9) As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:
- a) Final due date to escheat the warrants/checks.
 - b) Name of state and dormancy period for each state.
 - c) Number of warrants for each state and dollar amount.
 - d) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all Product types.
 - e) Explanation of any special circumstances or issues.
- Confirm ☒ Does Not Confirm ☐
- 10) Monthly Summary of Billed Charges by State Fiscal Year which includes a summary of claims paid for the period which includes both medical and pharmacy claims.
- Confirm ☒ Does Not Confirm ☐
- 11) Monthly Statement of Account (SOA) which includes all charges including claims and administrative fees s paid. It is a full picture of all income/expenses for the month.
- Confirm ☒ Does Not Confirm ☐
- x. Vendor will provide each of the following Financial Performance reports or reporting packages. The method for providing the report will be determined during implementation.
- 1) Performance Guarantees (PG), as outlined in Section 6.3, reports as follows:
- a) Monthly PG status report.
 - b) Quarterly PG report cards.
 - c) Annual PG report cards that include summary data and year end PG results.
- Confirm ☒ Does Not Confirm ☐
- 2) Monthly Performance Matrix reports as outlined in Exhibit 12, "Matrix Reports," and listed below:
- a) Reports 1 and 2: Charge Summary Paid and Incurred Reports.
 - b) Reports 3 and 4: Charge Summary Trend Paid and Incurred.
 - c) Reports 5 and 6: Coinsurance and Deductible, Full Population-Paid and Incurred.
 - d) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.
 - e) Reports 9 and 10: Copay-Incurred and Paid.
 - f) Report 11: Copay-Incurred (Claims Run out).

- g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
- h) Reports 14 and 15: Financial Summary-Paid and Incurred.
- i) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.
- j) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

Confirm ☒Does Not Confirm ☐

3) Monthly Triangulations reports with the following stratifications:

- a) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.
- b) Plan Design and/or Product, including a summary based on total membership.

Confirm ☒Does Not Confirm ☐

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

- a) Prompt pay for adjusted claims.
- b) Prompt pay for new claims.
- c) Claim count.
- d) Total interest paid.

Confirm ☒Does Not Confirm ☐

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

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

- a) Claims type.
- b) Total claims billed.
- c) Total claims paid.

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

- a) Denial reason.
- b) Number of claims for each denial reason.

c) Total charges for each denial reason.

Confirm ☒

Does Not Confirm ☐

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

a) Member ID.

b) Plan ID.

c) Member age.

d) Diagnosis.

e) Service start date.

f) Encounter service type.

g) Place of service.

h) Provider specialty description.

i) Paid amount.

Confirm ☒

Does Not Confirm ☐

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

a) Number of first level appeals received.

b) Number of first level appeals approved.

c) Number of first level appeals denied.

d) Number of second level appeals received.

e) Number of second level appeals approved.

f) Number of second level appeals denied.

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

Confirm ☒

Does Not Confirm ☐

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

a) Member ID.

b) Member First Name.

c) Member Last Name.

d) Type of Appeal Review Decision.

e) Type of Appeal Category.

f) Date Appeal Initiated.

g) Final Written Date.

h) Appeal Decision Description.

i) Medication Name, Strength, and Dosage.

j) Method Appeal Received.

k) Appeal Origin.

l) Drug Class.

Confirm ☒

Does Not Confirm ☐

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

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

Confirm ☒

Does Not Confirm ☐

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

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

Confirm ☒

Does Not Confirm ☐

2) Quarterly Case Management Clinical Outcomes.

Confirm ☒

Does Not Confirm ☐

3) Quarterly Preventive Care Service Utilization.

Confirm ☒

Does Not Confirm ☐

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

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

Confirm ☒

Does Not Confirm ☐

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

Confirm ☒

Does Not Confirm ☐

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

1) A quarterly utilization report detailing specialty pharmacy Rebates.

Confirm ☒

Does Not Confirm ☐

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

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

- a) Total Member calls received.
- b) Weekly ASA rate for Member calls.
- c) Weekly first contact resolution rate.
- d) Weekly second contact resolution rate.
- e) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.
- f) TAT for completing manual enrollment updates.
- g) Enrollment accuracy rate for the current month.
- h) Number and percentage of clean claims processed ≤ 30 days.
- i) Number and percentage of claims processed > 30 days.
- j) Number and percentage of claims processed > 60 days.
- k) Number and percentage of claims processed > 90 days.

Confirm ☒Does Not Confirm ☐

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

Confirm ☒Does Not Confirm ☐

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

- 1) Monthly recovery reporting package that includes, but it not limited to the following:
 - a) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).
 - b) Total requested or saved, by recovery type and recovery subcontractor.
 - c) Total received, by recovery type and recovery subcontractor included Plan recovery Vendors. (Example: The Plan's Subrogation Vendor's results included in reporting package alongside Vendor's other recovery results.)
 - d) Total by subcontractor, including Plan recovery Vendors.
 - e) Quarter and year to date results.
 - f) Trends.
 - g) If available, benchmark data.

Confirm ☒Does Not Confirm ☐

- 2) Monthly Plan specific investigation reports that include, but are not limited to, the following data:
 - a) Name of provider.
 - b) Number of Members impacted.

- c) Date case opened.
- d) Basis for review.
- e) Summary of case.
- f) Status of the case.
- g) Total projected Plan claims dollars associated with the case.
- h) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.

Confirm ☒ Does Not Confirm ☐

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

- a) Date of Service.
- b) Member Name.
- c) Subscriber Number.
- d) Claim Number.
- e) Original Paid Amount.
- f) Appropriate Paid Amount.
- g) Overpayment Amount.
- h) Amount Repaid to the Plan.
- i) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.
- j) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

Confirm ☒ Does Not Confirm ☐