

STATE OF NORTH CAROLINA
DURHAM COUNTY

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
23 INS 00738

BLUE CROSS AND BLUE SHIELD OF)
NORTH CAROLINA,)
Petitioner,)
v.)
NORTH CAROLINA STATE HEALTH)
PLAN FOR TEACHERS AND STATE)
EMPLOYEES,)
Respondent,)
and)
AETNA LIFE INSURANCE COMPANY,)
Respondent-Intervenor.)

RESPONDENT-INTERVENOR’S NOTICE OF FILING

Pursuant to N.C. Gen. Stat. §§ 150B-33(b)(3a), 150B-40(c)(4), 26 N.C.A.C. 3.0105 and 3.0115, Respondent-Intervenor Aetna Life Insurance Company (“Aetna”), respectfully submits this Notice of Filing and exhibits attached hereto (“Notice of Filing”) in support of its Motion for Partial Summary Judgment and Memorandum in Support of its Motion for Partial Summary Judgment filed contemporaneously herewith. Aetna relies on and hereby incorporates by reference into its Motion and Memorandum the following exhibits:

1. Excerpts from the August 30, 2023 Deposition of Dorothy Jones (“**D. Jones Dep.**”)
2. **(CONFIDENTIAL: FILED UNDER SEAL)** Excerpts from the September 7, 2023 30(b)(6) Deposition of Blue Cross NC/Aimee Forehand (“**Blue Cross NC 30(b)(6) Dep.**”)
3. Excerpts from the September 13, 2023 Deposition of Caroline Smart (“**C. Smart Dep.**”)
4. **(CONFIDENTIAL: FILED UNDER SEAL)** Excerpts from the September 15, 2023 Deposition of Roy Watson (“**R. Watson Dep.**”)

5. **(CONFIDENTIAL/HIGHLY CONFIDENTIAL ATTORNEYS' EYES ONLY: FILED UNDER SEAL)** Excerpts from the September 21, 2023 30(b)(6) Deposition of Aetna/Catherine Aguirre (“**Aetna 30(b)(6) Dep.**”)
6. Deposition Exhibit 5 – Excerpts of North Carolina State Health Plan for Teachers and State Employees RFP No.: 270-20220830TPAS (“**Dep. Ex. 5**”)
7. Deposition Exhibit 13 - Affidavit of Dorothy C. Jones (“**Dep. Ex. 13**”)
8. Deposition Exhibit 20 - April 5, 2022 Email from Dee Jones to Dale Folwell, et al. Re: BCNC Notification (“**Dep. Ex. 20**”)
9. Deposition Exhibit 21 - Email from Roy Watson to Dee Jones, et al. Re: FACETS Implementation _4.20.2022 (“**Dep. Ex. 21**”)
10. Deposition Exhibit 37 - Blue Cross NC’s Response to Technical Requirements (“**Dep. Ex. 37**”)
11. **(CONFIDENTIAL: FILED UNDER SEAL)** Deposition Exhibit 41 - Blue Cross Minimum Requirements Questions (“**Dep. Ex. 41**”)
12. **(CONFIDENTIAL: FILED UNDER SEAL)** Deposition Exhibit 42 - Blue Cross Technical Requirements Questions (“**Dep. Ex. 42**”)
13. **(CONFIDENTIAL: FILED UNDER SEAL)** Deposition Exhibit 43 - Addendum No. 1 signed by Blue Cross (“**Dep. Ex. 43**”)
14. Deposition Exhibit 86 – Excerpts of State Health Plan Third Party Administrative Services RFP Transparency Documents Review – Media Briefing Presentation PowerPoint (“**Dep. Ex. 86**”)
15. Deposition Exhibit 215 - August 25, 2022 Email from Caroline Smart to Matthew Rish, et al. Re: TPA RFP Cost Scoring (“**Dep. Ex. 215**”)
16. **(CONFIDENTIAL: FILED UNDER SEAL)** Deposition Exhibit 403 – Excerpts of October 4, 2023 Expert Report by Mary Wills, CPA (“**Dep. Ex. 403**”)
17. **(HIGHLY CONFIDENTIAL ATTORNEYS' EYES ONLY: FILED UNDER SEAL)** Deposition Exhibit 417 – Excerpts of October 4, 2023 Expert Report of Gregory Russo (“**Dep. Ex. 417**”)
18. **(CONFIDENTIAL: FILED UNDER SEAL)** Addendum No. 2 signed by Blue Cross NC, NAVIGATOR_002440–51 (“**2022 TPA RFP Add. 2**”)
19. Excerpts of North Carolina State Health Plan for Teachers and State Employees RFP No.: 270-20191001TPAS (“**2019 TPA RFP**”)

20. **(CONFIDENTIAL: FILED UNDER SEAL)** Cigna Healthcare’s Minimum Requirement Questions, SHP 0009425–27 (“**Cigna Min. Reqs. Questions**”)
21. Blue Cross Blue Shield of North Carolina’s January 12, 2023 Request for Protest Meeting on Request for Proposal #270-20220830TPAS, SHP 0076753–67 (“**Blue Cross NC Protest**”)
22. State Health Plan’s January 20, 2023 Response to Blue Cross Blue Shield of North Carolina Request for Protest Meeting on Request for Proposal #270-20220830TPAS, SHP 0025822–32 (“**Plan’s Resp. to Blue Cross NC Protest**”)

All exhibits designated CONFIDENTIAL or HIGHLY CONFIDENTIAL—ATTORNEYS’ EYES ONLY have been filed under seal pursuant to Section 7 of the Protective Order entered on April 26, 2023.

Respectfully submitted, this the 15th day of December, 2023.

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CERTIFICATE OF SERVICE

I hereby certify that I have this day served a copy of the foregoing **RESPONDENT-INTERVENOR'S NOTICE OF FILING** on the following via electronic transmission:

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This the 15th day of December, 2023.

/s/ Lee M. Whitman
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*Counsel for Respondent-Intervenor
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**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 1**

Excerpts from the August 30, 2023
Deposition of Dorothy Jones
(“D. Jones Dep.”)

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** CONFIDENTIAL **

PORTIONS CONTAIN ATTORNEYS' EYES ONLY

VIDEO DEPOSITION OF
DOROTHY CLEMENT JONES

AUGUST 30, 2023

9:18 a.m.

Raleigh, North Carolina

Reported by: Audra M. Smith, FCRR

Video by: John Roberts

1 Plan.

2 A Uh-huh.

3 Q Did you or anyone else at the Plan speak
4 with any prospective bidders before the 2022 TPA RFP
5 was posted?

6 MR. HEWITT: Object to form.

7 You can answer.

8 A Absolutely. We made a point of, once we
9 decided to go forward with the process and once we
10 had notified Blue Cross -- which is only fair --
11 then we offered to Cigna, we offered to Aetna, we
12 offered to United, and we offered to Blue Cross to
13 come in and schedule time to meet from that point,
14 which I believe was April, early April, to up until
15 which time we issued the RFP. So, like, let's get
16 on it quickly.

17 We offered them to come in and talk with
18 us about the RFP. And we stated to each and
19 every -- and it was me and Kendall that had all
20 those meetings. And we stated express -- explicitly
21 to each prospective respondent that we were going to
22 change the process.

23 We were moving to all yes-no questions.
24 There would still be minimum requirements, but
25 yes-no. We would move -- we would be doing

1 technical requirements, yes-no, and it was going to
2 be fairly simple scoring. And it would all be
3 expressed in the RFP. And then there would be the
4 cost proposal.

5 And so we invited everyone to ask their
6 questions, to create any objections, you know, offer
7 any commentary, like, what has been -- how should we
8 say? -- what has been difficult in the past? You
9 know, anything, anything was fair game. And Blue
10 Cross took us up on that. Aetna took us up on that.
11 UnitedHealthcare took us up on that. Cigna chose to
12 not participate, and they ended up not participating
13 in the response, the RFP response.

14 And those -- you know, we learned from all
15 of those comments. And did those conversations
16 inform how we put out the RFP? No, it did not
17 change whether we -- nobody asked us to change the
18 yes-no questions, including Blue Cross. Nobody
19 objected.

20 In fact, most people said, that's great,
21 because it's so much -- you know, it's much easier.
22 I don't have to spend days and days on creating
23 binders and binders of paper.

24 And both -- I don't even remember Blue
25 Cross having many -- too many comments. I believe

1 dealing with future" -- "like future contracts?"

2 So, you know, Blue Cross has a broad
3 network today. Aetna and United have a less broad
4 network. So their question was, "Well, how do you
5 want to do that?"

6 So the obvious answer is, we want to know
7 what those contracts are going to look like at the
8 go-live on the contract -- on the RFP. And
9 that's -- so how we incorporated feedback. And Blue
10 Cross had none. Blue Cross had no objections, as
11 you know in a process -- and it's on page -- let me
12 find it here on page of this RFP document that's so
13 long.

14 There are two opportunities for
15 respondents to ask questions about process, or
16 anything, you know, clarifications. There was a
17 submission of written requirements for the minimum
18 requirements. There was an opportunity for
19 questions, and there was another opportunity for
20 questions around the technical proposal and the cost
21 proposal.

22 So there was, in my mind, ample
23 opportunity for challenges to the process to occur.
24 So we took that to mean -- sorry -- that all vendors
25 were very comfortable, if not pleased.

1 BY MR. FELDMAN:

2 Q How many times, if any, did you meet with
3 anyone from Aetna about the 2022 TPA RFP before the
4 Plan posted the RFP?

5 A I think twice. I recall twice.

6 Q What was the first meeting?

7 A It would have been early. I don't have a
8 calendar, so I can't tell you. It would have
9 been -- like in early, maybe, the May, June time
10 frame. And then the other meeting was probably --
11 is maybe July.

12 Q As to the first of those meetings, did you
13 or someone at the Plan solicit the meeting, or did
14 someone from Aetna solicit the meeting?

15 A Oh, no, we did. We absolutely did. And
16 we reached out to all four vendors, asked them if
17 they wanted to come in and talk about it because we
18 were going out for an RFP.

19 Q I'm going to hand you a document that is
20 marked as Exhibit 8.

21 (Exhibit Number 8 marked for
22 identification as of this date.)

23 BY MR. FELDMAN:

24 Q This is a document produced by the State
25 Health Plan, and it is -- I'm sorry, it was produced

1 confirm/not confirm format that would incorporate
2 both the minimum requirements and the technical
3 requirements, and the cost proposal would be -- I
4 can't say it would be done a lot differently.
5 That's all I can articulate about that.

6 And then we offered them the opportunity
7 to ask any questions.

8 Q What questions did Aetna ask and who asked
9 them?

10 A I don't remember that more in detail. But
11 I do know that one of the specific concerns that
12 they brought up was how do we -- just asked us to be
13 clear about what we mean by network pricing and how
14 a future network might come into play in the
15 scoring.

16 Q Did anyone -- did anyone from Aetna follow
17 up with you after that meeting?

18 A Yes, I'm sure they did. Do I recall
19 exactly, no.

20 Q What do you remember about anyone from
21 Aetna following up with you?

22 A Unfortunately, I can only remember that
23 typically Daniel and/or Jim would have called,
24 thanked us for the meeting, and, you know, I would
25 have said, "Yep, great. Glad you came. That's why

1 BY MR. FELDMAN:

2 Q But I thought Blue Cross -- do you dispute
3 that Blue Cross was the low-cost bidder?

4 A No. I misstated that.

5 Q Okay. I just want to make sure I'm
6 following.

7 A And I apologize. You're working -- you're
8 thinking about just this right this moment, so --

9 Q I want to make sure I follow -- I
10 understand your testimony that you just gave.

11 A Uh-huh.

12 Q But I want to make sure that I do
13 understand the math.

14 A Uh-huh.

15 Q So Step 1, how many points out of the
16 310 -- and we know that Aetna and UMR each earned
17 310, and Blue Cross earned 303, right?

18 A Correct.

19 Q And that setting aside whether it's -- you
20 perceive that as a big deal or a small deal or
21 somewhere in between, Blue Cross confirmed
22 97.8 percent of the requirements that Aetna
23 confirmed, right?

24 A Aetna and UMR had 100 percent.

25 Q Right. Then Step 2 is, you rank the total

1 the 2022 RFP?

2 A We discussed RFP -- our modernization act,
3 modernization process in general with Segal, because
4 that's -- they're our benefit consultant, and those
5 conversations could have included discussions about
6 scoring.

7 Q When you refer to the modernization
8 process both now and in your affidavit, that's
9 referring to the process of eliminating narrative
10 requirements and replacing those with binary yes-no
11 questions; is that fair?

12 A Generally. Modernization is a very broad
13 word, and most everybody is using it right now,
14 especially in State government, so around technical
15 changes. So I would say, yes, "modernization," very
16 broad umbrella. But in our RFP processes
17 specifically, definitely wanted to eliminate the un-
18 -- the not-so-valuable narrative responses and move
19 to a more -- again, to use your word -- binary, you
20 know, yes-no process.

21 Q Why does the elimination of narratives and
22 replacement with binary choices create a more
23 effective negotiation process?

24 A Well, I'm not trying to be funny, but when
25 you try one way for a lot of years and it doesn't

1 help, then you want to change your process. And so
2 going to a binary process where it was yes-no, the
3 Plan was able to state: This is what we need.
4 You're either going to do it or not do it, and we're
5 not really going to give you pages and pages and
6 pages of opportunity to do a lot of marketing speak
7 and tell us about how you're gonna do it but not
8 really gonna do it. That became completely
9 invaluable.

10 And so it was the decision -- because
11 again, this particular RFP seemed to be fraught with
12 that, based on our experience, that that became the
13 only reasonable answer.

14 Q Your affidavit states that the time
15 commitment to evaluate multiple RFPs per year
16 significantly reduced staff's ability to meet other
17 responsibilities. Is that correct?

18 A Uh-huh.

19 Q Have Plan staff actually failed to meet
20 other job responsibilities because of their service
21 on RFP evaluation committees?

22 A Well, sure.

23 Q What sorts of responsibilities have they
24 failed to meet because of their time commitments
25 related to serving on RFP evaluation committees?

1 it was as sword -- you know, all of those elements,
2 whatever the elements were, it was a sword worth
3 falling on. Nah, you really need that? Do you
4 really need that?

5 And then reading all the narrative, which
6 was wandering all around and not really addressing
7 point to point, people just got frustrated with it
8 and got frustrated with the writing was done. And
9 if they were aware that the writing in a narrative
10 contradicted everything that they knew about the
11 vendor, any vendor, then that would be the bias.

12 Q They would decide based on what I'm
13 reading here, that -- that might not -- that bias
14 might lead to a decision that's not sound?

15 A Correct. And additionally -- and I
16 can't remember -- I don't remember the point spread,
17 but there was points for a "yes" and points for a
18 "no," or no points, and then some random scoring in
19 the middle. You know, so maybe it's 10 points for
20 yes, no points for no, and then if you put an answer
21 in that sort of explained something, you might have
22 gotten a 2, 3, 4, 5, 6. But again, that was
23 incredibly subjective.

24 And when I found out about that, that was
25 probably the one thing that made me insist that we

1 make such a big change.

2 Q Whose idea was this modernization process?

3 A It was mine.

4 Q Was the treasurer involved?

5 A No.

6 Q I saw your facial expression, tell me
7 about that.

8 A He's not a -- he's not the operational
9 guy, but he trusted me to create an objective
10 process.

11 And I had to tell him, I'm like, Oh, man,
12 I just learned, was not as subjective as I -- as
13 objective as I thought.

14 So he's like, Well, you need to fix that.

15 And I'm like, Yeah, we do. We need to fix
16 a lot of things about it.

17 And hence the journey.

18 Q When did that conversation occur?

19 A It was not a single conversation.

20 Q You had many conversations with the
21 treasurer about this?

22 A Yes.

23 Q Over -- are we talking about the course of
24 2021 or even dating back before then?

25 A We had several conversations about this

1 of communications, you know, policy. Nobody was,
2 "Please don't do that again."

3 Q Does that also include the board?

4 A The board definitely was fine with it.

5 Q Introduce -- or I'm going to hand you an
6 exhibit, Ms. Jones, marked as Exhibit 20.

7 (Exhibit Number 20 marked for
8 identification as of this date.)

9 MR. FELDMAN:

10 Q Do you recognize this document?

11 A I do.

12 Q And this document is an email that you
13 wrote to Treasurer Folwell on April 5, 2022?

14 A Correct.

15 Q And in that email, you told Treasurer
16 Folwell that you and Ms. Smart spoke with Aimee
17 Forehand and Roy Watson on the morning of April 5
18 and told them that the TP -- I'm sorry -- that the
19 Plan will be putting the TPA contract up for bid
20 later in 2022?

21 A Correct.

22 Q Tell me about the conversation that you
23 and Ms. Smart had with Ms. Forehand and Mr. Watson.

24 A Well, we had more -- a broader
25 conversation where we talked about changing the --

1 started transitioning customers five-plus years ago
2 prior to.

3 And while on day one, basic claims were
4 processing, which is great news, what we learned by
5 day two or three was that providers had gotten
6 dropped from the database, member claims were not
7 being paid, providers were not being paid, and those
8 were just the most of obvious, most urgent, most
9 immediate things that came up.

10 But beyond that, we would run into simple
11 individual issues that were, again, more impacting a
12 handful or, you know, a finite number of claims or
13 people, and Blue Cross staff could not figure out --
14 they didn't understand the systems well enough to
15 even understand how to fix it. And so that became
16 problematic because then we had to have people from
17 Benefit Focus on the phone, we had to have Caroline
18 and her staff on the phone for hours at a time,
19 probably at least at a point in time. They were
20 meeting three days a week for five or six hours a
21 day, which again, took the team away from their day
22 jobs and frustrated everybody.

23 And I acknowledged all of that routinely
24 to Roy and Aimee and Tunde, and it was a tough
25 situation. But a vendor is always going to be

1 expected to do better than that. And this was a big
2 challenge for us.

3 Q What, at a high level, were you referring
4 to with the phrase "lack of confidence and issue
5 resolution"?

6 A Part of what I just said, is they were
7 sitting on the phone together for, you know, six
8 hours a day, and three days a week or four days a
9 week, there would be issues that come up, and the
10 staff on -- the Blue Cross staff on the phone could
11 not understand the issue, the genesis of the issue,
12 and how to solve the issue. And so we ended up with
13 issues that stayed on the issue list for months
14 before they actually finally got a resolution.

15 Some of the issues required coding. And,
16 you know, in technology world, coding doesn't get --
17 you don't do a fix and then push it through the
18 system. They have -- I don't know what -- they have
19 scheduled releases of code, and, you know, those
20 scheduled releases just pushed the process out
21 further and further. And, you know, Roy -- in
22 fairness, Roy ponied up -- again, he was asked by
23 the board, Well, what are you going to do to
24 reciprocate or to pay the Plan back or to do
25 something to recognize Blue Cross' problem in all

1 this?

2 And they paid us a million dollars, but
3 that barely covered the reality -- and it was
4 appreciated, but that barely covered the cost of,
5 you know, our staff time or Benefit Focus time that
6 we had to cover, because we had to pay for their
7 implementation cost to go with FACETS.

8 So it was just -- you know, again, it was
9 not something that money was going to resolve. It
10 was time, knowledge, know-how. Through all this
11 process, you know, that Roy and Aimee -- and this is
12 Roy Watson and Aimee Forehand -- you know, just -- I
13 mean, Aimee especially who's been around Blue Cross
14 for a really long time, absolutely understands why
15 the Plan is frustrated. Absolutely.

16 And they came to the conclusion that they
17 did not have at all close to the right staffing
18 model, and they promised to fix it. They brought in
19 some director -- I don't even remember -- maybe in
20 '21 maybe, and she didn't work out. That director
21 was supposed to be working with us. She did not
22 work out at all, and they finally resolved that. I
23 just requested that she be removed from the Plan's
24 account, so I don't really know what happened. But
25 finally, they've added more people to the

1 operational staff, but it was still at a shared
2 services level and not directly for the Plan. But
3 they did hire a couple of ex-Plan staff, which was
4 good, to come onboard, and try to help improve
5 things.

6 Q What's Benefit Focus?

7 A An enrollment and eligibility services
8 vendor.

9 Q What are they -- what does an enrollment
10 and eligibility services vendor do?

11 A They are the gatekeeper, if you will, for
12 all members. Members go and enroll in Benefit
13 Focus, and Benefit Focus passes daily data from its
14 system to Blue Cross and its system to the pharmacy
15 benefit manager, and members enroll in their
16 benefits through Benefit Focus. And they -- and
17 Benefit Focus system has rules that identify what
18 they're eligible for, and that is the process, you
19 know, at a very high level, as to how that works
20 together.

21 Q And when you referred in your April 5,
22 2022, email to Treasurer Folwell about telling
23 Ms. Forehand and Mr. Watson that the general lack of
24 cooperation and support relative to data
25 transparency was one of the main reasons behind the

1 decision.

2 A Uh-huh.

3 Q What, at a high level, did you mean by
4 that "general lack of cooperation and support"?

5 A So in 20- -- and I'm having trouble with
6 the dates here. I think No Surprises Act passed in,
7 I think, 2020, late 2019, early 2020, I think. And
8 the outcome of that was federal regs around data
9 transparency. And we had been working with Blue
10 Cross to try to have more use of our data, the
11 Plan's data, you know, for a number of years, but
12 the federal -- with the federal regs sort of not
13 allowing contracts that are completely confidential,
14 you know, rate opportunities and cost opportunities
15 need to be more public, more transparent.

16 And so we had tried to work with Blue
17 Cross in 2021 to put some legislation forward to fix
18 the current statute to allow the Plan to use -- and
19 I use air quotes -- use our data more to our
20 benefit, and Blue Cross was not particularly
21 supportive or interested in that. There were times
22 they were supportive but not real -- really.

23 Q Had you discussed with Treasurer Folwell,
24 before you sent this April 25, 2022 email, the
25 prospect of a TPA RFP being issued in 2022?

1 A Yes.

2 Q What discussions had you had with
3 Treasurer Folwell prior to April 5, 2022, about the
4 prospect of an RFP being issued in 2022?

5 A Well, I can't -- I certainly can't
6 remember the specifics, but I know there was a
7 discussion in 20- -- 2020, 2021, we were talking
8 about, you know, if Blue Cross continues down this
9 path of being uncooperative around data
10 transparency, then maybe we just go out for an RFP,
11 and what does that look like? I guess that was in
12 '21.

13 Q I'm sorry. That was the treasurer that
14 said that?

15 A What's that?

16 Q That's the treasurer, you're saying, who
17 said that?

18 A Yes. Paraphrasing, obviously.

19 Because we, again, wanted to use our
20 data -- and I say "use our data." What I mean by
21 that is the Plan wanted to be able to use the claims
22 data to create better programs and better pricing in
23 some form of value-based payment. Or maybe not
24 really actually value-based payment, but some
25 programs where we could reduce health care cost, and

1 the way the statute was written, prohibited that.

2 So, again, asking for cooperation, went --
3 typically went nowhere. There was a brief respite
4 of cooperation in '21, but then, who knows what
5 happened, right? It could have been legislator, it
6 could have been something else, but that effort just
7 went away.

8 But then by the time '21 started to wind
9 down, we dropped the effort to -- you know, from the
10 immediate discussions, and then as FACETS went
11 south, those discussions started to pick up.

12 Q You say "those discussions started to pick
13 up," you're referring to discussions about issuing
14 the new RFP?

15 A Going out for another RFP, yes.

16 Q Those are discussions with the treasurer?

17 A Yeah. Just the staff and the treasurer
18 and the deputy chief of staff, and Sam Watts, the
19 legislative policy person who now sits in the
20 executive administrator seat.

21 Q Rough time frame, were those conversations
22 going in, say, the second half of 2021?

23 A I don't know that -- I think they started
24 in -- with FACETS. I mean --

25 Q When would it have been? Start with that.

1 I think we can do this because the timeline -- we'd
2 have to have the RFP drafted by June, but then all
3 through the process we could make it happen.

4 Q Would you describe the sort of overall
5 timing of the RFP process for the 2022 RFP as being
6 fast or slow or moderate?

7 A I would say it was moderate in the sense
8 that it still took seven, eight months, but we've --
9 we were able to, you know, reevaluate -- redo the
10 process and put in a new -- took a lot of time and
11 effort. People working on weekends and so forth.
12 Caroline was able to sort of turn the RFP Statement
13 of Work upside down into yes-no questions, and we
14 were able -- you know, everybody came together in
15 pushing out -- you know, okay, team work together to
16 come up with the scoring process. I believe Segal
17 had some conversation with that. And we were able
18 to put it out in late August of '22.

19 Q I'm going to hand you an exhibit marked as
20 21.

21 (Exhibit Number 21 marked for
22 identification as of this date.)

23 BY MR. FELDMAN:

24 Q I'm really going to ask you about the
25 email on the second page. Obviously, please review

1 BY MR. WHITMAN:

2 Q Now, do you remember the instruction that
3 Mr. Feldman gave you at the beginning of your
4 deposition today where he said, "Ms. Jones, if I ask
5 you a question and you don't ask me to clarify, I'm
6 going to -- I'm going to expect that you understood
7 my question."

8 Do you remember when he said that to you?

9 A Sure.

10 Q Okay. That's essentially what the Plan
11 was saying to the bidders when it gave them the
12 question-and-answer period, wasn't it?

13 A Absolutely.

14 Q Mr. Feldman also asked you a number of
15 questions about the scoring and weighting of scores
16 with regard to the cost proposal and the technical
17 requirements. But those scoring and how the scores
18 would be weighted, again, that was made known to all
19 the bidders during the question-and-answer period,
20 correct?

21 MR. FELDMAN: Object to form.

22 A Absolutely.

23 BY MR. WHITMAN:

24 Q So any of the questions that Mr. Feldman
25 asked you today about the scoring, the weighting,

1 those could have been asked by Blue Cross during the
2 Q and A period, couldn't they?

3 MR. FELDMAN: Objection to form.

4 A Yes.

5 BY MR. WHITMAN:

6 Q But they were not, were they?

7 A Correct.

8 Q Okay. Now, to your knowledge, Ms. Jones,
9 did anyone from Blue Cross and Blue Shield of North
10 Carolina ask the State Health Plan at any time
11 during the question-and-answer period for a
12 mathematical justification for the proposed scoring
13 in this RFP?

14 A No.

15 Q Now the same rules with regard to scoring
16 and weighting applied to all the bidders, didn't
17 they?

18 A Yes.

19 Q And if Blue Cross believed that the
20 scoring system was not fair, they had that
21 opportunity to raise that concern during Q and A,
22 correct?

23 MR. FELDMAN: Objection to form.

24 A Yes.

25

1 BY MR. WHITMAN:

2 Q Okay. And to your knowledge, Blue Cross
3 Blue Shield did not do that during the Q and A
4 period in this RFP, did they?

5 MR. FELDMAN: Objection to form.

6 A That is correct.

7 BY MR. WHITMAN:

8 Q Okay. All the bidders had to play by the
9 same rules with regard to scoring and all other
10 technical requirements of the RFP, correct?

11 A Correct.

12 Q At the end of the day, on technical
13 requirements as we know, two of three bidders
14 checked that they could comply with all 310
15 requirements, right?

16 A Correct.

17 Q So Blue Cross was the only one that did
18 not indicate to the State Health Plan that it could
19 and would satisfy all 310 technical requirements?

20 A That is correct.

21 Q Now, Mr. Feldman asked you a question
22 about if his daughter had taken a math test and got
23 97.7 percent on the math test, would it be fair that
24 she got a grade of 33 percent; do you recall that
25 question?

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 2**

CONFIDENTIAL: FILED UNDER SEAL

Excerpts from the September 7, 2023 30(b)(6)
Deposition of Blue Cross NC/Aimee Forehand
(**“Blue Cross NC 30(b)(6) Dep.”**)

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 3**

Excerpts from the September 13,
2023 Deposition of Caroline Smart
(“C. Smart Dep.”)

1 So it was all about just trying to get
2 everybody on the same page, make sure we all
3 understood how to work together and have the
4 appropriate resources.

5 So it was really just their really
6 wanting to do a great job, and we just needed a
7 level set, and things are moving along and
8 implementation is going well.

9 Q. You mentioned earlier, I'm forgetting
10 the context of your answer, about some
11 implementation phase that might begin November 1 or
12 somewhere around then.

13 Does that sound familiar?

14 A. A phase might begin in November? No,
15 it's not ringing a bell.

16 Q. What's the next major milestone in the
17 implementation?

18 A. From a technical perspective the next
19 major milestone is the testing, which starts the
20 first of next year. We have finished all the
21 requirements and the vendors are all in development
22 now, and the end of Q1 we'll start the testing
23 between the vendors. So to me, that's all the
24 pieces that have to tie together to make this work.

25 As I mentioned, things that are

1 A. Okay.

2 Q. Could I ask you to read the first
3 sentence of the first full paragraph of that
4 page 11, please.

5 A. "If vendors have questions, issues or
6 exceptions regarding any term, condition or other
7 component within this RFP, those must be submitted
8 as questions in accordance with the instructions in
9 Section 2.5, Proposal Questions."

10 Is that it?

11 Q. Yes, ma'am. Let me ask you to look at
12 page 20 of Exhibit 5.

13 For the record, we're discussing the
14 definitions that govern the terms of the RFP issued
15 for the -- for the 2022 TPA RFP.

16 At Section 2.8 specifically I would like
17 to point you to the definition for "Shall or Must."
18 Down at the bottom.

19 A. "'Shall or Must' denotes that which is a
20 mandatory requirement."

21 Q. Did the State Health Plan consider that
22 if a potential vendor such as Blue Cross had
23 questions about interpretations or meanings or the
24 requirements of the State Health Plan setting forth
25 any of the technical requirements as contained in

1 RFP, did you expect that offerer to raise its
2 questions in accordance with the terms of the RFP?

3 MR. FELDMAN: Objection to the
4 form.

5 A. Yes.

6 Q. Isn't it true that the schedule, the RFP
7 schedule that's contained in Section 2.4 of the RFP
8 contains specific dates by which, if they had any
9 questions, were seeking clarification, wanted to
10 raise issues that related to the RFP, those issues
11 could be raised before the State Health Plan?

12 MR. FELDMAN: Objection to the
13 form.

14 A. Yes.

15 Q. Mr. Feldman asked you in his direct
16 examination a question that there was no analysis of
17 the geo-access report.

18 Do you recall that line of questioning?

19 A. Yes.

20 Q. Do you recall whether prior to the time
21 that an offer was submitted by Blue Cross that at
22 any time Blue Cross Blue Shield raised any question,
23 sought clarification or asked for instruction from
24 the State Health Plan as to that requirement?

25 A. I do not recall any such inquiry.

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 4**

CONFIDENTIAL: FILED UNDER SEAL

Excerpts from the September 15, 2023
Deposition of Roy Watson
(“R. Watson Dep.”)

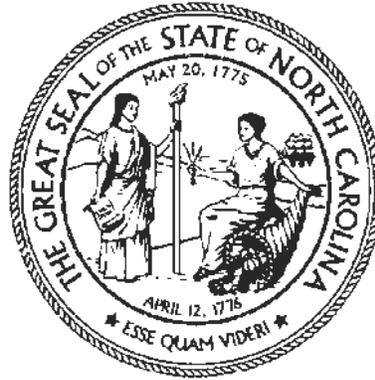
**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 5**

**CONFIDENTIAL/HIGHLY CONFIDENTIAL
ATTORNEYS’ EYES ONLY: FILED UNDER SEAL**

Excerpts from the September 21, 2023 30(b)(6)
Deposition of Aetna/Catherine Aguirre
(“Aetna 30(b)(6) Dep.”)

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 6**

Deposition Exhibit 5 – Excerpts of North Carolina
State Health Plan for Teachers and State Employees
RFP No.: 270-20220830TPAS
(“Dep. Ex. 5”)



STATE OF NORTH CAROLINA
THE NORTH CAROLINA STATE HEALTH PLAN
FOR TEACHERS AND STATE EMPLOYEES
REQUEST FOR PROPOSAL #: 270-20220830TPAS
THIRD PARTY ADMINISTRATIVE SERVICES

Date of Issue: August 30, 2022

Proposal Opening Date: November 7, 2022

At 10:00 AM ET

Direct all inquiries concerning this RFP to:

Vanessa Davison
Contracting Agent

Email: [Vanessa Davison @nctreasurer.com](mailto:Vanessa.Davison@nctreasurer.com)
SHPCContracting@nctreasurer.com

Phone: 919-814-4421

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

specifications herein. Vendors also are responsible for obtaining and complying with all addenda and other changes that may be issued in connection with this RFP.

If Vendors have questions, issues, or exceptions regarding any term, condition, or other component within this RFP, those must be submitted as questions in accordance with the instructions in Section 2.5 PROPOSAL QUESTIONS. If the State determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an Addendum. The State may also elect to leave open the possibility for later negotiation and amendment of specific provisions of the Contract that have been addressed during the question-and-answer period. Other than through this process, the State rejects and will not be required to evaluate or consider any additional or modified terms and conditions submitted with Vendor's proposal. This applies to any language appearing in or attached to the document as part of Vendor's proposal that purports to vary any terms and conditions or Vendors' instructions herein or to render the proposal non-binding or subject to further negotiation. Vendor's proposal shall constitute a firm offer. **By execution and delivery of this RFP Response, Vendor agrees that any additional or modified terms and conditions, whether submitted purposely or inadvertently, shall have no force or effect, and will be disregarded. Any bid that contains language that indicates the bid is non-binding or subject to further negotiation before a contractual document may be signed shall be rejected. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject Vendor's proposal as nonresponsive.**

If a Vendor desires modification of the terms and conditions of this solicitation, it is urged and cautioned to inquire during the question period, in accordance with the instructions in this RFP, about whether specific language proposed as a modification is acceptable to or will be considered by the State. Identification of objections or exceptions to the State's terms and conditions in the proposal itself shall not be allowed and shall be disregarded or the proposal rejected.

Contact with anyone working for or with the State regarding this RFP other than the State Contract Manager named on the face page of this RFP in the manner specified by this RFP shall constitute grounds for rejection of said Vendor's offer, at the State's election.

2.4 RFP SCHEDULE

The table below shows the *intended* schedule for this RFP. The State will make every effort to adhere to this schedule.

Event	Responsibility	Date and Time
Issue RFP	Plan	August 30, 2022
Phone call with potential Offerors	Plan	September 1, 2022, 10:00 a.m. ET To join the phone call with potential Offerors, dial 984-275-3153, Conference ID: 844 589 624#
Vendor Deadline for Submission of Written Minimum Requirements Questions	Vendor	September 12, 2022, 12:00 p.m. ET
Plan Responds to Minimum Requirements Questions	Plan	September 16, 2022
Deadline to Submit Minimum Requirements Responses	Vendor	September 26, 2022, 10:00 a.m. ET The public bid opening for this solicitation will be conducted via conference call. To hear the bid opening for this RFP,

		dial 877-810-9415, Access Code: 4542246#
Evaluation of Minimum Requirement Responses	Plan	September 27 – 29, 2022
Notify Vendors if Minimum Requirements Met. If met, Vendors will be provided information regarding access to claims information.	Plan	September 29, 2022
Issue Vendor's designated recipient, a link to Secure File Transfer Protocol (SFTP) system for attachments and data files	Plan	September 29 – 30, 2022
Vendor Deadline for Submission of All Written Questions	Vendor	October 10, 2022, 12:00 p.m. ET
Plan Responds to Questions (Addendum Posted on Ariba landing page.)	Plan	October 14, 2022
Opening of Proposals by Plan (Bid Closes)	Vendor	November 7, 2022, 10:00 a.m. ET
Evaluation of Proposals	Plan	November 8 – 16, 2022
Best and Final Offer (BAFO)	Plan	November 17 – 30, 2022
Plan Seek Approval from the Attorney General's Office	Plan	December 1 – 7, 2022
Present award recommendation to the Board	Plan	December, 2022
Award of the Contract	Plan & Vendor	December, 2022
Implementation Period	Plan & Vendor	January 1, 2023 – December 31, 2024
Services Begin	Vendor	January 1, 2025

2.5 PROPOSAL QUESTIONS

Upon review of the RFP documents, Vendors may have questions to clarify or interpret the RFP in order to submit the best proposals possible. To accommodate the Proposal Questions process, Vendors shall submit any such questions by the above due dates. Questions received after these dates will not receive a response.

Written questions shall be emailed to Vanessa.Davison@nctreasurer.com with a copy to SHPCContracting@nctreasurer.com by the date and time specified above. When submitting Minimum Requirements questions, Vendors should enter "RFP # 270-20220830TPAS: Minimum Requirements Questions" as the subject for the email. When submitting all other questions, Vendors should enter "RFP # 270-20220830TPAS Questions." Question submittals should include a reference to the applicable RFP section and be submitted in the format shown below in sequential order:

Question #	Reference	Vendor Question
1.	RFP Section, Page Number	Vendor question ...?

Questions received prior to the submission deadline dates in Section 2.4, the State's response, and any additional terms deemed necessary by the State will be posted in the form of an Addendum to this RFP on the Ariba landing page and can be accessed at the following link: <http://discovery.ariba.com/rfx/13956411>. No information, instruction, or advice provided orally or informally by any State personnel, whether made in response to a question or otherwise in connection with this RFP, shall be considered authoritative or binding. Vendors shall rely *only* on written material contained in an Addendum to this RFP.

2.6 PROPOSAL SUBMITTAL

2.6.1 RFP Phases for Submission

- a) This RFP requires that Vendors meet certain Minimum Requirements in order for technical and cost responses to be evaluated for possible Contract award (See Section 5.1). Therefore, submission of responses are divided into two (2) phases:
 - i. Minimum Requirements Submission
 - ii. Technical and Cost Proposal Submission
- b) Vendors that meet the Minimum Requirements will be notified and may provide Technical and Cost Proposals in response to the RFP. Vendors that do not meet the Minimum Requirements will be disqualified from further consideration.
- c) Vendors that meet the Minimum Requirements and submit the signed ATTACHMENT I: NONDISCLOSURE AGREEMENT, will be provided a de-identified medical claims file for repricing, census data and all other exhibits listed in ATTACHMENT A: PRICING. The files will be provided via SFTP. The instructions for accessing the data files are as follows:
 - i. The Plan will provide its Actuarial/Analytical and Health Benefits Consulting vendor Segal a listing of Vendors that meet the Minimum Requirements and copies of the NDA that identifies each Vendor's designated recipient and email address.
 - ii. Segal will send each Vendor's designated recipient a link to the SFTP system with all the data and exhibits identified above and in ATTACHMENT A: PRICING.
 - iii. The designated recipient may access the SFTP system and download each of the files.
- d) Sealed proposals, subject to the conditions made a part hereof and the receipt requirements described below, shall be received at the address indicated in the table below, for furnishing and delivering those items or Services as described herein.

Mailing and Office address for delivery of proposal via US Postal Service, special delivery, overnight, or any other carrier

PROPOSAL NUMBER: 270-20220830TPAS
 NC Department of State Treasurer
 State Health Plan Division
 3200 Atlantic Avenue
 Raleigh, NC 27604

Attention: Vanessa Davison, Contracting Agent

IMPORTANT NOTE: All proposals shall be physically delivered to the office address listed above on or before the proposal deadline in order to be considered timely, regardless of the method of delivery. **This is an absolute requirement.** All risk of late arrival due to unanticipated delay—whether delivered by hand, U.S. Postal Service, courier, or other delivery service is entirely on Vendor. It is the sole responsibility of Vendor to have the proposal physically in this office by the specified time and date of opening. The time of delivery will

2.7.2 Technical and Cost Proposal Contents

Vendors shall populate all attachments of this RFP that require Vendor to provide information and include an authorized signature where requested. Vendors' Technical and Cost Proposal responses shall include the following items and those attachments should be arranged in the following order:

- a) Completed and signed version of EXECUTION PAGES along with the body of the RFP, and signed receipt pages of any addenda released in conjunction with this RFP (if required to be returned).
- b) Completed Response to RFP Section 4.10 "Administrators for the Contract and HIPAA Privacy Officer."
- c) Completed ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE.
- d) Completed version of ATTACHMENT A: PRICING.
- e) ATTACHMENT B: INSTRUCTIONS TO VENDORS.
- f) Completed version of ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION.

2.8 DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

- a) **ADDENDUM:** Written clarification or revision to this RFP during the procurement process and prior to the close of bids.
- b) **ADMINISTRATIVE DECISION MEMO (ADM):** Document that outlines the Plan's business rules and/or requirements and the processes used by Vendor to support the Plan. The ADM must be signed by the Plan's Contract Administrator regarding day-to-day activities, and/or his/her delegate and Vendor's Contract Administrator regarding day-to-day activities, and/or his/her delegate.
- c) **AUDIT FILES:** A Full File that provides all records/transactions required to successfully validate vendor or partner data including, but not limited to, enrollment (i.e., demographics, Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
- d) **BAFO:** Best and Final Offer, submitted by a Vendor to alter its initial offer, made in response to a request by the State.
- e) **BEACON – (Building Enterprise Access for NC's Core Operation Needs):** State system that integrates employee benefit enrollment with HR and Payroll SAP software. It also supports related payroll processes, reporting, and other related services. Currently, enrollment data from BEACON is sent via daily EDI files to the Plan's eligibility and enrollment services vendor.
- f) **BENEFIT EFFECTIVE DATE:** The date Vendor is obligated to start processing claims.
- g) **BENEFIT YEAR:** The fiscal 12-month period which begins every January 1st and ends every December 31st during which yearly plan design features such as the copayments and co-insurance and specific benefit maximums accumulate.
- h) **BOARD OF TRUSTEES (BOARD):** The governing board whose members are appointed by the Governor, the North Carolina General Assembly, and the State Treasurer and who act as fiduciaries for the Plan in carrying out their duties and responsibilities as set forth in law.
- i) **BUSINESS REQUIREMENTS:** Customer (Plan) needs and expectations that will be memorialized in a Business Requirements Document.
- j) **BUSINESS REQUIREMENTS DOCUMENT (BRD):** Document that outlines the Business Requirements, for a benefit, program, or process and may include requirements for multiple Plan vendors.
- k) **CHANGE FILE:** An EDI file that provides records/transactions, including retroactivity, that have changed or are new since the last EDI file. Change Files are often desirable as they are smaller in size and are quicker to process than Full Files. With Change Files, successive files will contain only data that has changed since the preceding Change File or Full File.

- l) **CLARIFICATION:** A written response from a Vendor that provides an answer or explanation to a question posed by the State about that Vendor's proposal. Clarifications are incorporated into Vendor's proposal response.
- m) **CLOSE-OUT DOCUMENT:** A document developed by Vendor to tie up any loose ends from a project and officially deliver the project to the operations and/or business teams.
- n) **CMS:** Federal Centers for Medicare and Medicaid Services.
- o) **COBRA:** Consolidated Omnibus Budget Reconciliation Act of 1986, 29 U.S.C. §. 1161-1168 as applicable to the North Carolina State Health Plan pursuant to Title XXII of the Public Health Service Act, U.S.C. §§ 300bb-1 through 300bb-8. Provides certain former employees, retirees, spouses, former spouses, and Dependent children the right to temporary continuation of health coverage at group rates. The coverage, however, is only available when coverage is lost for specific qualifying events.
- p) **CONFLICT OF INTEREST:** Situations or circumstances through which Vendor, or entities or individuals closely affiliated with Vendor, will derive, or reasonably may be perceived as deriving, direct financial or other pecuniary benefit from its performance of this Contract other than through the compensation received according to the Contract for performance of the Contract, or that might impair, or reasonably be perceived as impairing, Vendor's ability to perform this Contract in the best interests of the State.
- q) **CONTRACT ADMINISTRATOR:** Representative of the Plan who will administer this Contract for the State.
- r) **CONTRACTING AGENT:** Representative of the Plan who corresponds with potential Vendors regarding this RFP.
- s) **COVERAGE TIER:** The type of coverage (employee only, employee + spouse, employee + child(ren), and employee + family) the Subscriber has elected.
- t) **CUSTOMER EXPERIENCE:** The service experience of customers.
- u) **DATA CENTER:** A facility that performs one or more of the following functions:
 - a. Physically houses various equipment, such as computers, servers (e.g., web servers, application servers, database servers), switches routers, data storage devices, load balances, wire cages or closets, vaults, racks, and related equipment;
 - b. Stores, manages, processes, and exchanges digital data and information;
 - c. Provides application services or management for various data processing, such as web hosting internet, intranet, and telecommunication and information technology.
- v) **DATA WAREHOUSE:** A Data Warehouse is a merged repository that stores data from multiple sources from an enterprise's various operational systems, that is constructed with predefined schemas designed for data analytics and reporting, for current and historical decision support information of raw data, whether structured or unstructured, from multiple sources, and its schema is undefined.
- w) **DELIVERABLE:** Refers to any service, duty, performance, or other contractual obligation of Vendor.
- x) **DEPENDENT:** An eligible Plan Member other than the Subscriber.
- y) **DEPLOYMENT PLAN:** A document developed by Vendor to outline the sequence of operations or steps that must be carried out to deploy new functionality or processes.

- z) **ELECTRONIC DATA INTERFACE (EDI):** Standard format for exchanging business data.
- aa) **EMPLOYING UNIT:** A North Carolina local education agency; community college; State department, agency, or institution; or association or examining board or commission, whose employees are eligible for membership in a State of North Carolina-supported retirement system as defined in Article 3B of Chapter 135 of the North Carolina General Statutes as may be amended from time to time. An Employing Unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the North Carolina General Statutes whose board of directors elects to become a participating employer in the Plan under N.C.G.S. § 135-39.17. Bona fide fire departments, rescue or emergency medical service squads, and National Guard units are deemed to be Employing Units for the purpose of providing benefits under this Article. An Employing Unit shall also mean an employer, as defined for local government employers by N.C.G.S. § 128-21(11) who has received legislative authority to and has elected to participate in the Plan.
- bb) **END-TO-END TESTING:** Testing that begins at the first step of the process and concludes with the last step. In this Contract, End-to-End Testing includes testing the process from the beginning step to the last step which includes testing with every Plan vendor involved in the item to be tested.
- cc) **ENTITY:** For the purposes of this Contract, Entity refers to a distinct grouping of Employing Units. They include, but are not limited to:
- a. **BEACON Groups** – Employing Units utilizing the BEACON payroll system.
 - b. **Universities** – Employing Units that are part of the North Carolina University System.
 - c. **Community Colleges** – Employing Units that are part of the North Carolina Community College System.
 - d. **Public Schools** – Employing Units that are part of the North Carolina Public Schools or Local Education Associations (LEAs).
 - e. **Charter Schools** – North Carolina Charter Schools that have elected to participate in the Plan.
 - f. **Local Governments** – Local Governments that have elected to participate in the Plan.
- dd) **E-PROCUREMENT SERVICES:** The program, system, and associated Services through which the State conducts electronic procurement.
- ee) **FOCUS AUDITS:** Audits performed on an as-needed basis at the Plan's discretion throughout the Plan Year. The North Carolina Office of the State Auditor may initiate an audit at any time.
- ff) **FULL FILE:** EDI file that provides all records/transactions between a date range or a complete historical dump of data. Full Files can also contain termination and future transactions based on the requirements. Full Files are larger in size and take longer to process. With Full Files, successive files will contain more and more and take longer and longer to process. For example, if Full Files are created each month, every Full File created will contain all records/transactions from the previous Full File and any additional records/transactions created during the current month. Examples of standard Full Files include but are not limited to:
- a. **Audit Files** – A Full File that provides all records/transactions required to successfully validate vendor or Partner data including, but not limited to enrollment (i.e., demographics and Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
 - b. **Seed File** – A Full File that provides all records/transactions required to successfully "seed" or baseline Plan data with a vendor, Partner, or the Plan. This data includes, but is not limited to enrollment (i.e., demographics Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
 - c. **Annual or Open Enrollment File** – A Full File that provides all records/transactions required to successfully validate vendor or Partner data for the subsequent Plan Year, including but not limited to enrollment (i.e., demographics and Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group). Vendors and Partners may request that an annual enrollment Full File is broken up into several files due to file size processing limitations.

- gg) **GO-LIVE:** The first time a system or service can be used after all tests have been completed and the functionality has been implemented. There shall be a Go-Live date in every Implementation Plan.
- hh) **GROUP:** The entity through which Members are “grouped” to enroll and be invoiced (i.e., Employing Units, Retirement Systems, direct bill, and COBRA).
- ii) **HEALTH BENEFIT REPRESENTATIVE (HBR):** The employee designated by the Employing Unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The North Carolina Retirement Systems is the HBR for retired state employees.
- jj) **HEALTH ASSESSMENT:** Individual health questionnaires that provide a systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease.
- kk) **HIPAA:** The Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.§. 1301 et seq. The law provides uniform federal privacy protection standards for consumers across the country. The standards protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Federal Department of Health and Human Services, these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. The term HIPAA also includes all amendments and implementing regulations including specifically the HITECH Act of 2009, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 11-5.
- ll) **IMPLEMENTATION PLAN:** Documentation of the agreed upon target dates for meeting milestones and Deliverables that must be completed for the provision of services to Go-Live. Implementation Plans shall be utilized for the initial implementation and Go-Live of the Contract and for any subsequent Amendments or activities that require Vendor system development or Plan vendor integration. Implementation Plans shall include a description of the co-dependencies and tasks, identification of business, and/or deliverable owner(s).
- mm) **INTERACTIVE VOICE RESPONSE (IVR):** A technology that allows a computer to interact with humans through the use of voice and keypad inputs.
- nn) **LOAD RATE:** The number of enrollment transactions that successfully pass the EDI edits and load automatically into Vendor's system without manual intervention. The enrollment transaction should be counted at the Contract or family level.
- oo) **Mapped or Mapped Member:** The Plan's EES vendor “maps” Members into a specific plan design and/or premium for the start of each year's open enrollment. If Members take no action, they remain in that plan and premium for which they were “Mapped” for the following year. Example: All Plan members enrolled in the Enhanced PPO Plan (80/20) for the current benefit year are mapped to the Base PPO Plan (70/30) without the tobacco credit for the following year. The Subscriber has the opportunity to change that Mapped enrollment during open enrollment.
- pp) **MAY:** Denotes that which is permissible, not mandatory
- qq) **MEDICAL MANAGEMENT:** A general term applied to practices of utilization management (UM), case management (CM), and disease management (DM), alone or in combination with each other.
- rr) **MEMBER:** Any Subscriber enrolled in the North Carolina State Health Plan for Teachers and state employees, or a Dependent currently enrolled in the health benefit plan for which a premium is paid.
- ss) **N.C.G.S.:** North Carolina General Statutes.

- tt) **PARTIES TO THE CONTRACT:** The Parties (Parties) to this Contract are the Plan and Vendor(s) selected through the RFP process.
- uu) **PARTNER:** State sister agencies or other governmental units including BEACON, the State Retirement Systems, the University system, community college system, and public school systems.
- vv) **PERFORMANCE GUARANTEE:** A contractual obligation or performance standard Vendor must comply with or be subject to contractual fee reductions, payments to the Plan, or legal remedies.
- ww) **PLAN YEAR:** A twelve-month period which runs from January 1 through December 31.
- xx) **PLAN'S AUDITORS:** Includes external audit Vendors engaged by the Plan, internal Plan auditors, and Certified Public Accountants.
- yy) **PLAN DESIGN:** Each version of the Health benefit Product is known as the Plan Design. For example, the Plan currently has three (3) PPO Plan Designs for Active Members: Enhanced PPO Plan (80/20), Base PPO Plan (70/30), and the HDHP.
- zz) **PRODUCT:** Health benefit Products are generally differentiated by the network and provider reimbursement methodology but may have other differentiating characteristics. The Plan currently offers two (2) different Products: Preferred Provider Organizations (PPO) and Medicare Advantage Plans.
- aaa) **PROTECTED HEALTH INFORMATION (PHI):** Shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information created or received by the Business Associate from or on behalf of the Covered Entity.
- bbb) **QUALIFIED PROPOSAL:** A responsive proposal submitted by a responsible Vendor.
- ccc) **REBATES:** The amounts paid to Vendor (a) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (b) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescription drugs by Members. Rebates include all revenue received by Vendor from outside sources related to the Plan's utilization or enrollment in programs. These would include, but are not limited to access fees, market share fees, rebates, formulary access fees, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers, and data warehouse vendors.
- ddd) **REDACT:** For purposes of this RFP, to edit a document by obscuring or removing information that is considered confidential or proprietary as defined by N.C.G.S. § 132-1.2. Any redactions must be done in black.
- eee) **REQUEST FOR PROPOSAL (RFP):** The document which establishes the bidding and contract requirements and solicits bid proposals to meet the purchase needs of the State as identified herein.
- fff) **SECURE FILE TRANSFER PROTOCOL (SFTP):** SFTP in which a standard network protocol is used to exchange files over a Transmission Control Protocol/Internet Protocol based network.
- ggg) **SERVICE PERIOD:** The initial service period begins upon the Plan's acceptance of all implementation Deliverables for which all TPA services are in effect. The Service Periods for this Contract equate to the Plan Year.
- hhh) **SERVICES:** The tasks and duties undertaken by Vendor to fulfill the requirements and specifications of this RFP.
- iii) **SHALL OR MUST:** Denotes that which is a mandatory requirement.
- jjj) **SHOULD:** Denotes that which is recommended or preferred, but not mandatory.

- kkk) **SPLIT CONTRACT:** Retiree who is Medicare primary with one or more Dependents that are non-Medicare primary or vice versa.
- lll) **STANDARD AUDITS:** Audits performed on an ongoing quarterly basis by the Plan's Auditors and/or the North Carolina Office of the State Auditor. Standard Audits are used to measure claims accuracy, generally, and associated with Performance Guarantees and identify overpayments
- mmm) **STATE:** The State of North Carolina, including any of its sub-units recognized under North Carolina law.
- nnn) **STATE AGENCY:** Any of the more than 30 employing units within the executive branch of the State, including its departments, boards, commissions, institutions of higher education, and other institutions.
- ooo) **STATE BUSINESS DAY:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, except for North Carolina state holidays as defined by the Office of State Human Resources: <http://www.osp.state.nc.us/holsched.htm>.
- ppp) **SUBCONTRACTOR:** An entity having an arrangement with a Plan vendor, where the Plan vendor uses the Products and/or services of that entity to fulfill some of its obligations under its contract with the Plan, while retaining full responsibility for the performance of all of its (Vendor's) obligations under the contract, including payment to the Subcontractor. The Subcontractor has no contractual relationship with the Plan, only with Vendor.
- qqq) **SUBSCRIBER:** The primary health benefit plan contract holder.
- rrr) **TEST PLAN:** The document or tool developed by Vendor to manage, organize, and track test cases.
- sss) **TIER 1 PROVIDER:** In-network provider that meets the established high quality and low cost criteria.
- ttt) **TIER 2 PROVIDER:** In-network provider that does not meet the Tier 1 provider quality and/or cost criteria.
- uuu) **THIRD PARTY ADMINISTRATOR (TPA):** A Vendor that provides administrative services and assumes responsibility for administering health benefit plans including claims processing without assuming financial risk for claims payments.
- vvv) **THIRD PARTY ADMINISTRATIVE (TPA) SERVICES:** Services provided by the Third Party Administrator.
- www) **UNIT TESTING:** Testing performed in isolation of interdependencies.
- xxx) **VENDOR:** Supplier, bidder, proposer, company, firm, corporation, partnership, individual, or other entity submitting a response to this RFP.
- yyy) **VENDOR AUDIT SCHEDULE:** Schedule that outlines the dates and turnaround times for each step of the monthly enrollment audits between Plan Vendors.

3.0 METHOD OF AWARD AND PROPOSAL EVALUATION PROCESS

3.1 METHOD OF AWARD

Pursuant to N.C.G.S. § 135-48.34, this solicitation is not subject to the requirements of Article 3 of Chapter 143 of the North Carolina General Statutes. Contracts will be awarded in accordance with N.C.G.S. § 135-

Only information which is received in response to this RFP will be evaluated; reference to information previously submitted or available elsewhere shall not be evaluated or considered.

The State shall conduct a comprehensive, fair, and impartial evaluation of the proposals received in response to this request. Proposals will be evaluated according to completeness, content, and experience with similar work, the ability of Vendor and its staff, and cost(s). Specific evaluation criteria are listed in Section 3.4 EVALUATION CRITERIA, below.

Vendors are cautioned that this is a request for offers, not an offer or request to contract, and the State reserves the unqualified right to reject any and all offers at any time if such rejection is deemed to be in the best interest of the State.

The State reserves the right to reject all original offers and request one or more of Vendors submitting proposals within a competitive range to submit a best and final offer (BAFO), based on discussions and negotiations with the State, if the initial responses to the RFP have been evaluated and determined to be unsatisfactory.

Upon completion of the evaluation process, the State will make Award(s) based on the evaluation and post the award(s) to IPS under the RFP number for this solicitation. Award of a Contract to one Vendor does not mean that the other proposals lacked merit, but that, all factors considered, the selected proposal was deemed most advantageous and represented the best value to the State.

b) Evaluation Committee

An Evaluation Committee (Committee) will be established to review each proposal and recommend a Vendor. The Plan may engage the professional services of Plan vendors to assist in the evaluation process. The Plan reserves the right to alter the composition of the Committee or to designate other staff to assist in the process. Other designated staff and senior management from the Department of State Treasurer may attend meetings, discussions, and/or presentations during the evaluation process. However, all decisions regarding scoring and the final recommendation will be made solely by Committee members.

The Committee will review and evaluate all proposals submitted by the deadline specified in this RFP. This Committee will be responsible for the entire evaluation process. Committee participants are obligated to keep information identified as trade secret and proprietary confidential.

Technical Proposals meeting the Minimum Requirements described in Section 5.1 will be considered and evaluated as follows:

- 1: Evaluation of Technical Proposal
- 2: Evaluation of Cost Proposal
- 3: Determination of Successful Proposal Based on the Combination of Technical & Cost

c) Approval for Contract Award

Upon completion of the evaluation, the Committee will present their findings and recommendations to the Board. The Board, with the guidance of the Committee, will make the final award recommendation. The Plan's Executive Administrator will award the Contract after approval by the Plan's Board and Attorney General's Office. A Contract is not binding until the Plan's Executive Administrator and State Treasurer have signed the Acceptance of Proposal.

3.4 EVALUATION CRITERIA

a) Overall Scoring Weights:

Each Vendor's proposal will be evaluated and scored on several factors. The Technical Proposal includes the written proposal and oral presentation, if applicable. The Technical Proposal and the Cost Proposal will be scored separately based on the overall point scale described below.

The total points scale will reflect the following weights:

Technical Proposal	50%
Cost Proposal	50%
Total:	100%

b) Technical Requirements & Specifications:

Scoring points for the Technical Proposal will be allocated as follows:

TECHNICAL AREAS	MAXIMUM POINTS
Section 5.2.1 Account Management	20
Section 5.2.2 Finance and Banking	19
Section 5.2.3 Network Management	28
Section 5.2.4 Product and Plan Design Management	4
Section 5.2.5 Medical Management	18
Section 5.2.6 Enrollment, EDI, and Data Management	40
Section 5.2.7 Customer Experience	52
Section 5.2.8 Claims Processing and Appeals Management	16
Section 5.2.9 Claims Audit, Recovery, and Investigation	25
Section 5.2.10 Initial Implementation and Ongoing Testing	3
Section 5.2.11 Reporting	48
Total	310

The Vendors will be ranked in descending order based on the total points earned. The Vendor earning the least points out of the total 310 will receive the rank of one (1). The bids will fall in line according to total scored points, with the Vendor earning the most points out of the total 310 receiving the highest rank. Should two (2) Vendors earn the same score in the technical points, they will be given equal rank.

c) Cost Proposal:

Cost Proposals will be scored based upon the Vendor's response to ATTACHMENT A. The maximum number of total points will be awarded to Vendor offering the most competitive cost proposal with others receiving points proportionately.

Vendor responses to the cost specifications in ATTACHMENT A will be evaluated in three (3) categories representing 10 total points.

- 1) Network Pricing – six (6) points

- a) Projected claim costs will be calculated for each Vendor based on their response to the cost specifications.
 - b) The highest ranked (or lowest network pricing) proposal will receive the full six (6) points allocated to this section.
 - c) All other proposals will be ranked and will receive points based on the following criteria: within 0.5% of the first ranked proposal = 6 points; within 1.0% = 5 points; within 1.5% = 4 points, within 2.0% = 3 points, within 2.5% = 2 points, within 3.0% = 1 point, greater than 3.0% = 0 points.
- 2) Administrative Fees – two (2) points
- a) Projected administrative fees will be calculated for each Vendor based on their response to the cost specifications.
 - b) The highest ranked (or lowest administrative fees) proposal will receive the full two (2) points allocated to this section.
 - c) All other proposals will be ranked and may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals.
- 3) Network Pricing Guarantees – two (2) points
- a) Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.
 - b) The proposal that offers the network pricing guarantees with the greatest value will be ranked the highest and will receive the full two (2) points allocated to this section.
 - c) All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.

The Vendors will be ranked in descending order based on the total cost proposal points earned. The Vendor earning the least cost proposal points out of the total 10 will receive the rank of one (1). The bids will fall in line according to total cost proposal points, with the Vendor earning the most points out of the total 10 receiving the highest rank. Should two Vendors earn the same score in the cost proposals, they will be given equal rank.

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 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

5.1.2 Finance and Banking Minimum Requirements

- a. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.
- b. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website:
<https://www.nctreasurer.com/media/3791/open>
- c. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.
- d. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.
- e. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:
 - i. State banking: <https://www.nctreasurer.com/media/3791/open>
 - ii. Cash management: <https://www.osc.nc.gov/state-agency-resources/statewide-cash-management>
 - iii. Escheats: <https://www.nccash.com/holder-information-and-reporting>
 - iv. High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."
- f. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.

5.1.3 Network Management Minimum Requirements

- a. Vendor agrees the Plan is a government payor.
- b. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.
- c. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.
- d. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
- e. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.
- f. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.
- g. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.
- h. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.

- i. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.
- j. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.
- k. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.
- l. Vendor will administer other reference-based pricing models, if requested by the Plan.

5.1.4 Product and Plan Design Management Minimum Requirements

- a. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.
 - i. Enhanced PPO Plan (80/20): <https://www.shpnc.org/media/2583/download?attachment>
 - ii. Base PPO Plan (70/30): <https://www.shpnc.org/media/2582/download?attachment>
 - iii. HDHP: <https://www.shpnc.org/media/2584/open>
- b. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the Primary Care Provider (PCP) listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.
- c. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.
- d. Vendor will integrate real-time or near real-time deductible and/or out-of-pocket (OOP) accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.
- e. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.
- f. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.
- g. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

5.1.5 Medical Management Programs Minimum Requirements

- a. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
- b. Vendor will carve-out PBM services from this Contract.
- c. Vendor will customize any of the Medical Management programs, if requested by the Plan.

5.1.6 Enrollment, EDI, and Data Management Minimum Requirements

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

- i. 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.

5.1.11 Reporting Minimum Requirement

- a. 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."

5.2 TECHNICAL PROPOSAL REQUIREMENTS AND SPECIFICATIONS

Vendor shall complete ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE which addresses the technical requirements below.

5.2.1 Account Management

5.2.1.1 Overview and Expectations

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

5.2.1.2 Resources

- a. Vendor addressed the following in the Minimum Requirements Table or ATTACHMENT K:
 - i. Vendor has provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives. Vendor shall provide the Plan with contact information for one (1) such client to complete a reference call related to the services in this RFP.
 - ii. Vendor has one (1) or more current or former ASO clients with more than 25,000 Medicare primary members.
 - iii. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.
 - iv. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.
 - v. Vendor has a "firewall" between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.
- b. Vendor shall confirm it will provide a dedicated resource for each of the following roles:
 - i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to Plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.
 - ii. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment and Group Set-Up.
 - iii. **Member Services Manager** – Responsible for all customer service functions and reporting.

- iv. **Claims Services Manager** – Responsible for claims payments and recoveries.
 - v. **Enrollment and Group Set-Up**– Responsible for all enrollment, enrollment files, and reconciliation services.
 - 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.
 - vii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process and must continue to support the Plan for a minimum of 90 days after the implementation date of January 1, 2025, if requested by the Plan. Such support includes, but is not limited to, weekly calls with the Plan and the designated account management team; maintenance of issue tracking logs; and issue resolution.
- c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed. Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:
- i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.). This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic initiatives.
 - ii. **Director of Network Management** – Responsible for overall management of Vendor's network including provider contracting, network development, and/or provider relations functions. This resource will work with the Plan to develop, implement, and maintain custom provider reimbursement models or other provider initiatives as requested by the Plan.
 - iii. **Actuary** - Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating Return on Investment (ROI) in order to measure financial effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) as well as alternate payment models (Accountable Care Organizations, Clinically Integrated Networks, etc.). Will be required, upon request, to provide sufficient data and documentation to the Plan to independently verify calculations. The Actuary shall be a Fellow of the Society of Actuaries with a primary focus in Health Benefit Systems.
 - iv. **Privacy Officer** - Responsible for ensuring compliance with all applicable laws and regulations, including, but not limited to, HIPAA, Patient Protection and Affordable Care Act (PPACA), and the Employee Retirement Income Security Act of 1974 (ERISA). Responsible for maintaining internal controls to protect Protected Health Information (PHI) and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.
 - v. **Attorney** - Responsible for communicating program and policy updates to the Plan and coordinating as necessary with the Plan's internal counsel and staff. Responsible for promptly reviewing materials for Vendor and providing appropriate, legally justifiable, feedback to the Plan. This person must be well-versed in Chapter 135 of the North Carolina General Statutes and Chapter 58 of the North Carolina General Statutes, to the extent that North Carolina Department of Insurance (DOI) regulations apply to the Plan.

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

- a. Vendor shall confirm each of the following:

- i. Vendor will meet with the Plan within two (2) weeks of a new request or initiative and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan. Meeting topics could include, but would not be limited to, data requests, network and/or Product development, pilots, and other initiatives.
- 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 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 24 hours of the request, unless extended by the Plan.
- v. Vendor will work with the Plan and other Plan vendors as needed to resolve issues. This includes providing the specific Vendor resources and expertise needed to address the specific issue(s), not just the account management team; and multiple meetings per week prior to and after Go-Live before all services are normalized.
- vi. Vendor will keep the Plan informed of changing state and federal rules, mandates, or other requirements to ensure compliance.
- vii. Upon request, Vendor will provide written documents outlining internal processes and procedures and, when requested by the Plan, agree to alter internal processes to meet the needs of the Plan.
- viii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.

5.2.2 Finance and Banking

5.2.2.1 Overview and Expectations

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

5.2.2.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.
 - ii. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website: <https://www.nctreasurer.com/media/3791/open>.

- iii. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.
 - iv. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.
 - v. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:
 - 1) State banking: <https://www.nctreasurer.com/media/3791/open>
 - 2) Cash management: <https://www.osc.nc.gov/state-agency-resources/statewide-cash-management>
 - 3) Escheats: <https://www.nccash.com/holder-information-and-reporting>
 - 4) High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."
 - vi. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.
 - ii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer.
 - iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable.
 - iv. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.
 - v. Vendor will provide access to up to three (3) years of historical receipts and claims funding data.
 - vi. Vendor will provide electronic submission of deposit reports and disbursement funding as well as detailed backup documentation to support the transactions.
 - vii. Vendor will provide historical check register detail and receipts as well as claims funding data.
 - viii. Vendor has internal quality control programs and audits that will ensure the accuracy of all financial reporting to the Plan.
 - ix. Vendor will batch claims and other disbursements for payment via check or automatic clearing house (ACH) from the Plan's bank account on a weekly basis as determined by the Plan.
 - x. Vendor will hold payment of weekly claims and other disbursements until funding is authorized and requisitioned by the Plan.
 - xi. Vendor will limit the aggregate dollar amount of claims paid each week if requested by the Plan to manage cash flow.
 - xii. Vendor will deposit checks received into the Plan's bank account within 24 hours of receipt to comply with the State's banking and cash management requirements.

- xiii. Vendor will provide a daily reporting package of deposited receipts as required by the Plan (see Reporting Section 5.2.11).
- xiv. Vendor will provide a weekly reporting package of claims and other disbursement as required by the Plan (see Reporting Section 5.2.11).
- xv. Vendor will customize the reporting of any deposits, disbursements, or other financial transactions as required by the Plan.
- xvi. Vendor will notify and report on all warrants/checks to be escheated prior to the submitting state filings, and if required by the Plan, adhere to a prior approval process for escheats.
- xvii. Vendor will recommend uncollectible accounts for write-off and adhere to a prior approval process.
- xviii. Vendor will notify and consult with the Plan at least 60 days in advance, or as soon as practical, of any system or business process change as it relates to handling, processing, or reporting of the Plan's financial transactions.
- xix. Vendor will process ad hoc check requests, such as a settlement check to a Member, as requested by the Plan.

5.2.3 Network Management

5.2.3.1 Overview and Expectations

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

5.2.3.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor agrees the Plan is a government payor.
 - ii. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.
 - iii. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.
 - iv. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

- v. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.
 - vi. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.
 - vii. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.
 - viii. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.
 - ix. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.
 - x. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.
 - xi. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.
 - xii. Vendor will administer other reference-based pricing models, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support transparency by allowing the Plan, at its request, to directly view any contracts associated with Vendor's network. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules. The Plan will take steps to protect Vendor's confidential data and proprietary information in accordance with applicable state and federal laws and regulations.
 - ii. Vendor will provide services to Members who travel outside the United States and have an urgent medical need.
 - iii. Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.
 - iv. Vendor will customize "hidden providers" (e.g., an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon) payment policies, as requested by the Plan.
 - v. Vendor will work with the Plan to ensure reimbursement rates for virtual visits with network providers are set appropriately.
 - vi. Vendor will provide transition of care services to assist Members when their provider is no longer in the network.
 - vii. Vendor offers a "narrow" network in North Carolina that may be utilized by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
 - viii. Vendor has a network management team that will support the Plan on any custom or private label network solutions.

- ix. Vendor has a provider credentialing team that could be utilized to credential potential network providers if the Plan were to develop a network solution that may include providers that are not currently enrolled in Vendor's other networks.
- x. Vendor has the ability to communicate directly with providers and will communicate Plan specific information to providers, as requested by the Plan.
- xi. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for specific services such as, but not limited to, specialty pharmacy.
- xii. Vendor has experience with each of the following alternative models of care or clinically integrated systems and will work with the Plan to deploy Vendor's solution or develop a similar custom solution for the Plan. Vendor shall confirm it has experience with each alternative payment model listed below:
 - 1) Patient-Centered Medical Homes.
 - 2) Hospital At Home Programs.
 - 3) Accountable Care Organizations.
 - 4) Community Care Organizations.
 - 5) Integrated Delivery Networks.
 - 6) Shared Risk/Savings.
 - 7) Pay-for-Performance.
 - 8) Global Payment/Capitation.
 - 9) Primary Care Incentives.
- xiii. Vendor will support the integration and ongoing operations of any of the aforementioned alternative payment models or clinically integrated systems that may be designed and managed by other Plan vendors.
- xiv. Vendor has the system capability to support capitated payments.
- xv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.
- xvi. If the Plan deploys a custom network or reimbursement models, Vendor's provider portal will allow Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.
- xvii. If the Plan deploys a custom network, Vendor will administer Plan specific provider contract documents which may include, but is not limited to, network participation agreements (NPA), reimbursement exhibits, pricing policies, fee schedules, and pricing development and maintenance policies.
- xviii. Vendor acknowledges any NPA developed to support a custom network for the Plan is not subject to review by DOI since the Plan is self-funded and not subject to DOI regulations except for those specifically noted in Chapters 58 and 135 of the North Carolina General Statutes.
- xix. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support any custom alternative payment models or networks implemented for the Plan.
- xx. Vendor will provide a dedicated provider call center, with a Plan specific phone number and greeting if the Plan implements a full, custom provider network.

5.2.4 Product and Plan Design Management

5.2.4.1 Overview and Expectations

The Plan seeks a Vendor that offers innovation in both Product and Plan Designs. Vendor should have an efficient business rules-based claims system that can not only support state, federal, and other custom benefits

but also accommodate unique medical and claims processing policies. Vendor should be nimble in its approach to piloting new programs and demonstrate "speed to market" when rolling out new Products, Plan Designs, and benefit features to meet the challenges facing state government health plans.

5.2.4.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

- i. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.
 - 1) Enhanced PPO Plan (80/20): <https://www.shpnc.org/media/2583/download?attachment>
 - 2) Base PPO Plan (70/30): <https://www.shpnc.org/media/2582/download?attachment>
 - 3) HDHP: <https://www.shpnc.org/media/2584/open>
- ii. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the PCP listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.
- iii. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.
- iv. Vendor will integrate real-time or near real-time deductible and/or OOP accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.
- v. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.
- vi. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.
- vii. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

b. Vendor shall additionally confirm each of the following:

- i. Vendor's systems will support each of the following Plan Design features. Vendor shall confirm each Plan design feature below:
 - 1) Applying a copay and a deductible to the same service.
 - 2) Applying a copay based on the providers network tier.
 - 3) Waiving the emergency room copay when the Member is admitted for an inpatient stay and/or an observation stay.
 - 4) Applying a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
 - a) PCP.
 - b) Specialist.
 - c) Urgent Care.
 - d) Emergency Room (ER).
 - e) Physical Therapy.
 - f) Occupational Therapy.
 - g) Speech and Hearing Therapy.
 - h) Outpatient Behavioral Health.

- i) Per Inpatient Confinement.
- 5) Setting benefit limits by age.
- 6) Setting benefit limits by frequency of service.
- 7) Setting benefit limits by confinement.
- 8) Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.
- ii. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.
- iii. Vendor will, upon request, administer a four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an out-of-area (OOA) benefit, and a non-network benefit.
- iv. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.
- v. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.
- vi. Vendor will administer member cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.
- vii. Vendor will implement incentive programs where Plan Members are given gift cards, or other incentives, for seeing certain providers and/or completing certain tasks.
- viii. Vendor will, upon request, integrate with other Plan vendors or Partners to deliver value-based and/or incentive benefits.
- ix. Vendor will, upon request, implement a Health Reimbursement Account (HRA) for Plan Members with each of the following features. Vendor shall confirm each HRA feature below:
 - 1) HRA annual balances based on the number of family Members enrolled.
 Example:
 Subscriber only = \$600 starting balance.
 Subscriber + one (1) Dependent = \$1200 starting balance.
 Subscriber + two (2) or more Dependents = \$1800 starting balance.
 - 2) Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.2.
 - 3) HRA account reconciliation services to support the Plan's banking and financial reporting requirements.
 - 4) Proration that reduces the starting HRA amount for Members who enroll after the beginning of the Benefit Year.
 - 5) Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.
 - 6) Automatic claims reimbursement functionality from the HRA.
 - 7) Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.
 - 8) Annual HRA rollover functionality.
 - 9) Ability to customize the HRA Member portal, as requested by the Plan.
 - 10) Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.
 - 11) HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.
 - 12) HRA Debit Card.
 - 13) Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.
 - 14) Ability to provide an HRA on a copay-based plan like the Enhanced PPO Plan (80/20).

- 15) Ability to customize HRA reports, as requested by the Plan.
- x. Vendor offers Health Savings Account (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.
- xi. Upon request, Vendor will administer a self-funded Group Medicare Supplement Plan.
- xii. Vendor will work with the Plan to implement benefits that may not be finalized and/or approved until close to the effective date. While it is the Plan's preference to have all benefits approved by the Board more than six (6) months in advance, there are dependencies, such as final budget approval by the North Carolina General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.

5.2.5 Medical Management Programs

5.2.5.1 Overview and Expectations

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

5.2.5.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
 - ii. Vendor will carve-out PBM services from this Contract.
 - iii. Vendor will customize any of the Medical Management programs, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
 - i. Vendor will customize any medical policy, if requested by the Plan.
 - ii. Vendor will provide comprehensive, holistic, evidence-based medical policies and Medical Management of Members' physical and behavioral health, including substance misuses, which focus on quality, positive Member outcomes, and cost efficiencies.
 - iii. Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation, if requested by the Plan.
 - iv. Vendor will keep the Plan apprised of disease trends within the population and provide reporting that summarizes overall Plan health.
 - v. Vendor will appropriately identify and engage Members in each of the following types of programs:
 - 1) Transition of Care (TOC) programs;
 - 2) High utilizer outreach and management programs; and,
 - 3) Complex case management programs.
 - vi. Vendor will provide "Hospital at Home" and/or other programs to promote transition from inpatient-hospital to home setting when appropriate.
 - vii. Vendor will offer wellness and prevention programs to support Plan Members.

- viii. Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members, if requested by the Plan.
- ix. Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, Vendor, and any other Plan vendors or Plan Partners involved in the program administration.
- x. Vendor will provide disease management Health Coaching Services.
- xi. Vendor will transition specific specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.
- xii. Vendor will provide claims and analytical data to support the transition of specific specialty medications to the Plan's PBM.
- xiii. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.
- xiv. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.
- xv. Vendor will meet with the Plan and the Plan's PBM to coordinate medical and pharmacy management programs.
- xvi. Vendor will perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.

5.2.6 Enrollment, EDI, and Data Management

5.2.6.1 Overview and Expectations

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

5.2.6.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will support the Plan's Group set-up structure which includes establishing, maintaining, and reporting on more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. A list of the Plan's current Group structure, which includes Group and Entity identifiers, can be found in Exhibit 3, "Group Structure."
 - ii. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.
 - iii. Vendor will have the capability to accept and at least 500,000 transactions in a single file transmission.
 - iv. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.

- v. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.
- vi. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."
- vii. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.
- viii. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.
- ix. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.
- x. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer

Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

- xi. Vendor will serve as the Plan's RRE under Section 111 of MMSEA Expanded Reporting Option.
- xii. As an Expanded Reporter, Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to obtain Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare rules, to determine which Plan Members' Medicare information requires updating.
- xiii. Vendor will update Vendor's system with the necessary updates from the Medicare audit and send Members' updated Medicare information to the Plan's EES vendor.
- xiv. Vendor will store and utilize the MBI, in addition to other Member identification numbers, such as SSN.
- xv. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.
- xvi. Vendor will maintain Medicare primacy effective and termination dates.
- xvii. Vendor will maintain multiple Medicare entitlement reasons.
- xviii. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.
- xix. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).

- xx. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.
- xxi. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.
- xxii. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.
- xxiii. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a new PCP. The final workflows will be defined during Contract implementation. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP synchronization requirements.
- xxiv. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)
 - 1) Plan's logo.
 - 2) Plan's messaging.
 - 3) Plan's network (if applicable).
 - 4) Out-of-NC network.
 - 5) Member out-of-pockets.
 - 6) Plan's Rx BIN and PBM information.
 - 7) Group Name (e.g., Wake County Schools, University of North Carolina, Department of Transportation).
 - 8) Member's unique ID number.
 - 9) Member's selected PCP.
- xxv. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of CCC and reporting needs under sections 6055 and 6056 of the IRS code.
- xxvi. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- xxvii. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- xxviii. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.
- xxix. Vendor will implement a process with the Plan to respond to DQ issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.
- xxx. Vendor will release data to the Plan as described in state and federal law.
- xxxi. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.

- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support Plan eligibility as defined by North Carolina General Statutes Chapter 135, Article 3B, Part 4.
 - ii. Vendor will accept industry standard and/or custom data files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:
 - 1) ASC X12 EDI transaction sets.
 - 2) XML files.
 - 3) Flat/ Fixed Files.
 - 4) APIs.
 - iii. Vendor will accept and process multiple data files within the same day.
 - iv. Vendor will accept and process multiple concurrent file transmissions.
 - v. Vendor will process "change" records as either terminated or added records.
 - vi. Vendor will load and process "terminated" and "add" transactions for the same Members within the same day.
 - vii. Vendor will exchange the enrollment and eligibility data using secure protocols.
 - viii. Vendor will provide a copy of outbound files delivered to other Plan vendors to the Plan via SFTP or SharePoint based on instructions from the Plan.
 - ix. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.
 - x. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits. Thresholds will be determined during implementation.
 - xi. Vendor will have a Load-Rate of at least 98% on accurate transactions received via EDI from the Plan's EES vendor.
 - xii. In addition to accepting and processing daily enrollment data file from the Plan's EES vendor, Vendor will manually load any data that cannot be processed automatically within three (3) State Business Days.
 - xiii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan's EES vendor.
 - xiv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Members.
 - xv. Vendor will accept and store multiple Member ID numbers from the Plan's EES vendor such as a unique member ID created by the EES vendor and MBI and/or the Member SSN.
 - xvi. Vendor will use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card.
 - xvii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- xxxvii. Upon notification by the Plan's COBRA Administration and Billing (CABS) vendor, Vendor will hold claims for individual Groups that have not paid their premium bill.
- xxxviii. Vendor will confirm that the monthly, custom claims data file that will be provided to the Plan can be sent as a Full File or Change File. The specific requirements will be developed during the implementation.
- xxxix. Vendor will confirm that it will provide reference tables and data dictionaries, with thorough field descriptions, to support the monthly, custom claims data files and that the reference tables and data dictionaries will be updated as needed and sent to the Plan within three (3) State Business Days of any change.
- xxxx. Vendor will conduct a Medicare repricing exercise to benchmark Vendor's network rates against Medicare reimbursement rates. The details of the repricing exercise shall be formalized in an ADM and memorialized via an Amendment to the Contract, as needed.

5.2.7 Customer Experience

5.2.7.1 Overview and Expectations

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

5.2.7.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.
 - ii. Vendor will have a dedicated toll-free number for Plan Members.
 - iii. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.
 - iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
 - v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.
 - vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
 - vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."
 - viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.
 - ix. Vendor will co-brand letters or other materials Vendor sends to Members.

- x. Vendor will customize the portal with the Plan's branding (logo).
 - xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will receive emails from Plan Members and respond to their inquiries.
 - 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.
 - iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.
 - iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.
 - v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.
 - vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.
 - vii. Vendor will provide copies of call notes to Members upon request.
 - viii. Vendor will provide reports, based on call reason type, to the Plan upon request.
 - ix. Vendor will provide an escalation team to respond and resolve inquiries from the Plan.
 - x. When appropriate, Vendor will mail apology letters to Plan Members who have been impacted by a Vendor error.
 - xi. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.
 - 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.
 - xiii. Vendor will customize the materials available to Plan Members via the secure Member portal.
 - 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.
 - 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.
 - xvi. Vendor's secure member portal will capture Plan Members' preferences for communication.
 - 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.
 - xviii. Vendor's mobile application and secure portal will allow Members to order a new ID card.

- xix. Vendor will provide a mobile application that includes a virtual ID card for Members who prefer to use mobile technology.
- 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.
- xxi. Vendor's member portal will provide and moderate online forums and live chat groups.
- 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.
- xxiii. Vendor's member portal will allow Members to:
 - 1) View claims and claim payment status.
 - 2) View and print EOBs.
 - 3) View deductible and OOP accumulations.
 - 4) Single-Sign-On (SSO) to the HSA vendor, if applicable.
 - 5) View HRA claims, if applicable.
 - 6) View HRA Balances, if applicable, including, but not limited to:
 - a) Initial HRA Funding.
 - b) Rollover Funds.
 - c) Incentive Funds.
 - 7) Order new HRA or HSA debit cards, if applicable.
 - 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.
 - 9) Complete a Health Assessment that could be customized by the Plan.
- 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.
 - 2) Disease Management Nurse notes.
 - 3) Case Management notes.
 - 4) Health Coach notes.
 - 5) Vendor analytical system alerts, such as gaps in care.
 - 6) Progress towards Incentives earned, if applicable.
- 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.
 - 2) Search for procedure/service cost.
- 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.
- 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.
- xxviii. Vendor will conduct other surveys, as requested by the Plan.

- 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.
- xxx. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.
- xxxi. Vendor will attend Wellness Fairs and other promotional events around the State, as requested by the Plan.
- 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.
- xxxiii. Vendor will provide language interpreters, including sign language, at events as requested by the Plan.
- xxxiv. Vendor will, upon request, provide Marketing and Communication resources to the Plan to develop materials.
- 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.
- 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.
- xxxvii. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPACA.
- xxxviii. Vendor will suppress specific Member communications, upon request from the Plan.

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.
 - 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.
 - 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).
 - 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.
 - v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.
 - vi. Vendor will provide a weekly summary of any claims totaling ≥ \$100,000.00 to the Plan's Contract Administrator for day to day activities. The summary shall include the total charge, total allowed amount, Member cost share, and a short description of circumstance of the claim, including a status of the Member's condition.
 - vii. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.
 - viii. Vendor will coordinate benefits with other commercial payors.
 - ix. Vendor will support all future state and federal requirements at no additional cost to the Plan.
 - x. Vendor will produce EOBs that meet all Federal requirements.
 - xi. Vendor will prevent Subscribers from having access to the Dependents EOBs when the Subscriber does not have custodial rights.
 - xii. Vendor will mail EOBs directly to Dependents 18 years of age or older without a copy to the Subscriber.
 - xiii. Vendors will mail a Dependent's EOB to a different address if a different address exists in the Dependent's demographic record.
 - xiv. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.
 - xv. Vendor will provide a single, combined Medical and HRA EOB, as requested by the Plan.

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

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.
 - 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.
 - 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.
 - 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.
 - v. Vendor will customize any standard audit reports to meet the Plan's specific audit needs.
 - vi. Vendor will provide claims files to the Plan's Auditors on a monthly basis.
 - vii. Vendor will provide feedback on all site visit claims within two (2) weeks of the end of the on-site visit. Vendor will also respond to any findings in the draft audit report within two (2) weeks of receipt.
 - viii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within 30 days of the final report, or another timeframe as specified by the Plan.
 - 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.
 - 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.
 - 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.
 - xii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.
 - xiii. Vendor will customize any recovery or investigation reports, if requested by the Plan.
 - 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.

- 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.
- 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.
- xvii. Vendor will, upon request by a Member covered through the Retirement System, establish a payment plan. The payment plan shall not exceed six (6) months without the Plan's prior approval.
- xviii. Vendor will consider 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.
- xix. Vendor will allow the Plan to perform onsite reviews and validations of Vendor's internal processes.
- xx. Vendor will provide workflows, data, and other materials to review Vendor's processes within 30 days of request.
- xxi. Vendor will work with the Plan to develop process improvement plans.
- xxii. Vendor will provide monthly recovery reports and will customize those reports, if requested by the Plan.
- xxiii. Vendor will track and report actual cost savings dollars against targets, and if available, benchmarks.
- xxiv. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.
- xxv. Vendor will provide Plan specific investigation reports on a monthly basis and customize these reports, as requested by the Plan.

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.
 - 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.
 - 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.

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).
 - ii. Vendor will customize any report, as requested by the Plan.
 - iii. Vendor will combine claims and financial data in reporting.
 - 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.
 - v. Vendor will produce ad hoc reports within 10-15 days of a request to support the Plan's responsibilities to the Board of Trustees and/or North Carolina General Assembly.
 - vi. Vendor will include Book of Business and other internal and/or external benchmarks in reports, when requested by the Plan.
 - 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).

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.
- 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.
 - 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.
- 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.
 - 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.
 - 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.
 - 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.
 - b) Any documentation from the banking institution of the deposited amounts posted daily, e.g., bank deposit slips, electronic deposit report, lockbox report, etc.
 - 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.
 - d) Ability to produce Member level detail when requested by the Plan.

- 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.
 - 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.
 - 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.
 - 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.
 - 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.
 - 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.
 - 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.
 - 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.
- 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.
 - 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.
 - 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.
 - 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.
- 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.
 - 2) Monthly Deductible and Out-of-Pocket reports, by Plan Design, by month.
 - 3) Monthly COB reports that identify savings associated with both Medicare and Commercial COB.
 - 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.
 - 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.
 - 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.
 - 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.

- 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.
- 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.
 - 2) Quarterly Case Management Clinical Outcomes.
 - 3) Quarterly Preventive Care Service Utilization.
- 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.
 - 2) Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.
- 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.
- 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 \leq 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.
 - 2) A Quarterly Web Trends Report that provides statistics on Plan Members transaction history compared to Vendors' Book of Business data.
- 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.
- 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.
- 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.

5.3 COST PROPOSAL REQUIREMENTS

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

Vendor shall:

- a) Submit a Cost Proposal and include the Cost Proposal separate from the Technical Proposal; and
- b) Submit the Cost Proposal in accordance with ATTACHMENT A: PRICING.

6.0 CONTRACT ADMINISTRATION

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

6.1 DISPUTE RESOLUTION

The Parties agree that it is in their mutual interest to resolve disputes informally. A claim by Vendor shall be submitted in writing to the Plan's Contract Administrator for resolution. A claim by the State shall be submitted in writing to Vendor's Contract Administrator for resolution. The Parties shall negotiate in good faith and use all reasonable efforts to resolve such dispute(s). During the time the Parties are attempting to resolve any dispute, each shall proceed diligently to perform their respective duties and responsibilities under this Contract.

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

1.1.2 Providers by County

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

1.1.3 Provider Listing

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

1.2 Network Pricing

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

1.2.1 Claims Repricing File

A claims repricing file, containing participant claims experience for calendar year 2021, will be made available through a secure file transfer protocol to Vendors meeting the minimum requirements.

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

Using the repricing file referenced above, **Vendors are to provide the contracted allowed amount for each service in the file**. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.

Three (3) fields must be populated:

- **NetStatus** (representing Vendor's proposed standard network) – Y / L / N
 - Y – Currently under contract
 - L – Letter of intent
 - N – Not under contract or Out-of-Network provider
- **ContAmt** – Repriced claim based on Vendor contract amount (or Allowed Amount) for the proposed network
- **ContType** (contract type) – (A, B, C, D, F, O)
 - A – Ambulatory Payment Classification
 - B – Bundled payment
 - C - Capitated
 - D – Discount off eligible charges
 - F – Fee schedule
 - O – Other contract arrangement

The file should be repriced for the provider network being proposed by Vendor.

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

ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE

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

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

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 7**

Deposition Exhibit 13 - Affidavit of Dorothy C. Jones
(“Dep. Ex. 13”)



STATE OF NORTH CAROLINA
DURHAM COUNTY

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
23 INS 00738

BLUE CROSS AND BLUE SHIELD OF)
NORTH CAROLINA,)
)
Petitioner,)
v.)
)
NORTH CAROLINA STATE HEALTH)
PLAN FOR TEACHERS AND STATE)
EMPLOYEES,)
)
Respondent.)
)
and)
)
AETNA LIFE INSURANCE COMPANY,)
)
Respondent-Intervenor.)
_____)

AFFIDAVIT OF DOROTHY C. JONES

I, Dorothy C. Jones, being duly sworn, depose and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I was employed by the North Carolina Department of State Treasurer and appointed as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees ("Plan") from June 2017 until December 16, 2022.

3. As Executive Director, one of my responsibilities was for the Plan's contracting activities with outside vendors. Preparing, issuing and evaluating requests for proposals ("RFPs") to select vendors to which contracts will be awarded is a significant component of the Plan's contracting activity. The Plan routinely conducted several RFPs per year, for a wide range of services and vendors, and routinely had several RFPs in ongoing in various stages at any given time.

4. One major type of vendor with which the Plan contracts is the Plan's third-party administrator ("TPA"), which provides administrative services to support the Plan's operations. I served as Executive Administrator for the Plan during the development and drafting of Request for Proposals # 270-20220830TPAS ("2022 TPA RFP"), which is the subject of this contested case, as well as the previous TPA RFP in 2019.

5. Neither the North Carolina Department of State Treasurer nor the Plan has adopted regulations for its contracting activities. Some contracting activities of the department are subject to Department of Administration procedures, but the 2022 TPA RFP (and previous TPA RFPs) were exempt from those procedures pursuant to N.C. Gen. Stat. § 135-48.34. Therefore, no statutes or administrative rules establish procedures for the 2022 TPA RFP. The Plan has an internal contract procurement policy and procedure, but it does not specify what information the plan should request from vendors in any given RFP.

6. Prior to the 2022 TPA RFP, the plan issued RFPs for its TPA contract on numerous occasions, most recently in 2017 and 2019. Prior to the 2022 TPA RFP, Blue Cross and Blue Shield of North Carolina ("Blue Cross") had been awarded the Plan's TPA contract in a number of consecutive RFPs, and had served as the Plan's TPA almost continuously for over 40 years.

7. Beginning in approximately December 2021, I directed the Plan's Director of Contracting and Compliance to modernize its contracting processes, including RFPs, in order to address certain problems resulting from the way in which RFPs were historically drafted and evaluated. One main goal of the modernization effort was to eliminate narrative responses to minimum requirements and technical requirements in RFPs.

8. Minimum requirements and technical requirements are part of the "scope of work" of a given RFP, i.e, the specific work or tasks the vendor will be contracted to perform for the

Plan. Tasks that are absolutely required and non-negotiable are designated minimum requirements, and those that are beneficial to and strongly preferred by the Plan, but not necessarily essential or critical, are designated as technical requirements.

9. The Plan's RFPs contain the contract terms between the Plan and the vendor whose response (proposal) is selected. After competing proposals are evaluated, the selected vendor's response to the RFP (including its responses to the "minimum requirements" and "technical requirements," and its cost proposal) are attached to the RFP and become part of the contract. As a result, a vendor's responses to the RFP requirements are binding contractual obligations if its proposal is accepted and is signed by the vendor upon submission as confirmation of this fact.

10. Minimum requirements and technical requirements in previous RFPs (including the 2019 RFP for the TPA contract) described the Plan's requirements and included open-ended questions asking vendors to provide certain information, describe how the vendor would meet the Plan's requirements, and/or describe any limitations on its ability to meet the Plan's requirements. The resulting proposals were consistently very long, narrative discussions with subjective or vague language, and included voluminous attachments and materials that the Plan's evaluation committee had to review and assess.

11. In addition, competing vendors frequently responded to the same requirements differently, and included different forms of supporting information, which required subjective judgments as to whether and to what extent each vendor met each requirement.

12. As a result, evaluating and scoring RFPs was extremely time consuming for the evaluation committees. The Plan has limited staff, and the time commitment to evaluate multiple RFPs per year significantly reduced the staff's ability to meet their other responsibilities, and made some staff reluctant to participate on evaluation committees. Further, the necessity of parsing

narrative responses also made reaching consensus difficult, resulted in disagreements and tension between committee members, introduced bias and subjectivity, and made it difficult to ensure that competing proposals were evaluated fairly and consistently.

13. Further, the Plan experienced multiple issues and disputes in the past when vendors (including Blue Cross) resisted performance of contract requirements, by relying on equivocal, subjective, and/or vague language in their RFP narrative responses.

14. Therefore, my goals in the modernization effort for RFPs included:

- a. Improving objectivity in evaluating and scoring RFP responses, to ensure fairness and consistency;
- b. Avoiding equivocation and subjectivity in RFP responses that could undermine vendors' contractual obligations;
- c. Simplifying and shortening the RFP evaluation process, reducing the time commitment by Plan staff serving on the evaluation committee;
- d. Reducing difficulty in parsing subjective narrative responses and stress on the evaluation committee to reach consensus; and
- e. Reducing reluctance of Plan staff to serve on evaluation committees.

15. By approximately March 2022, Plan leadership had reached consensus to implement a two-choice format for minimum requirements and technical requirements, in which each of the Plan's requirements was stated, and vendors could choose "confirm" (agree to meet) that requirement or "does not confirm" (does not agree to meet) that requirement. Vendors would not be asked *or allowed* to respond with narrative language that could undermine or complicate their responses.

16. Plan leadership decided it was acceptable to forego vendors' written explanations of how the vendor would meet requirements. The Plan's contracts typically include an implementation period before the contract term begins in which the Plan's staff and vendors collaborate to develop processes, integrate their systems, and ensure that all contract requirements are met. These process details are finalized in an administrative decision memo between the Plan and a vendor.

17. Further, because the RFP responses are binding contract terms, the vendor assumes responsibility to meet each requirement. In the event a vendor ultimately cannot or does not meet a given requirement, the Plan can exercise contractual remedies, including performance guarantees, termination of a contract, and/or suing the vendor for breach of contract and damages or specific performance. The objective format for the RFP requirements therefore shifts more of the risk of non-performance to the vendor compared with the earlier, narrative format.

18. Also, narrative responses describing how requirements would be met are not always effective in preventing nonperformance. The Plan has had instances with past RFPs where a vendor that provided narrative responses was still unable to perform contract requirements.

19. The Plan's leadership considered the concerns of some Plan staff about doing away with narrative responses. The quote on page 3 of Blue Cross's Motion to Compel (from page SHP 0025036 of the Plan's discovery document production) was a June 8, 2022 comment by Vanessa Davison on an early draft of technical requirements. Ms. Davison was not the Plan's Director of Procurements and Contracts as the Motion states. Ms. Davison was one of the Plan's Contracting Agents, which are not part of the Plan's leadership team. Regardless, I was aware of and considered concern at the time. However, the Plan's leadership decided that the benefits of

not accepting narrative responses resolved or outweighed the types of concerns Ms. Davison raised for the reasons discussed above.

20. The Plan first used the modernized, non-narrative format for RFP responses in an RFP issued in May 2022 for its pharmacy benefits management audit contract. The 2022 TPA RFP that is the subject of this contested case was the second RFP in which the Plan used the modernized format.

21. From the beginning of the drafting process for the 2022 TPA RFP in approximately April 2022 until it was completed and publicly posted for vendors on August 30, 2022, all drafts followed the modernized, non-narrative format.

22. The 2022 TPA RFP clearly stated that that narrative responses to the minimum requirements and technical requirements would not be accepted (See RFP Attachment K (Minimum Requirements), Attachment L (Technical Proposal)).

23. The 2022 TPA RFP also called for cost proposals in which Vendors were required to identify their network of healthcare providers under contract or binding letters of intent, and to quantify their network pricing. The Plan did not require vendors to submit copies of such contracts or letters of intent to validate or verify their networks or pricing, in part because the cost proposal (which determines the cost of healthcare services incurred by the Plan for its members) is also a binding contract term, for which the Plan has contractual remedies if the approved vendor cannot meet. Not requiring such supporting documentation for the cost proposals was not new. Prior TPA RFPs (including the most recent TPA RFP in 2019) required no such documentation.

24. The Plan also did not require vendors to submit provider contracts and/or letters of intent because the Plan had insufficient staff and time to review or verify contracts or letters of

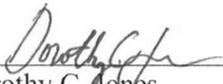
intent for many thousands of healthcare providers per vendor, and each vendor's network pricing was accompanied by a certified actuarial opinion. Further, the Plan would likely discover any misrepresentation of a vendor's provider network during the implementation period, which would greatly harm the vendor's reputation, especially if the misrepresentation were intentional, and the Plan could have remedies for fraudulent misrepresentation or other claims. Accordingly, consistent with past TPA RFPs, the Plan considered it reasonable to rely on the networks and network pricing in the vendors' cost proposals.

25. The Plan staff and the State Treasurer held a phone call with all interested vendors September 1, 2022 in which the new format of the RFP was discussed, including the prohibition on narrative responses to the technical and minimum requirements, and vendors were invited to ask questions. In addition, before the RFP was made public, the Plan invited prospective vendors to meet with our Director of Contracting and Compliance and me about the upcoming TPA RFP. We held several meetings with individual vendors between June and August 2022, including Blue Cross, in which we explained the non-narrative format and the Plan's reasons for the change.

26. The 2022 TPA RFP also allowed for two rounds of written questions from interested vendors before the submission of responses, and specifically urged vendors to raise any questions, issues or exceptions to the RFP and/or any desired modification of the terms and conditions of this solicitation during the question period. (RFP Section 2.3). The RFP stated that "If the State determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an Addendum." (RFP Section 2.3)

27. No vendor objected to the non-narrative format of the RFP during either the Sept. 1 phone call or the individual meetings with vendors in June-August 2022, and no vendor raised

any questions, exceptions, or desired modification to the RFP format (including the non-narrative format and the information requested in the cost proposals) during the written question and answer periods. Accordingly, no changes were considered or made to require different or additional information or documents from vendors in response to the 2022 TPA RFP.



Dorothy C. Jones

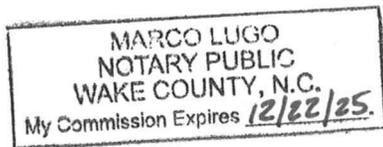
Sworn to and subscribed before me this the 16th day of June, 2023.



Notary Public

My Commission Expires: 12/22/2025

[NOTARIAL STAMP OR SEAL]



**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 8**

Deposition Exhibit 20 - April 5, 2022 Email from
Dee Jones to Dale Folwell, et al. Re: BCNC Notification
(“Dep. Ex. 20”)



Message

From: Dee Jones [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=421FCFB9EC28424C96835AB1056C9150-DEE JONES]
Sent: 4/5/2022 2:59:46 PM
To: Dale Folwell [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=02f1cc8246e14a78a7e1992a0a6051fe-Dale Folwel]
CC: Dee Jones [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=421fcfb9ec28424c96835ab1056c9150-Dee Jones]; Anna Yount [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=400c38b564b945028c59be0ff3c5b0b6-Anna Yount]; Caroline Smart [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1173c514153d4c7088e63f2c589feac1-Caroline Sm]
Subject: BCNC Notification

Treasurer,

Caroline and I spoke with Aimee and Roy this morning and informed them of the following:

1. The Plan intends to transition employer billing from BCNC to iTEDIUM in 2024. This process is starting now with iTEDIUM having to build the technology necessary to support these efforts. The purpose behind this change is to place core functionality with the most appropriate vendor. Employer billing is an "extra" for BCNC and not part of their core activity of processing claims and managing a network.
2. The Plan will be putting the TPA contract up for bid later this year. The expectation is that the RFP will be on the street in Q3 2022 with award in Dec/Jan time frame. The new contract will be live for Open Enrollment for the 2025 Plan Year. The disappointing FACETS transition, lack of confidence in issue resolution and general the lack of cooperation and support relative to data transparency are the main reasons behind the decision.

Dee Jones

Executive Director
State Health Plan
Cell: 919.215.2795
Email: dee.jones@nctreasurer.com

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 9**

Deposition Exhibit 21 - Email from Roy Watson to
Dee Jones, et al. Re: FACETS Implementation _4.20.2022
(“Dep. Ex. 21”)



Message

From: Roy Watson [Roy.Watson@bcbsnc.com]
Sent: 4/20/2022 9:40:28 PM
To: Dee Jones [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=421fcfb9ec28424c96835ab1056c9150-Dee Jones]; Tunde Sotunde [Tunde.Sotunde@bcbsnc.com]
CC: Dale Folwell [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=02f1cc8246e14a78a7e1992a0a6051fe-Dale Folwel]
Subject: RE: FACETS Implementation_04.20.2022

Hey Dee,

Thanks for the feedback regarding the summary we've been providing within the tracking log. As mentioned, we will continue to iterate the summary until we get it to a place where it is easier for the Plan to reconcile the progress that is being made. We will provide an updated summary for your review.

In regards to the claims, we are releasing Plan claims on a regular cadence. As you know, claims volumes have been extremely volatile industry wide since the pandemic began, which can result in difficulty comparing or benchmarking claims payment to any other "normal" time period. We will continue to provide you with claims processed/paid data in the summary tab of the tracking log. Will also include some historical information so you can compare.

To that end, we are continuing to monitor the Plans weekly claims payment volume and will be happy to walk through that information with you at any time the Plan would like to discuss. In the meantime, we've looked at the Plan's average claims funding in the first 16 weeks over the 4 year period (2018 – 2021) compared to the Plan's average payment in the first 16 weeks of 2022 and those numbers are \$47.4 million and \$48.0 million respectively. Although there has been some volatility in the weekly funding amounts, your average claims funding in 2022 is aligned with your previous 4 year average. Again, we'll be happy to discuss claims payment volumes at the Plan's convenience in order to provide additional clarity.

We understand that we are not currently meeting the Plan's service expectations and I sincerely apologize for that. We are accountable and committed to resolving the Plan's concerns. I am confident we will get back on track and provide the Plan with the level of service you expect and deserve.

Thanks, Roy

Roy Watson, Jr | Vice President, Group and State Segment
o 919.765.3117 | m 919.418.6458
Roy.Watson@bcbsnc.com

Betsy Brann | Administrative Assistant
o 919.765.7122 | m 919.939.3840
Betsy.Brann@bcbsnc.com

We RESOLVE.
To help North Carolinians stay healthy.





Blue Cross Blue Shield of North Carolina
4611 University Drive, Durham, NC 27707

From: Dee Jones <Dee.Jones@nctreasurer.com>
Sent: Wednesday, April 20, 2022 1:24 PM
To: Tunde Sotunde <tunde.sotunde@bcbsnc.com>; Roy Watson <roy.watson@bcbsnc.com>
Cc: Dale Folwell <Dale@Nctreasurer.com>; Dee Jones <Dee.Jones@nctreasurer.com>
Subject: FACETS Implementation_04.20.2022

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Tunde and Roy,

While there is progress being made, there continue to be weekly if not daily issue discoveries, member concerns and resolution shortfalls. Additionally, I remain concerned that claims payments have not been fully caught up. To underscore our concerns, Blue Cross NC staff advised Plan staff as recently as yesterday that there are simply too many open issues to be able to address individual enrollment concerns in a timely manner.

On a positive note, I am relieved to hear that Blue Cross NC has finally recognized the need to have a dedicated SHP Team – unfortunately, it took almost 5 years to determine the changes made in 2017 did not work.

A synopsis of the tracking log and subsequent progress is below.

- On the 3/08/2022 tracking log, there were 52 items on the OPEN list and 50 items on the CLOSED list for a total of 102 items identified.
- On the 3/25/2022 tracking log, there were 56 items on the OPEN list and 63 items on the CLOSED list for a total of 119 items identified.
- On the 4/14/2022 tracking log, there are 22 items on the OPEN Incident list, 34 items on the CLOSED Incident list; 15 items on the OPEN Feature list, 4 items on the CLOSED Feature list; 13 items on the OPEN General Inquiries list, and 40 items on the CLOSED General Inquiries list.

While I appreciate the attempt at a revised breakdown, it's hard to reconcile the progress. It appears that there have been at TOTAL of 128 issues identified, 78 issues resolved and 50 OPEN items as of 4/14/2022.

I have already discussed this with Roy, but it is for all of the reasons above, the Plan has lost confidence in Blue Cross NC and will be posting a TPA RFP later this year to proactively ensure that the Plan's needs are met.

Regards,

Dee Jones

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State Health Plan
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STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 10**

Deposition Exhibit 37 - Blue Cross NC’s
Response to Technical Requirements
(“Dep. Ex. 37”)

ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE

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

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

5.2.1 Account Management

5.2.1.1 Overview and Expectations

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

5.2.1.2 Resources

- a. Vendor addressed the following in the Minimum Requirements Table or ATTACHMENT K:
 - i. Vendor has provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives. Vendor shall provide the Plan with contact information for one (1) such client to complete a reference call related to the services in this RFP.
 - ii. Vendor has one (1) or more current or former ASO clients with more than 25,000 Medicare primary members.
 - iii. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.
 - iv. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.
 - v. Vendor has a "firewall" between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.
- b. Vendor shall confirm it will provide a dedicated resource for each of the following roles:
 - i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to Plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.

Confirm

Does Not Confirm



- ii. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment and Group Set-Up.
Confirm Does Not Confirm
- iii. **Member Services Manager** – Responsible for all customer service functions and reporting.
Confirm Does Not Confirm
- iv. **Claims Services Manager** – Responsible for claims payments and recoveries.
Confirm Does Not Confirm
- v. **Enrollment and Group Set-Up**– Responsible for all enrollment, enrollment files, and reconciliation services.
Confirm Does Not Confirm
- vi. **Data Manager** – Responsible for providing expertise in data analytics and modeling as well as coordinating data requests, data testing, and data exchanges, including any data files to Plan vendors, Plan partners, and the Plan.
Confirm Does Not Confirm
- vii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process and must continue to support the Plan for a minimum of 90 days after the implementation date of January 1, 2025, if requested by the Plan. Such support includes, but is not limited to, weekly calls with the Plan and the designated account management team; maintenance of issue tracking logs; and issue resolution.
Confirm Does Not Confirm
- c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed. Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:
 - i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.). This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic initiatives.
Confirm Does Not Confirm
 - ii. **Director of Network Management** – Responsible for overall management of Vendor's network including provider contracting, network development, and/or provider relations functions. This resource will work with the Plan to develop, implement, and maintain custom provider reimbursement models or other provider initiatives as requested by the Plan.
Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

a. Vendor shall confirm each of the following:

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

5.2.2 Finance and Banking

5.2.2.1 Overview and Expectations

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

5.2.2.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.
 - ii. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website: <https://www.nctreasurer.com/media/3791/open>

- iii. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.
 - iv. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.
 - v. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:
 - 1) State banking: <https://www.nctreasurer.com/media/3791/open>
 - 2) Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
 - 3) Escheats: <https://www.nccash.com/holder-information-and-reporting>
 - 4) High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."
 - vi. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.
Confirm Does Not Confirm
 - ii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer.
Confirm Does Not Confirm
 - iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable.
Confirm Does Not Confirm
 - iv. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.
Confirm Does Not Confirm
 - v. Vendor will provide access to up to three (3) years of historical receipts and claims funding data.
Confirm Does Not Confirm
 - vi. Vendor will provide electronic submission of deposit reports and disbursement funding as well as detailed backup documentation to support the transactions.
Confirm Does Not Confirm
 - vii. Vendor will provide historical check register detail and receipts as well as claims funding data.
Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

5.2.3 Network Management

5.2.3.1 Overview and Expectations

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

5.2.3.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor agrees the Plan is a government payor.
 - ii. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.
 - iii. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.
 - iv. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
 - v. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.
 - vi. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.
 - vii. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.
 - viii. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.

- ix. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.
 - x. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.
 - xi. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.
 - xii. Vendor will administer other reference-based pricing models, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support transparency by allowing the Plan, at its request, to directly view any contracts associated with Vendor's network. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules. The Plan will take steps to protect Vendor's confidential data and proprietary information in accordance with applicable state and federal laws and regulations.
 Confirm Does Not Confirm
 - ii. Vendor will provide services to Members who travel outside the United States and have an urgent medical need.
 Confirm Does Not Confirm
 - iii. Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.
 Confirm Does Not Confirm
 - iv. Vendor will customize "hidden providers" (e.g., an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon) payment policies, as requested by the Plan.
 Confirm Does Not Confirm
 - v. Vendor will work with the Plan to ensure reimbursement rates for virtual visits with network providers are set appropriately.
 Confirm Does Not Confirm
 - vi. Vendor will provide transition of care services to assist Members when their provider is no longer in the network.
 Confirm Does Not Confirm
 - vii. Vendor offers a "narrow" network in North Carolina that may be utilized by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
 Confirm Does Not Confirm
 - viii. Vendor has a network management team that will support the Plan on any custom or private label network solutions.
 Confirm Does Not Confirm

- ix. Vendor has a provider credentialing team that could be utilized to credential potential network providers if the Plan were to develop a network solution that may include providers that are not currently enrolled in Vendor's other networks.
Confirm Does Not Confirm
- x. Vendor has the ability to communicate directly with providers and will communicate Plan specific information to providers, as requested by the Plan.
Confirm Does Not Confirm
- xi. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for specific services such as, but not limited to, specialty pharmacy.
Confirm Does Not Confirm
- xii. Vendor has experience with each of the following alternative models of care or clinically integrated systems and will work with the Plan to deploy Vendor's solution or develop a similar custom solution for the Plan. Vendor shall confirm it has experience with each alternative payment model listed below:
 - 1) Patient-Centered Medical Homes.
Confirm Does Not Confirm
 - 2) Hospital At Home Programs.
Confirm Does Not Confirm
 - 3) Accountable Care Organizations.
Confirm Does Not Confirm
 - 4) Community Care Organizations.
Confirm Does Not Confirm
 - 5) Integrated Delivery Networks.
Confirm Does Not Confirm
 - 6) Shared Risk/Savings.
Confirm Does Not Confirm
 - 7) Pay-for-Performance.
Confirm Does Not Confirm
 - 8) Global Payment/Capitation.
Confirm Does Not Confirm
 - 9) Primary Care Incentives.
Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

5.2.4 Product and Plan Design Management

5.2.4.1 Overview and Expectations

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

5.2.4.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.
 - 1) Enhanced PPO Plan (80/20): <https://www.shpnc.org/media/2583/download?attachment>
 - 2) Base PPO Plan (70/30): <https://www.shpnc.org/media/2582/download?attachment>
 - 3) HDHP: <https://www.shpnc.org/media/2584/open>
 - ii. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the PCP listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.
 - iii. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.
 - iv. Vendor will integrate real-time or near real-time deductible and/or OOP accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.
 - v. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.
 - vi. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.
 - vii. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.
- b. Vendor shall additionally confirm each of the following:
 - i. Vendor's systems will support each of the following Plan Design features. Vendor shall confirm each Plan design feature below:
 - 1) Applying a copay and a deductible to the same service.

Confirm Does Not Confirm
 - 2) Applying a copay based on the providers network tier.

Confirm Does Not Confirm
 - 3) Waiving the emergency room copay when the Member is admitted for an inpatient stay and/or an observation stay.

Confirm Does Not Confirm
 - 4) Applying a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
 - a) PCP.

Confirm Does Not Confirm

- b) Specialist.
Confirm Does Not Confirm
- c) Urgent Care.
Confirm Does Not Confirm
- d) Emergency Room (ER).
Confirm Does Not Confirm
- e) Physical Therapy.
Confirm Does Not Confirm
- f) Occupational Therapy.
Confirm Does Not Confirm
- g) Speech and Hearing Therapy.
Confirm Does Not Confirm
- h) Outpatient Behavioral Health.
Confirm Does Not Confirm
- i) Per Inpatient Confinement.
Confirm Does Not Confirm
- 5) Setting benefit limits by age.
Confirm Does Not Confirm
- 6) Setting benefit limits by frequency of service.
Confirm Does Not Confirm
- 7) Setting benefit limits by confinement.
Confirm Does Not Confirm
- 8) Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.
Confirm Does Not Confirm
- ii. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.
Confirm Does Not Confirm
- iii. Vendor will, upon request, administer a four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an out-of-area (OOA) benefit, and a non-network benefit.
Confirm Does Not Confirm

- iv. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.
 Confirm Does Not Confirm
- v. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.
 Confirm Does Not Confirm
- vi. Vendor will administer member cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.
 Confirm Does Not Confirm
- vii. Vendor will implement incentive programs where Plan Members are given gift cards, or other incentives, for seeing certain providers and/or completing certain tasks.
 Confirm Does Not Confirm
- viii. Vendor will, upon request, integrate with other Plan vendors or Partners to deliver value-based and/or incentive benefits.
 Confirm Does Not Confirm
- ix. Vendor will, upon request, implement a Health Reimbursement Account (HRA) for Plan Members with each of the following features. Vendor shall confirm each HRA feature below:
 - 1) HRA annual balances based on the number of family Members enrolled.
 Example:
 Subscriber only = \$600 starting balance.
 Subscriber + one (1) Dependent = \$1200 starting balance.
 Subscriber + two (2) or more Dependents = \$1800 starting balance.
 Confirm Does Not Confirm
 - 2) Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.2.
 Confirm Does Not Confirm
 - 3) HRA account reconciliation services to support the Plan's banking and financial reporting requirements.
 Confirm Does Not Confirm
 - 4) Proration that reduces the starting HRA amount for Members who enroll after the beginning of the Benefit Year.
 Confirm Does Not Confirm
 - 5) Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.
 Confirm Does Not Confirm

- 6) Automatic claims reimbursement functionality from the HRA.
Confirm Does Not Confirm
- 7) Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.
Confirm Does Not Confirm
- 8) Annual HRA rollover functionality.
Confirm Does Not Confirm
- 9) Ability to customize the HRA Member portal, as requested by the Plan.
Confirm Does Not Confirm
- 10) Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.
Confirm Does Not Confirm
- 11) HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.
Confirm Does Not Confirm
- 12) HRA Debit Card.
Confirm Does Not Confirm
- 13) Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.
Confirm Does Not Confirm
- 14) Ability to provide an HRA on a copay-based plan like the Enhanced PPO Plan (80/20).
Confirm Does Not Confirm
- 15) Ability to customize HRA reports, as requested by the Plan.
Confirm Does Not Confirm
- x. Vendor offers Health Savings Account (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.
Confirm Does Not Confirm
- xi. Upon request, Vendor will administer a self-funded Group Medicare Supplement Plan.
Confirm Does Not Confirm

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

Confirm Does Not Confirm

5.2.5 Medical Management Programs

5.2.5.1 Overview and Expectations

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

5.2.5.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
 - ii. Vendor will carve-out PBM services from this Contract.
 - iii. Vendor will customize any of the Medical Management programs, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
 - i. Vendor will customize any medical policy, if requested by the Plan.

Confirm Does Not Confirm
 - ii. Vendor will provide comprehensive, holistic, evidence-based medical policies and Medical Management of Members' physical and behavioral health, including substance misuses, which focus on quality, positive Member outcomes, and cost efficiencies.

Confirm Does Not Confirm
 - iii. Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation, if requested by the Plan.

Confirm Does Not Confirm
 - iv. Vendor will keep the Plan apprised of disease trends within the population and provide reporting that summarizes overall Plan health.

Confirm Does Not Confirm
 - v. Vendor will appropriately identify and engage Members in each of the following types of programs:
 - 1) Transition of Care (TOC) programs;

Confirm Does Not Confirm

- 2) High utilizer outreach and management programs; and,
Confirm Does Not Confirm
- 3) Complex case management programs.
Confirm Does Not Confirm
- vi. Vendor will provide "Hospital at Home" and/or other programs to promote transition from inpatient-hospital to home setting when appropriate.
Confirm Does Not Confirm
- vii. Vendor will offer wellness and prevention programs to support Plan Members.
Confirm Does Not Confirm
- viii. Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members, if requested by the Plan.
Confirm Does Not Confirm
- ix. Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, Vendor, and any other Plan vendors or Plan Partners involved in the program administration.
Confirm Does Not Confirm
- x. Vendor will provide disease management Health Coaching Services.
Confirm Does Not Confirm
- xi. Vendor will transition specific specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.
Confirm Does Not Confirm
- xii. Vendor will provide claims and analytical data to support the transition of specific specialty medications to the Plan's PBM.
Confirm Does Not Confirm
- xiii. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.
Confirm Does Not Confirm
- xiv. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.
Confirm Does Not Confirm
- xv. Vendor will meet with the Plan and the Plan's PBM to coordinate medical and pharmacy management programs.
Confirm Does Not Confirm

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

Confirm

Does Not Confirm

5.2.6 Enrollment, EDI, and Data Management

5.2.6.1 Overview and Expectations

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

5.2.6.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

- i. Vendor will support the Plan's Group set-up structure which includes establishing, maintaining, and reporting on more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. A list of the Plan's current Group structure, which includes Group and Entity identifiers, can be found in Exhibit 3, "Group Structure."
- ii. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.
- iii. Vendor will have the capability to accept and at least 500,000 transactions in a single file transmission.
- iv. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.
- v. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.
- vi. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."
- vii. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.
- viii. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.
- ix. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.
- x. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer

Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

- xi. Vendor will serve as the Plan's RRE under Section 111 of MMSEA Expanded Reporting Option.
- xii. As an Expanded Reporter, Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to obtain Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare rules, to determine which Plan Members' Medicare information requires updating.
- xiii. Vendor will update Vendor's system with the necessary updates from the Medicare audit and send Members' updated Medicare information to the Plan's EES vendor.
- xiv. Vendor will store and utilize the MBI, in addition to other Member identification numbers, such as SSN.
- xv. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.
- xvi. Vendor will maintain Medicare primacy effective and termination dates.
- xvii. Vendor will maintain multiple Medicare entitlement reasons.
- xviii. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.
- xix. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).
- xx. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.
- xxi. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.
- xxii. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.
- xxiii. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a

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

- xxiv. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)
 - 1) Plan's logo.
 - 2) Plan's messaging.
 - 3) Plan's network (if applicable).
 - 4) Out-of-NC network.
 - 5) Member out-of-pockets.
 - 6) Plan's Rx BIN and PBM information.
 - 7) Group Name (e.g., Wake County Schools, University of North Carolina, Department of Transportation).
 - 8) Member's unique ID number.
 - 9) Member's selected PCP.
 - xxv. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of CCC and reporting needs under sections 6055 and 6056 of the IRS code.
 - xxvi. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
 - xxvii. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
 - xxviii. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.
 - xxix. Vendor will implement a process with the Plan to respond to DQ issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.
 - xxx. Vendor will release data to the Plan as described in state and federal law.
 - xxxi. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support Plan eligibility as defined by North Carolina General Statutes Chapter 135, Article 3B, Part 4.

Confirm Does Not Confirm
 - ii. Vendor will accept industry standard and/or custom data files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:
 - 1) ASC X12 EDI transaction sets.
 - 2) XML files.

- 3) Flat/ Fixed Files.
 Confirm Does Not Confirm
- 4) APIs.
 Confirm Does Not Confirm
- iii. Vendor will accept and process multiple data files within the same day.
 Confirm Does Not Confirm
- iv. Vendor will accept and process multiple concurrent file transmissions.
 Confirm Does Not Confirm
- v. Vendor will process "change" records as either terminated or added records.
 Confirm Does Not Confirm
- vi. Vendor will load and process "terminated" and "add" transactions for the same Members within the same day.
 Confirm Does Not Confirm
- vii. Vendor will exchange the enrollment and eligibility data using secure protocols.
 Confirm Does Not Confirm
- viii. Vendor will provide a copy of outbound files delivered to other Plan vendors to the Plan via SFTP or SharePoint based on instructions from the Plan.
 Confirm Does Not Confirm
- ix. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.
 Confirm Does Not Confirm
- x. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits. Thresholds will be determined during implementation.
 Confirm Does Not Confirm
- xi. Vendor will have a Load-Rate of at least 98% on accurate transactions received via EDI from the Plan's EES vendor.
 Confirm Does Not Confirm
- xii. In addition to accepting and processing daily enrollment data file from the Plan's EES vendor, Vendor will manually load any data that cannot be processed automatically within three (3) State Business Days.
 Confirm Does Not Confirm
- xiii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan's EES vendor.
 Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

5.2.7 Customer Experience

5.2.7.1 Overview and Expectations

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

5.2.7.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.
 - ii. Vendor will have a dedicated toll-free number for Plan Members.
 - iii. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.

- iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
- v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.
- vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
- vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."
- viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.
- ix. Vendor will co-brand letters or other materials Vendor sends to Members.
- x. Vendor will customize the portal with the Plan's branding (logo).
- xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.

b. Vendor shall additionally confirm each of the following:

- i. Vendor will receive emails from Plan Members and respond to their inquiries.
 Confirm Does Not Confirm
- ii. Upon request, Vendor will provide expanded hours of operation during the OE period at no additional cost to the Plan. The Plan's enrollment and eligibility call center is generally open on Saturdays during OE.
 Confirm Does Not Confirm
- iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.
 Confirm Does Not Confirm
- iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.
 Confirm Does Not Confirm
- v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.
 Confirm Does Not Confirm
- vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.
 Confirm Does Not Confirm
- vii. Vendor will provide copies of call notes to Members upon request.
 Confirm Does Not Confirm

- viii. Vendor will provide reports, based on call reason type, to the Plan upon request.
Confirm Does Not Confirm
- ix. Vendor will provide an escalation team to respond and resolve inquiries from the Plan.
Confirm Does Not Confirm
- x. When appropriate, Vendor will mail apology letters to Plan Members who have been impacted by a Vendor error.
Confirm Does Not Confirm
- xi. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.
Confirm Does Not Confirm
- xii. Vendor will support single sign-on to and from the Plan's PBM customer portal, the Plan's EES vendor and other Plan vendor sites, as requested by the Plan.
Confirm Does Not Confirm
- xiii. Vendor will customize the materials available to Plan Members via the secure Member portal.
Confirm Does Not Confirm
- xiv. In addition to displaying the Plan's branding, Vendor will display the name of the Member's Employing Unit (e.g., Department of State Treasurer, Retirement System, Wake County Schools, etc.) once the Member has logged into the secure member site.
Confirm Does Not Confirm
- xv. Vendor will, upon request, segregate and provide secure Member portal access to a Dependent, or a Dependent's designee, in a court-ordered scenario such as a Medical Support Notice.
Confirm Does Not Confirm
- xvi. Vendor's secure member portal will capture Plan Members' preferences for communication.
Confirm Does Not Confirm
- xvii. Vendor's secure portal will allow a Plan Member to print a temporary ID card that include the Plan's PBM information and custom ID card elements.
Confirm Does Not Confirm
- xviii. Vendor's mobile application and secure portal will allow Members to order a new ID card.
Confirm Does Not Confirm
- xix. Vendor will provide a mobile application that includes a virtual ID card for Members who prefer to use mobile technology.
Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

1) View claims and claim payment status.

Confirm Does Not Confirm

2) View and print EOBs.

Confirm Does Not Confirm

3) View deductible and OOP accumulations.

Confirm Does Not Confirm

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

Confirm Does Not Confirm

5) View HRA claims, if applicable.

Confirm Does Not Confirm

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

a) Initial HRA Funding.

b) Rollover Funds.

c) Incentive Funds.

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

- xxviii. Vendor will conduct other surveys, as requested by the Plan.
 Confirm Does Not Confirm
- xxix. Vendor will attend Plan-hosted OE events to educate members on Plan options. The Plan representatives are generally on the road across the State or hosting online webinars during most of September and October promoting OE. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.
 Confirm Does Not Confirm
- xxx. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.
 Confirm Does Not Confirm
- xxxi. Vendor will attend Wellness Fairs and other promotional events around the State, as requested by the Plan.
 Confirm Does Not Confirm
- xxxii. Upon request, Vendor will provide resources to conduct biometric screenings at wellness events. If requested, Vendor shall have the ability to send the biometric results to the Members' PCPs.
 Confirm Does Not Confirm
- xxxiii. Vendor will provide language interpreters, including sign language, at events as requested by the Plan.
 Confirm Does Not Confirm
- xxxiv. Vendor will, upon request, provide Marketing and Communication resources to the Plan to develop materials.
 Confirm Does Not Confirm
- xxxv. Vendor will assist with the Plan's benefit booklet review and/or provide guidance regarding the Plan's benefit booklets which includes individual books for each plan offered.
 Confirm Does Not Confirm
- xxxvi. Vendor will develop and implement new letters and/or communication materials for Members and/or Providers to support any programs implemented for the Plan.
 Confirm Does Not Confirm
- xxxvii. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPACA.
 Confirm Does Not Confirm
- xxxviii. Vendor will suppress specific Member communications, upon request from the Plan.
 Confirm Does Not Confirm

5.2.8 Claims Processing and Appeals Management

5.2.8.1 Overview and Expectations

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

5.2.8.2 Services

- a. Vendor confirmed the following in the Minimum Requirements:
 - i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.
 - ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
 - iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.
 - iv. Vendor will customize any appeals letters, as requested by the Plan.
 - v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.
 - vi. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan – Medicare Part B."
 - vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.
 - viii. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."

- b. Vendor shall additionally confirm each of the following:
 - i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.

Confirm Does Not Confirm
 - ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.

Confirm Does Not Confirm
 - iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).

Confirm Does Not Confirm

- iv. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add edits at the Plan's request.
Confirm Does Not Confirm
- v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.
Confirm Does Not Confirm
- vi. Vendor will provide a weekly summary of any claims totaling \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 Does Not Confirm

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

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

Confirm Does Not Confirm

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

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

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

Confirm Does Not Confirm

2) Quarterly report of any uncollectible accounts:

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

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

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

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

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

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

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

Confirm Does Not Confirm

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

- g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
- h) Reports 14 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

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 11**

CONFIDENTIAL: FILED UNDER SEAL

Deposition Exhibit 41 - Blue Cross
Minimum Requirements Questions
(“Dep. Ex. 41”)

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 12**

CONFIDENTIAL: FILED UNDER SEAL

Deposition Exhibit 42 - Blue Cross
Technical Requirements Questions
(“Dep. Ex. 42”)

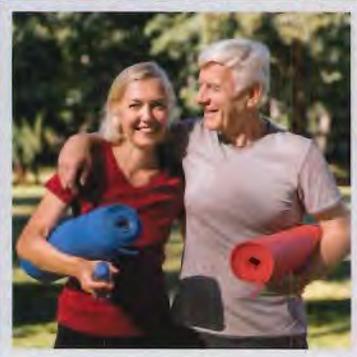
**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 13**

CONFIDENTIAL: FILED UNDER SEAL

Deposition Exhibit 43 - Addendum No. 1 signed by Blue
Cross (“**Dep. Ex. 43**”)

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 14**

Deposition Exhibit 86 – Excerpts of State Health Plan
Third Party Administrative Services RFP Transparency
Documents Review – Media Briefing Presentation PowerPoint
(“Dep. Ex. 86”)



State Health Plan Third Party Administrative Services RFP Transparency Documents Review Media Briefing Presentation

Major Steps in the TPA Evaluation Process

- The Plan received initial inquiries from four potential bidders.
- The Plan received minimum requirement proposals from: Aetna, Blue Cross NC, and UMR.
- All three bidders passed the minimum requirements and were allowed to submit full proposals.
- The technical and cost components of the RFP were weighted 50/50.
- The evaluation committee objectively reviewed all technical proposals and scored proposals in accordance with the RFP criteria.
- Segal, the Plan's actuarial consulting firm, reviewed the cost proposals and presented its findings along with scoring to the evaluation committee.
- Following the technical proposal evaluation and the initial cost proposal evaluation, the evaluation committee submitted a request for best and final offers (BAFO #1) to all three bidders.
- Segal reviewed BAFO #1 proposals and presented its findings and final scoring to the evaluation committee.
- The evaluation committee concluded its review and voted to present all three proposals to the Board for their consideration with a recommendation to award to the highest point recipient.

Scoring Summary of RFP

	Maximum Points	Vendor		
		Aetna	Blue Cross NC	UMR
TOTAL TECHNICAL POINTS	310	310	303	310
BAFO #1 COST POINTS	10	8	8	7
FINAL RANKING TECHNICAL		3	1	3
FINAL RANKING COST		3	3	1
FINAL RANKING TECHNICAL AND COST		6	4	4

- Weighting is 50/50 technical vs cost.
- Aetna and UMR tied for first place on technical.
- Aetna and Blue Cross NC tied for first place on cost.
- Consequently, Aetna wins overall.

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 15**

Deposition Exhibit 215 - August 25, 2022 Email from
Caroline Smart to Matthew Rish, et al. Re: TPA RFP Cost Scoring
(“Dep. Ex. 215”)

Message

From: Caroline Smart [Caroline.Smart@nctreasurer.com]
Sent: 8/25/2022 2:45:31 PM
To: Matthew Rish [Matthew.Rish@nctreasurer.com]; Kuhn, Stephen [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=46024d291b6540739b86102699395c17-Kuhn, Steph]; Vieira, Kenneth C. [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f7dd15d3e0654a97bb693bc1a23e1eb7-Vieira, Ken]; Wang, Peter [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aab3f8f064464e409206a69f41bcf9da-Wang, Peter]; Wohl, Stuart [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=6f70feb61f154acfbcd15b2103f78154-Wohl, Stuar]
CC: Dee Jones [Dee.Jones@nctreasurer.com]; Kendall Bourdon [Kendall.Bourdon@nctreasurer.com]; Charles Sceiford [Charles.Sceiford@nctreasurer.com]
Subject: RE: TPA RFP Cost scoring

CAUTION: External Sender

I don't believe we need a minimum on #2. If they have access problems, it should show up in the pricing in those areas.

Caroline Smart

Sr. Director, Plan Integration
State Health Plan
Office: (919) 814-4454

3200 Atlantic Avenue, Raleigh, NC 27604
www.SHPNC.org



Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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IMPORTANT: When sending confidential or sensitive information, encryption should be used.

From: Matthew Rish <Matthew.Rish@nctreasurer.com>
Sent: Thursday, August 25, 2022 9:26 AM
To: Kuhn, Stephen <SKuhn@segalco.com>; Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Wohl, Stuart <SWohl@Segalco.com>
Cc: Dee Jones <Dee.Jones@nctreasurer.com>; Caroline Smart <Caroline.Smart@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>; Charles Sceiford <Charles.Sceiford@nctreasurer.com>
Subject: RE: TPA RFP Cost scoring
Importance: High

Steve,

See my thoughts below in red.

Caroline/Kendall, do you want to weigh in on #2? I like the idea, but not sure what that means for the document.

Thanks,



SHP 0086294

Matt

Matthew T. Rish

Sr. Director of Finance,
Planning & Analytics
State Health Plan
Office: (919) 814-4413
Mobile: (919) 621-0275

3200 Atlantic Avenue, Raleigh, NC 27604
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Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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From: Kuhn, Stephen <SKuhn@segalco.com>
Sent: Wednesday, August 24, 2022 10:33 AM
To: Matthew Rish <Matthew.Rish@nctreasurer.com>; Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Wohl, Stuart <SWohl@Segalco.com>
Cc: Dee Jones <Dee.Jones@nctreasurer.com>; Caroline Smart <Caroline.Smart@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>; Charles Sceiford <Charles.Sceiford@nctreasurer.com>
Subject: RE: TPA RFP Cost scoring

Matt,

We have a few questions/comments:

1. The current cost specifications don't mention scoring. Is it correct to assume that the scoring specifics will be in the technical specifications? **I would appreciate Segal drafting some language on the scoring, then we will drop it in accordingly. If you could get me something ASAP today, that would be most appreciated!**
2. Network access – Did you want to make this a minimum qualification? For example, "Bidder's network must offer at least XX% overall network access using the access distance definitions provided." **Caroline/Kendall...thoughts?**
3. Disruption – This will be captured in the "Network" sections as the projected claims will be a function of network size and discounts. Just confirming there will be no other disruption scoring criteria. **Correct**

Here is a brief summary of our interpretation of the cost sections that will be included in the scoring:

Score Category	Points	Cost Specifications Section	Cost Section Attachments	Comments
Network Pricing	3	1.2, 1.5	A-3, A-4, A-5, A-6, A-9	Projected claim costs
Admin Fees	1	1.3	A-7	Projected administrative expenses
Guarantees	1	1.4	A-8 (and possibly A-6)	Value of guaranteed network pricing terms
Access	0	1.1	A-1, A2	Do you want to make this a minimum qualification?

Please let me know if you would like to discuss.

Thanks,
Steve

Stephen L. Kuhn
Segal
T 617.424.7341 | M 617.875.7018

From: Matthew Rish <Matthew.Rish@nctreasurer.com>
Sent: Tuesday, August 23, 2022 10:23 AM
To: Kuhn, Stephen <SKuhn@segalco.com>; Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Wohl, Stuart <SWohl@Segalco.com>
Cc: Dee Jones <Dee.Jones@nctreasurer.com>; Caroline Smart <Caroline.Smart@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>; Charles Sceiford <Charles.Sceiford@nctreasurer.com>
Subject: TPA RFP Cost scoring

CAUTION: External Sender

Steve and Team,

We have discussed internally and would like to score the Network, Admin and Guarantees sections. We're thinking 1 point each for Admin and Guarantees and 3 points for Network. Then the bidders can be ranked 4, 3, 2, 1 (assuming 4 bidders). We would then do the same on the Technical scores and combine the rankings for a total score.

Let me know if any questions. Then we would need to get this into the documents.

Thanks,
Matt

Matthew T. Rish

*Sr. Director of Finance,
Planning & Analytics*
State Health Plan
Office: (919) 814-4413
Mobile: (919) 621-0275

3200 Atlantic Avenue, Raleigh, NC 27604
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Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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Thank you.

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 16**

CONFIDENTIAL: FILED UNDER SEAL

Deposition Exhibit 403 – Excerpts of October 4,
2023 Expert Report by Mary Wills, CPA
(“Dep. Ex. 403”)

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 17**

**HIGHLY CONFIDENTIAL ATTORNEYS' EYES
ONLY: FILED UNDER SEAL**

Deposition Exhibit 417 – Excerpts of October 4, 2023
Expert Report of Gregory Russo
(“Dep. Ex. 417”)

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 18**

CONFIDENTIAL: FILED UNDER SEAL

Addendum No. 2 signed by Blue Cross NC
NAVIGATOR_002440–51
(“2022 TPA RFP Add. 2”)

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 19**

Excerpts of North Carolina State Health Plan
for Teachers and State Employees
RFP No.: 270-20191001TPAS
(“2019 TPA RFP”)



STATE OF NORTH CAROLINA

THE NORTH CAROLINA STATE HEALTH PLAN

FOR TEACHERS AND STATE EMPLOYEES

Request for Proposal #: 270-20191001TPAS

THIRD PARTY ADMINISTRATIVE SERVICES

Date of Issue: October 1, 2019

Proposal Opening Date: January 3, 2020

At 02:00 PM ET

Direct all inquiries concerning this RFP to:

Sharon L. Smith

Manager of Contracting & Compliance

Email: Sharon.Smith@nctreasurer.com

SHPContracting@nctreasurer.com

Phone: 919-814-4432

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

herein or to render the proposal non-binding or subject to further negotiation. Vendor’s proposal shall constitute a firm offer. **By execution and delivery of this RFP Response, the Vendor agrees that any additional or modified terms and conditions, whether submitted purposely or inadvertently, shall have no force or effect, and will be disregarded. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject Vendor’s proposal as nonresponsive.**

If a Vendor desires modification of the terms and conditions of this solicitation, it is urged and cautioned to inquire during the question period, in accordance with the instructions in this RFP, about whether specific language proposed as a modification is acceptable to or will be considered by the State. Identification of objections or exceptions to the State’s terms and conditions in the proposal itself shall not be allowed and shall be disregarded or the proposal rejected.

Contact with anyone working for or with the State regarding this RFP other than the State Contract Manager named on the face page of this RFP in the manner specified by this RFP shall constitute grounds for rejection of said Vendor’s offer, at the State’s election.

2.4 RFP SCHEDULE

The table below shows the *intended* schedule for this RFP. The State will make every effort to adhere to this schedule.

Event	Responsibility	Date and Time
Issue RFP	Plan	October 1, 2019
Vendor Deadline for Submission of Written Minimum Requirements Questions	Vendor	October 8, 2019
Plan Responds to Minimum Requirements Questions (Posted on IPS)	Plan	October 14, 2019
Deadline to Submit Minimum Requirements Proposals including executed Attachment I	Vendor	October 21, 2019
Notify Vendors if Minimum Requirements Met		October 29, 2019
Issue Vendor’s designated recipient, a link to Secure File Transfer Protocol (SFTP) system for attachments and Data Files	Plan	October 29-31, 2019
Vendor Deadline for Submission of All Written Questions	Vendor	November 7, 2019
Plan Responds to Questions (Posted on IPS)	Plan	November 15, 2019
Opening of Proposals by Plan (Bid Closes)	Vendor	January 3, 2020
Evaluation Period (Review of Proposals and Finalist Presentations)	Plan	January 15-28, 2020
Proposed Finalist Presentations	Vendor	February 6-10, 2020
Best and Final Offer (BAFO)	Plan	February 11-14, 2020
Plan Seeks Approval from the Attorney General’s Office	Plan	February 17-26, 2020
Present award recommendation to the Board	Plan	February 27-28, 2020
Award of the Contract	Plan & Vendor	February 28, 2020
Implementation Period	Plan & Vendor	March 1, 2020 through December 31, 2021
Services Begin	Vendor	January 1, 2022

2.5 PROPOSAL QUESTIONS

Upon review of the RFP documents, Vendors may have questions to clarify or interpret the RFP in order to submit the best proposals possible. To accommodate the Proposal Questions process, Vendors shall submit any such questions by the above due dates. Questions received after these dates will not receive a response.

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.

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 20**

CONFIDENTIAL: FILED UNDER SEAL

Cigna Healthcare's Minimum Requirement
Questions SHP 0009425–27
(**“Cigna Min. Reqs. Questions”**)

**RESPONDENT-INTERVENOR’S
NOTICE OF FILING – No. 21**

Blue Cross Blue Shield of North Carolina’s
January 12, 2023 Request for Protest Meeting on
Request for Proposal #270-20220830TPAS
SHP 0076753-67
(“Blue Cross NC Protest”)

January 12, 2023

Hand-Delivered

Mr. Sam Watts
Acting Executive Administrator
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, North Carolina 27604

**Re: Blue Cross Blue Shield of North Carolina's
Request for Protest Meeting on Request for Proposal
#270-20220830TPAS**

Dear Mr. Watts:

Blue Cross Blue Shield of North Carolina (Blue Cross NC) requests a protest meeting on, and reconsideration of, the North Carolina State Health Plan for Teachers and State Employees' (the Plan's) decision to award the 2025-2027 contract for third-party administrative services to Aetna.

Blue Cross NC makes this request under section 15 of Attachment B of RFP #270-20220830TPAS. The Plan's contract for third-party administrative services was awarded no earlier than December 14, 2022. This request for a protest meeting is submitted within 30 calendar days of December 14 and is therefore timely.

This request is based on the limited information now available to Blue Cross NC. To seek transparency on the Plan's decision-making process, Blue Cross NC has submitted two requests under North Carolina's Public Records Act, N.C. Gen. Stat. § 132-6, for documents related to the 2022 RFP. Those requests were submitted on December 15 and December 20, 2022. To date, Blue Cross NC has not received any records or any timeline for their production. Blue Cross NC therefore reserves all rights, remedies, and arguments related to the Plan's award.

An executive summary and the substance of the protest follow below.

EXECUTIVE SUMMARY

- The Plan's 2022 RFP relied on arbitrary criteria and a distorted scoring system.
- The scoring system assigned no points to the strength, depth, and breadth of each bidder's provider network. Those networks play a pivotal role in North Carolinians' access to high-quality health care.
- The RFP also did not analyze the disruption that a change in network would cause to Plan members, such as the need to change providers, the need to adjust to different approaches to reviewing claims, and the need to request new prior authorizations for certain treatments. This lack of analysis contradicted the RFP's stated objective of selecting a vendor with a broad network with the least disruption.
- The Plan's scoring of cost proposals used vague standards—standards that appear to have been dispositive.
- The RFP scored technical proposals based only on answers to 310 yes-or-no questions. Even though the subjects of the 310 questions varied significantly in impact to Plan members, all 310 answers received the exact same weight.
- The Plan refused to allow *any* narrative explanation of any vendor's technical capabilities. Thus, the Plan lacks information on Aetna's detailed capabilities on those requirements.
- The scoring system in the 2022 RFP differs dramatically from the Plan's 2019 RFP. For example, the 2019 RFP scored cost proposals on a 10,000-point scale; the 2022 RFP scored cost proposals on a 10-point scale.
- The change in the scoring system in the 2022 RFP had a pivotal impact. Had Blue Cross NC been awarded just one more point for its cost proposal, it would have won the bid.
- Blue Cross NC confirmed 303 of the RFP's 310 technical requirements. At a post-award meeting, the Plan told Blue Cross NC that it lost the bid because of the seven non-confirmed requirements. If the Plan had allowed Blue Cross NC to explain why it did not confirm those requirements, the Plan would have seen that those explanations enhanced the strength and credibility of Blue Cross NC's proposal. The Plan instead penalized Blue Cross NC for the careful nature of its responses. The RFP's ban on explanations also limited the Plan's ability to evaluate other vendors' confirmed responses.

BACKGROUND

1. The 2022 RFP

The Plan provides health care coverage to hundreds of thousands of teachers, state employees, retirees, and their dependents.

Blue Cross NC is a fully taxed, not-for-profit North Carolina insurance company with a mission to support health care in North Carolina. It has major operation centers in Durham and Winston-Salem, and it employs nearly 5,000 North Carolinians.

On August 30, 2022, the Plan issued the 2022 RFP, seeking a vendor to manage its health plan by assembling a network of providers, negotiating discounts with those providers, processing claims, and administering other services. A copy of the 2022 RFP is attached to this letter as Exhibit 1. The RFP set a deadline of September 26, 2022, for vendors to submit responses to certain minimum requirements.

Three vendors met those minimum requirements and were allowed to move on to the next phase of the RFP: Blue Cross NC, Aetna, and United Healthcare. Each of these vendors then submitted a proposal on November 7, 2022, responding to questions on costs and technical requirements. Blue Cross NC's response to these technical requirements is attached as Exhibit 2.

The 2022 RFP process evaluated each vendor's proposal on two main criteria: (1) a cost proposal and (2) responses to 310 technical questions. The RFP stated that each vendor's final score would be divided equally between these two elements. *See* 2022 RFP § 3.4(a).

Cost proposals were scored on a 10-point scale, with three different cost categories evaluated: network pricing (with six available points), administrative fees (with two available points), and a network-pricing guarantee (with two available points):

- The network-pricing element involved the “repricing” of a set of claims data that the Plan provided to each vendor. Each vendor was asked to state what the total cost of the identified claims would be based on the vendor’s negotiated prices. According to the RFP, the proposal that reflected the lowest network pricing would receive a full six points for this category, as would any proposal within 0.5% of the lowest-priced vendor. Other vendors would receive fewer points depending on how close their proposal was to the lowest-priced vendor.
- The administrative-fees element evaluated the administrative fees that each vendor proposed to charge the Plan for its third-party administrative services. The lowest-cost proposal would receive the full two points available for this category. The remaining proposals would receive zero or one point.
- The network-pricing-guarantee element evaluated, in theory, the refunds that each vendor was willing to offer the Plan if the vendor failed to deliver on its stated ability to negotiate prices with providers. The 2022 RFP stated that the Plan would decide the “value” of each vendor’s network-pricing guarantee “based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.” The proposal that offered network-pricing guarantees “with the greatest value” would receive the full two points available for this category. All other proposals would receive “one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.” 2022 RFP § 3.4(c)(3)(c).

During a post-award meeting on December 16, 2022, Plan officials told Blue Cross NC that its cost proposal tied for first place with Aetna, and that its administrative-fee proposal offered lower costs than Aetna’s proposal. Blue Cross NC received the full six points available for network pricing. The officials also said that Blue Cross NC received the full two points for administrative fees. Blue Cross NC received a total cost score of eight points, so it apparently received zero points for its network-pricing guarantee. Plan officials also told Blue Cross NC that Aetna also received a cost score of eight and that United received a cost score of seven.

On the technical requirements, the 2022 RFP process allocated one point to each of 310 technical questions or sub-questions. *See* 2022 RFP § 3.4(b). If a vendor

confirmed a technical requirement, that vendor received one point; if not, that vendor received zero points. For scoring purposes, the RFP weighted each of the 310 technical requirements the same. In the December 16 meeting, the Plan told Blue Cross NC that it received a technical-proposal score of 303 out of 310 possible points, and that Aetna and United each received 310 points.

2. Differences between the 2022 RFP and 2019 RFP

The 2022 RFP departed in many ways from the RFP that the Plan used in 2019.

a. Scoring of Cost Proposals

As noted above, the 2022 RFP evaluated each vendor's cost proposal on a 10-point scale.

The 2019 RFP, in contrast, scored each vendor's cost proposal on a 10,000-point scale. *See* 2019 RFP § 3.4(c)(i).

By compressing the cost-scoring scale by a factor of 1,000, the 2022 RFP's scoring process eliminated almost all distinctions between cost proposals. The RFP's scoring results confirm this point. The scoring yielded almost no difference in cost scores among vendors. Two of the three vendors received a cost score of 8 out of 10, while the third received a cost score of 7.

The 2022 RFP also used a different form of cost scoring from the 2019 RFP. The 2019 RFP said that the Plan would award the maximum number of points to the vendor with the "lowest total cost[,] with others receiving points proportionately." 2019 RFP § 3.4(c). In contrast, the 2022 RFP stated that the maximum number of points would be awarded to the vendor "offering the most competitive cost proposal, with others receiving points proportionately." 2022 RFP § 3.4(c). The 2022 RFP did not explain how the committee evaluating each vendor's proposal would decide which proposal was "most competitive."

b. Weight Given to Cost and Technical Scores

The 2022 RFP also changed the relative weight given to each vendor's scores for the cost and technical elements.

The 2019 RFP provided that the cost score would account for 40% of each vendor's final overall score, with the technical proposal accounting for the remaining 60%. *See* 2019 RFP § 3.4(a). The 2022 RFP changed this approach and weighted vendors' cost and technical proposals equally. *See* 2022 RFP § 3.4(a).

Combined with the change to the method for scoring cost proposals described above, the 2022 RFP *increased* the importance of cost scores, while *decreasing* the ability to measure differences in each vendor's cost proposal.

c. Permitted Responses to Technical Questions

As noted above, the 2022 RFP restricted each vendor's ability to respond to the Plan's 310 technical questions. Vendors were allowed to give only a binary yes-or-no response to each question. The Plan did not allow vendors to add any explanation or other information.

The 2019 RFP, in contrast, allowed vendors to offer narrative responses to similar technical questions. (The 2019 RFP is attached as Exhibit 3.) Blue Cross NC provided narrative responses for nearly all of the technical questions in the 2019 RFP. These narrative responses allowed Blue Cross NC to describe the basis for its responses and to state whether there would be any impact to the Plan or its members as a result. As discussed below, the inability to do so here prevented Blue Cross NC from providing helpful context and explanation for its responses. If Blue Cross NC could not confirm any element of a proposed requirement—even an immaterial element—it was forced to answer “no” without further explanation.

d. Scoring of Technical Proposals

The 2022 RFP also changed the scoring method for each vendor's responses to technical questions.

The 2019 RFP stated that each vendor's responses to the Plan's technical questions would be scored on a 10,000-point scale, just as the cost proposals were. *See* 2019 RFP § 3.4(b). The 2022 RFP, in contrast, used a 310-point scale, with one

point being awarded for the response to each of the 310 yes-or-no technical questions in the RFP. *See* 2022 RFP § 3.4(b). This change dramatically increased the importance of a vendor's response to each yes-or-no question.

e. Eliminated Preference for a North Carolina Vendor

The 2019 RFP stated a preference for vendors "with resources in North Carolina." 2019 RFP § 5.2.2.1. The 2022 RFP eliminated this preference.

BASIS FOR PROTEST

As shown below, the award of this contract to Aetna was an arbitrary and capricious decision. That award is not in the best interests of the Plan or its members.

1. Failure to Score Each Vendor's Network

For members, network strength is critical to whether the Plan meets the members' health needs. Plan members stretch across North Carolina, from Murphy to Manteo. Those members, regardless of their geographic location, deserve high-quality health care that is actually available to them. That availability requires a deep provider network.

The RFP's stated scoring process failed to consider these critical issues. Instead, the Plan treated Blue Cross NC's and Aetna's networks as equivalent as long as both vendors met certain minimum thresholds. Those networks, however, are not equivalent at all. Based on a preliminary review of publicly available data, Blue Cross NC has 38% more provider locations in North Carolina than does Aetna. In the vast majority of North Carolina's 100 counties, Blue Cross NC also has more provider locations than Aetna has.

The scoring system further failed to consider whether choosing a given vendor, with its network, would cause disruption to the Plan's members. Disruption can come in many forms, including forcing members to change providers because their Blue Cross NC provider is not in Aetna's network. The 2022 RFP itself noted the importance of minimizing disruption: it stated that the Plan was seeking a vendor that provided "a broad provider network with the least

disruption.” 2022 RFP, att. A, § 1.1. The RFP undermined this goal by assigning no points to it.

2. Scoring of Cost Proposals

The RFP’s scoring system for cost proposals was arbitrary.

The RFP does not explain, for example, why the administrative-fee and network-pricing-guarantee categories each received two points, even though administrative fees reflect *actual* costs to the Plan and its members, while pricing guarantees are rebates that will be paid only if a vendor does not meet its pricing commitments. Had the administrative fee received more weight than the network-pricing guarantee, Blue Cross NC would have received the highest overall score, because it was apparently the only vendor that received all available points for administrative fees.

The RFP also used vague and undefined standards for scoring network-pricing guarantees. The RFP states that the “proposal that offers the network pricing guarantee with the greatest value will be ranked the highest” and will receive two points. 2022 RFP § 3.4(c)(3)(b). It does not say, however, how the Plan would decide which guarantee provides “the greatest value,” or what that term even means.

The RFP is equally vague on how many points would be awarded to the vendors that were not ranked highest on network-pricing guarantees. The RFP says that the vendor that does not provide the “greatest value” through its network-pricing guarantee “may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.” 2022 RFP § 3.4(c)(3)(c). It does not explain how the Plan would decide whether to award zero points or one point.

Based on this vague scoring, the Plan apparently awarded Blue Cross NC zero points for its network-pricing guarantee. That unexplained decision was pivotal. Had the Plan awarded Blue Cross NC even one point here, Blue Cross NC would have received the highest overall score.

Indeed, if Blue Cross NC had received only one point on the network-pricing guarantee, Blue Cross NC would have won by a margin *three times higher* than Aetna’s winning margin. Under those circumstances, Blue Cross NC would have

won nine of the ten available points on its cost proposal. That is equivalent to 279 of the 310 available technical points. Blue Cross NC's total score thus would have been 582 (279 plus 303). Aetna's total score would have been 558 (248—80 percent of the available cost proposal points—plus 310).

In the post-award meeting with Blue Cross NC, the Plan's representatives said that Blue Cross NC did not rank the highest on the guarantee because of the amount of its administrative fee that Blue Cross NC agreed to put at risk if the guarantee failed.

In view of the context here, however, the Plan had no reason to put dispositive weight on these guarantees. Under the 2019 contract with the Plan, Blue Cross NC consistently met its contracted discounts.

3. Scoring of Technical Proposals

The Plan's method for scoring technical proposals was equally arbitrary. The Plan evaluated each vendor's technical proposal based only on yes-or-no responses to 310 technical requirements. The Plan awarded one point for each requirement that was confirmed and zero points for each requirement that was not.

This scoring presumes that each of the 310 technical requirements deserves equal weight. The Plan has offered no justification for this equal weighting.

Some of the 310 technical requirements are central to the proper functioning of the Plan's third-party administrator. For example, vendors were asked to confirm that they have experience with, and will support the implementation of, care models designed to reduce costs for Plan members. *See* Requirements 5.2.3.2(b)(xii) and (xiii). Vendors were also asked to confirm their ability to provide services to members who have an urgent medical need while outside the United States. *See* Requirement 5.2.3.2(b)(ii).

Other requirements are less central—for example, the vendor's ability to display the name of a member's employer in the vendor's online portal (Requirement 5.2.7.2(b)(xiv)) and confirmation that the vendor would provide and moderate online chat groups (Requirement 5.2.7.2(b)(xxi)).

Despite the difference in these and other technical requirements, the Plan gave every one of them the same scoring weight. That equal weight was arbitrary.

In addition, because the Plan demanded that vendors give yes-or-no answers to the 310 technical requirements, the Plan did not consider whether any vendor—including the winning vendor, Aetna—had conditions or limits on its ability to meet the requirements. Instead, the yes-or-no scoring motivated each vendor to superficially “confirm” its ability to meet each requirement *regardless* of its current capabilities or any limits on the vendor’s ability to satisfy the requirement in the future.

The binary form of the questions also penalized Blue Cross NC for its attention to detail. Because Blue Cross NC knew the history and context of the Plan’s stated requirements, it truthfully noted the seven requirements that it could not confirm without additional discussion. It received zero points for those responses. The Plan’s refusal to consider any explanation for these responses led to a decision that was uninformed and arbitrary.

Because all the Plan relied on here was a small number of technical requirements with no allowance for an explanation, the Plan could not adequately complete its due diligence review of Blue Cross NC’s proposal. The binary response format also precluded the Plan from properly assessing the remaining vendors on the same technical requirements that they had marked “confirmed.”

In sum, the Plan could not make a reliable and informed decision about the technical capabilities of any vendor by treating each of 310 technical requirements as equally important, then refusing to accept any explanation on a vendor’s detailed capabilities. The Plan nonetheless made its decision on that basis. At the post-award meeting with Blue Cross NC, Plan representatives admitted that because Blue Cross NC and Aetna had the same cost scores, the Plan awarded the bid to Aetna based on the difference in the vendors’ technical scores. Seven superficial yes-or-no answers, out of 310 technical questions, decided the entire RFP.

Choosing the vendor of a multi-billion-dollar contract that affects hundreds of thousands of North Carolinians based on seven yes-or-no responses—and refusing to accept any explanation about those responses—is illogical and arbitrary.

4. Failure to Allow Explanations on Technical Questions

The Plan's decision to award Blue Cross NC zero points for each "not confirmed" response assumes that those responses reflect a deficiency. But the opposite is true.

Had the RFP allowed Blue Cross NC to submit narrative explanations with its answers, those explanations would have shown the legitimate reasons why Blue Cross NC did not confirm seven technical requirements.

If Blue Cross NC had been allowed to do so, it would have offered the following information on the seven technical requirements at issue:

- a. Requirement 5.2.3.2(b)(iii): "Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States."

Blue Cross NC did not confirm this sweeping condition for good reason. On rare occasions, key out-of-state providers (for example, the Mayo Clinic) might provide care to members without first getting prior authorization for that care. Under the terms of contracts between Blue entities and these out-of-state providers, the provider is not charged a penalty for providing this care. Because of these contracts, Blue Cross NC could not accurately state that the exact same utilization-management and payment rules would apply to every single provider across the country.

Requiring mechanical sameness across all providers would not be in the best interest of the Plan or its members. Rigid enforcement of a prior-authorization requirement could prevent Plan members from receiving necessary medical care. And it would not produce any cost savings or other benefits for the Plan, for several reasons:

- First, the waiver of these penalties is rare. In over 99% of cases, these out-of-state providers get prior authorization.
- Second, in virtually all cases, the provider *would have* received prior authorization had it sought it. Thus, mechanically enforcing a requirement of prior authorization would deny treatment to Plan members over a mere "touch foul."

- Third, this lack of absolute sameness across the country is a necessary result of having out-of-state providers in the Blue network—a network that provides significant benefits to Plan members.
- Fourth, Blue Cross NC believes that the out-of-state providers at issue demand similar penalty waivers from all third-party administrators, including Aetna and United. It is therefore unlikely that these vendors can comply with the absolute-sameness requirement stated in the RFP.
 - b. Requirement 5.2.7.2(b)(xxiv): “Vendor’s member portal will accept and display Member-specific information from the other systems and Vendor’s health team, including . . . Electronic medical and health records, Disease Management Nurse notes, Case Management notes, [and] Health Coach notes”

These requirements—four of the seven technical questions not confirmed by Blue Cross NC—are not technically feasible or not in the best interest of the Plan’s members.

Blue Cross NC’s member portal does not allow it to display electronic medical records (EMRs) from a provider. Providers have different and widely varying EMR systems, so displaying EMRs on a member’s portal would require a universal platform that is compatible with each provider’s system. Blue Cross NC is not aware of any third-party administrator that can offer this feature. It believes that the other vendors who confirmed this requirement did not appreciate its full implications.

In addition, the three categories of notes discussed in this technical requirement are notes made for the third-party administrator’s own internal use, not notes meant for members’ review. At times, the notes contain candid comments on whether a patient is following a provider’s recommended course of treatment.

The Plan has not once raised the question of access to these internal notes during Blue Cross NC’s long history as the Plan’s third-party administrator. Even so, because of the scoring method that the Plan used to evaluate proposals here, this issue was given near-dispositive weight.

- c. Requirement 5.2.8.2(b)(v): “Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.”

Blue Cross NC does not allow assignment of benefits to providers for out-of-network claims. This policy exists for the benefit of the Plan and its members. If an out-of-network provider can count on receiving payment directly from Blue Cross NC, that provider will have little incentive to join the Blue Cross NC network. The lack of such an incentive would undermine Blue Cross NC’s ability to negotiate discounts for Plan members. Thus, treating assignment of benefits for out-of-network providers as a preferred feature of a vendor is a serious mistake.

By itself, moreover, assignment of benefits would have little benefit to Plan members. If this requirement is meant to streamline billing for out-of-network services and therefore reduce the burden on Plan members, it will not be enough to meet that objective. Any streamlining of billing would occur only when the out-of-network payment made by Blue Cross NC under an assignment of benefits is accepted as payment in full.

If, in contrast, the requirement of assignment of benefits is motivated by a concern that a large benefits payout to a member might not get paid to a provider, Blue Cross NC has already implemented safeguards to prevent this from occurring.

- d. Requirement 5.2.6.2(b)(xvi): “Vendor will use the unique Member ID number provided by the [Plan’s eligibility and enrollment] vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the [eligibility and enrollment] vendor will be the sole Member ID on the ID Card.”

Blue Cross NC had good reasons for not confirming this requirement as well. This requirement is technically infeasible and would cause needless headaches for Plan members.

As the Plan knows, each of its vendors—including its eligibility vendor and its pharmacy-benefits vendor—has its own form of member ID. Each vendor’s form of ID is designed to be compatible with that vendor’s systems. Blue Cross NC, for example, has a sixteen-character form of ID that includes a particular prefix. When

a Plan member visits a provider, that provider is familiar with and expects to see a sixteen-character form of ID and is prepared to use that form of ID in its billing systems.

Because of providers' expectations, enforcing a "single ID number" requirement would be counterproductive for the Plan's members. It would cause confusion and disruption with providers.

As the above discussion shows, Blue Cross NC had good reason for not confirming these seven out of 310 technical requirements in its proposal. If the Plan had allowed Blue Cross NC to explain these points, it would have done so. Then, the Plan—in the proper exercise of its diligence—would have been able to assess confirmed responses from other vendors on the same point.

In any event, if the Plan had scored the technical proposal less mechanistically, the outcome of this RFP would have been different.

CONCLUSION AND REQUEST FOR RELIEF

The Plan has described the criteria and scoring of the 2022 RFP as a modernization effort, but there was nothing modern about this RFP process.

Instead, the Plan took a complex decision—selecting the third-party administrator for a health plan that covers hundreds of thousands of North Carolinians—and tried to turn it into a checklist. That approach ignored critical issues that will affect the welfare of the State and the welfare of the Plan's members.

The Plan's third-party administration is not a back-office function. Instead, the third-party administrator has responsibilities that play a central role in defining member benefits. The administrator must also deliver a provider network with the strength, depth, and reach to offer high-quality, accessible health care to Plan members.

The Plan gave short shrift to these factors when it chose its next third-party administrator. That choice was arbitrary and capricious.

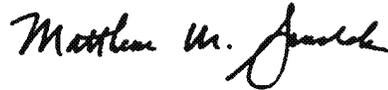
Mr. Sam Watts
January 12, 2023
Page 15

In light of the problems noted above, Blue Cross NC respectfully requests that the Plan (a) declare Blue Cross NC the winning vendor and award Blue Cross NC the contract, or (b) in the alternative, vacate its award to Aetna and conduct a new and more sound RFP process.

We look forward to meeting with the Plan to discuss these issues further.

Sincerely,

ROBINSON, BRADSHAW & HINSON, P.A.



Matthew W. Sawchak

MWS/wp
Attachments: Exhibits 1-3

**RESPONDENT-INTERVENOR'S
NOTICE OF FILING – No. 22**

State Health Plan's January 20, 2023 Response to
Blue Cross Blue Shield of North Carolina Request for Protest
Meeting on Request for Proposal #270-20220830TPAS
SHP 0025822-32
("Plan's Resp. to Blue Cross NC Protest")



January 20, 2023

Delivered via U.S. certified mail and electronic mail

Mr. Matthew Sawchak (msawchak@robinsonbradshaw.com)
Robinson, Bradshaw & Hinson, P.A.
434 Fayetteville Street, Suite 1600
Raleigh, North Carolina 27601

RE: Response to Blue Cross Blue Shield of North Carolina's Request for Protest Meeting on Request for Proposal #270-20220830TPAS

Dear Mr. Sawchak:

On January 12, 2023, the North Carolina State Health Plan for Teachers and State Employees ("Plan") received your letter delivered on behalf of your client Blue Cross Blue Shield of North Carolina ("BCBS") and titled "Blue Cross Blue Shield of North Carolina's Request for Protest Meeting on Request for Proposal #270-20220830TPAS" ("Protest Letter"). This response is intended to answer that request pursuant to § 15 of Attachment B of the Request for Proposal ("RFP") #270-20220830TPAS ("Third-Party Administrative Services RFP" or "TPA RFP"). The service period for this new third-party administrative services contract begins two years from now.

After carefully reviewing the reasons and requests stated in your Protest Letter, I have determined that your positions are without merit and am therefore denying your requests.

THE NORTH CAROLINA STATE HEALTH PLAN

The North Carolina Department of State Treasurer ("DST") is an agency of the State of North Carolina, led by the State Treasurer of North Carolina ("Treasurer"). The Plan, a division of DST, is a benefit program of the State of North Carolina that provides healthcare benefits to eligible North Carolina teachers, active State employees, retired teachers and State employees, and their dependents in accordance with applicable federal and state law and the Plan's regulations and policies. Established by N.C. Gen. Stat. § 135-48.20, the Board of Trustees for the Plan ("Board"), entrusted with fiduciary responsibilities, decides key matters and assists the Treasurer and the Plan. The Board is a bipartisan body that includes trustees representing key segments of the population the Plan serves, including active State employees, teachers, and retired State employees.

Due to rapidly increasing healthcare costs, funding that has not increased at the same rate, and the aging and declining health of the Plan member pool (due in part to the inability to

attract young and healthy dependents into the Plan because of high family premiums), the Plan is facing a \$4.2 billion budget gap over the next five years. This is an existential threat to the Plan.

This budget shortfall is in addition to the liability the Plan faces for future healthcare needs, which the Treasurer and the Board have been working to address for the last six years. The Treasurer and the Board have made it the Plan's explicit policy to cap or reduce the Plan's costs and implement strategic initiatives that will enable the Plan to lower dependent premiums to attract younger, healthier members to the Plan. The Plan has implemented finance-improving measures across the Plan's entire area of operations, including implementation of modest premiums for members who had been paying nothing for their coverage, improved cost savings from the 2023–2025 Pharmacy Benefit Manager contract, and significant cost savings from the 2021–2023 Medicare Advantage contract, to name a few.

Despite the Plan's ongoing efforts, healthcare costs continue to rise, and the budget shortfall persists, threatening the financial sustainability of the Plan for its current and future members, as well as the ability of the Plan to comply with N.C. Gen. Stat. § 135-48.1 *et seq.* and other applicable laws.

As a part of the high priority of reducing costs, the Treasurer and the Board have also made seeking transparency in healthcare costs a priority of the Plan. The ultimate goal for the transparency of healthcare costs is improved healthcare outcomes for Plan members at lower costs. To that end, the Plan implemented the Clear Pricing Project ("CPP"), partnering with thousands of healthcare providers to promote affordable, quality care and to increase transparency, predictability, and value for Plan members, in addition to reducing costs to the Plan.

Lastly, consistent with the Plan's authorizing statutes, the Treasurer set a priority for the Plan to update, improve, and streamline its Request for Proposals procurement process. In the past, the Plan's procurement process was overly laborious and time-consuming, producing reams of documentation without discernible improvement in the performance of the Plan's vendors.

RFP #270-20220830TPAS, the TPA RFP, was the second RFP to be revised and operated according to this modernization strategy, but the first RFP qualifying under N.C. Gen. Stat. § 135-48.34 as exempt from the requirements of Article 3 of Chapter 143. Modernization of the RFP process and the TPA RFP included these objectives:

- 1) Ensure that vendors are able and willing to work with the Plan to meet the priorities and requirements of the Plan and the RFP without qualification.



- 2) Avoid “micromanaging” every possible detail from the outset to provide the Plan flexibility and adaptability; instead, use Administrative Decision Memos and Business Requirements Documents to implement initiatives as needed.
- 3) Refine the scope of work to focus on the Plan’s key, non-negotiable items and move those items to the Minimum Requirements portion of the RFP.
- 4) Increase the overall objective analysis of RFPs by moving away, as much as reasonably possible, from subjective parsing of vendors’ own descriptions of their capabilities.
- 5) Revise the scoring methodology to ensure fair and objective scoring, efficient analysis by the Evaluation Committee, clarity for the Board, the decision-maker, and alignment with the Plan’s priorities.

To achieve these objectives in the TPA RFP, the Plan exercised its judgment to structure the RFP in the following ways: limiting vendor responses to the scope of work requirements presented in Attachments K and L to “Confirm” or “Does Not Confirm”; equally weighting each technical requirement; scoring technical requirements as either zero or one; and revising the cost analysis to reflect the importance the Plan places on the three components—six points for Network Pricing, two points for Administrative Fees, and two points for Pricing Guarantees.

In addition, the Plan structured the TPA RFP to support and clarify the Board’s decision-making role, which is established in N.C. Gen. Stat. § 135-48.33(a). The Treasurer and the Plan do not view the Board as a mere “rubber stamp,” so the Plan took steps to enable careful, thoughtful evaluation, deliberation, and full participation by the Board. One result was that, rather than being screened out by the Evaluation Committee, all three vendor proposals were presented to the Board for their review. It was *the Board* that then voted, unanimously, to award to Aetna Life Insurance Company (“Aetna”) the new third-party administrative services contract, which will begin two years from now.

The determining priorities mentioned above governed the Plan’s judgments and the structure and evaluation of the TPA RFP.

PROCESS FOR REQUEST FOR PROPOSAL #270-20220830TPAS

The modernized TPA RFP was made publicly available via the Interactive Purchasing System, the State’s online contracting portal, on August 30, 2022. By its terms, the TPA RFP mandated that “[t]he State shall conduct a comprehensive, fair, and impartial evaluation of the proposals.” The TPA RFP process consisted of two main stages: first, interested vendors submitted responses to the “Minimum Requirements Proposal” portion; after establishing their ability to meet the Plan’s minimum requirements, vendors then submitted responses to the Technical Proposal and Cost Proposal portions of the TPA RFP.



As with all of the Plan's RFPs, this was a voluntary process, and no vendor was mandated by contract or law to participate. Before any vendor submissions were made, the Plan held a conference call with interested vendors on September 1, 2022, regarding the TPA RFP structure and process. BCBS, Aetna, Cigna Insurance Company, and UMR, Inc., participated in that call. The Plan then issued Addendum #1 to the TPA RFP on September 16, 2022, responding to questions submitted by these interested vendors and making changes to several areas of the TPA RFP. Three of the interested vendors—BCBS, Aetna, and UMR, Inc.—submitted responses in the first stage of the process, the Minimum Requirements Proposal, by the deadline on September 26, 2022.

The Minimum Requirements Proposal, the components of which were defined in Section 2.7.1 of the TPA RFP, ensured each vendor could meet basic operational prerequisites to perform TPA services. The TPA Minimum Requirements Table included in TPA RFP Section 5.1 elicited key information from each vendor, such as: experience with large, self-funded clients, data security practices, financial health and stability, and demonstrated compliance with federal health information privacy law and regulations.

Vendors were also required to complete "Attachment K: Minimum Requirements Response" as the form for submitting responses to TPA RFP Sections 5.1.1 through 5.1.11. As noted above, the responses to the items listed in Attachment K were required to be either "Confirm" or "Does Not Confirm." In addition to the modernization objectives mentioned above, the purpose of requiring vendors to specifically confirm their ability to meet the wide variety of the Plan's minimum requirements was to preclude equivocation by vendors, discussed further below. As specific terms of the third-party administrative services contract, responses that were incomplete or did not comply with these requirements were subject to rejection.

In accordance with the terms of the TPA RFP, the Evaluation Committee then considered each vendor's comprehensive Minimum Requirements Proposal response with the assistance of subject matter experts in data security, finance, and federal health information privacy law. After the Evaluation Committee determined that each vendor met the Plan's minimum requirements stated in the TPA RFP, the vendors were given access to the worksheets and data files necessary to complete the second stage, responding to the Technical and Cost Proposals. Again, the vendors had the opportunity to ask questions relating to the RFP, specifically the technical and cost components. The Plan issued Addendum #2 to the TPA RFP on October 14, 2022, responding to all questions submitted by the three vendors.

The contents of the Technical and Cost Proposals were set forth in TPA RFP Section 2.7.2. Notably, the Technical Proposal consisted of 310 requirements divided into eleven main categories addressing matters ranging from member enrollment to plan design to finance and banking and more. Vendors were required to complete and submit "Attachment L: Technical Requirements Response," which again requested vendors to simply confirm their ability to meet the Plan's stated requirements. Again, the purpose of requiring clarity and



accuracy from all interested vendors was to reduce subjective interpretations on the part of Plan staff and to avoid negation or qualification of an ability to meet a Plan technical requirement through an explanatory description.

“Attachment A: Pricing” of the RFP comprised the Cost Proposal, which was scored based on three primary components: Network Pricing, Administrative Fees, and Network Pricing Guarantees. To complete the Network Pricing exercise, each vendor was given access to some actual Plan claims data and then asked to reprice the claims according to the vendor’s expected network discounts. This enabled the Plan to understand the financial value of each vendor’s network while also implicitly demonstrating the breadth of that network. The Administrative Fees component represented the cost charged to the Plan by the vendor for performance under the TPA RFP, and the Network Pricing Guarantees component was where each vendor could offer compensation back to the Plan if their network fails to deliver promised discounts (particularly due to rises in healthcare costs). The Cost Proposal itself consisted of ten total points a vendor could score: six points for its Network Pricing, two points for its Administrative Fees, and two points for its Network Pricing Guarantees. The Evaluation Committee, with assistance from its actuarial and health benefits consultant, The Segal Company (“Segal”), evaluated each vendor’s Proposal responses and scored them according to the terms of the TPA RFP.

As set out in the TPA RFP, the requirements in the Technical Proposal constituted half of each vendor’s score and those in the Cost Proposal constituted the other half. For the Technical Proposal component, vendors were ranked based on the total points earned out of the 310 available. The vendor earning the fewest points out of the total 310 received the rank of one. The vendor earning the most points out of the total 310 received the highest rank. To avoid subjectivity or favoritism, the TPA RFP specified that if two vendors earned the same number of points by meeting the requirements in the Technical Proposal, they would be equally ranked. In its response to the Technical Proposal’s requirements, BCBS failed to confirm its ability to meet seven of the Plan’s listed items, while the other vendors confirmed their ability to meet all 310. Thus, BCBS’ proposal earned the fewest points and received the rank of one.

The scoring and ranking methodology for the Cost Proposal was similar and also explained in the TPA RFP. Vendors were ranked based on the total Cost Proposal points earned out of the 10 available. The vendor earning the fewest points out of the total 10 received the rank of one, and the vendor earning the most points out of the total 10 received the highest rank. As with the Technical Proposal, multiple vendors earning the same Cost Proposal score were equally ranked. BCBS’ Cost Proposal response received eight points, which tied with another vendor for the most and so received the (highest) rank of three.

After reviewing the responses to the requirements of the Technical and Cost Proposals and combining the rankings, BCBS earned a final score of four, while the other two vendors earned scores of six and four. Thus, the Evaluation Committee presented all three vendors to the Plan’s Board for their consideration with a recommendation to award the third-party



administrative services contract to the vendor with the highest point total. During its meeting on December 14, 2022, the Board unanimously voted to award this contract to Aetna.

BCBS' CLAIM OF ARBITRARINESS LACKS MERIT

In the Protest Letter, you claim that the TPA RFP and its award to a vendor other than BCBS was “arbitrary,” “illogical,” and “capricious.” Therefore, you request that the award of the TPA RFP to Aetna should be rescinded and instead awarded to BCBS or that a new RFP process should be conducted. Your assertions are addressed in turn below.

Fundamentally, your assertion that the TPA RFP and its award were arbitrary is not supported by the facts and is, therefore, without merit.

A. Differences between the 2022 TPA RFP and prior RFPs

First, you incorrectly equate the mere existence of differences between the recently completed TPA RFP process and prior RFPs with unreasonableness and unfairness. In reality, the differences between the 2022 TPA RFP and prior RFPs were based on choices that were made logically in furtherance of the Plan’s fiduciary responsibilities and priorities.

For example, you complain that the scoring of the Cost Proposal was based on a 10-point scale instead of a 10,000-point scale. This complaint is meaningless, however, because BCBS’ bid was in no way adversely affected. How can BCBS now complain that the scoring of the Cost Proposal was incorrect or unfair if they received the highest ranking?

As another example, you complain that the 2022 TPA RFP eliminated the preference stated in prior RFPs for a vendor “with resources in North Carolina.” Protest Letter, p. 7. Again, this is meaningless. First, the Plan appropriately deemed this additional preference unnecessary, because any vendor confirming its ability to meet requirements in the Minimum Requirements and Technical Proposal portions is attesting to its “resources in North Carolina.” Second, in keeping with the Treasurer’s, the Board’s, and the Plan’s concerns about the consolidation, monopolistic behavior, and lack of transparency in the healthcare industry, such a preference was deemed inappropriate, anti-competitive, and detrimental to the proper exercise of fiduciary responsibilities.

The truth is that the Plan has been continuously refining and improving its RFP process over multiple years, the TPA RFP process conducted in 2019 improved upon prior RFPs, and the recently completed TPA RFP process continued that improvement in ways that will benefit the Plan’s members and Plan administration for years to come.

To be clear, you do not include these complaints about the differences between the 2022 TPA RFP and prior RFPs as a basis for BCBS’ protest of the award (so they will not be



evaluated as such). Apparently, these concerns are raised simply to cast doubt on the validity of the current RFP and the Plan's priorities and objectives, discussed above. Regardless, such post-award concerns by BCBS about the differences between RFP processes essentially amount to a complaint that the Plan failed to design its RFP process to favor BCBS, the incumbent.

B. Evaluation and weighting of the TPA RFP requirements

A second issue you raised reveals an incorrect belief that if a requirement of the TPA RFP, whether in the Minimum Requirements, the Technical Proposal, or the Cost Proposal, did not match BCBS' own priorities then there must not exist a fair, good faith, and reasoned decision by the Plan regarding that requirement. Specifically, you complain about the TPA RFP's scoring methodology in at least two ways: (1) that the Plan did not weight the requirements stated in the TPA RFP how BCBS thinks it should and (2) that the Plan did not permit BCBS to fully explain why it could not meet certain requirements.

1. BCBS' complaint about how the Plan weighted its requirements

Regarding the first complaint, the Plan is tasked with fairly, and in good faith, structuring and reviewing the RFP process and the TPA RFP to achieve its given objectives and priorities in service of the best interests of the Plan's members, to whom the Treasurer, the Board, and Plan staff owe a fiduciary duty. In exercising its duty, the Plan is not mandated to operate according to a particular vendor's internal mechanisms, procedures, and priorities. Instead, Plan staff carefully discerned and articulated requirements in the TPA RFP that we believe will best benefit the Plan's members.

In your Protest Letter you state that "the Plan could not make a reliable and informed decision" by choosing to equally weight the 310 items in the Technical Proposal and limiting vendors to confirming their ability to meet the requirements. Protest Letter, p. 10. In reality, these requirements, although presented slightly differently in the latest TPA RFP, are virtually unchanged from prior RFPs.

You have implied that the Plan's approach to the 2022 TPA RFP—such as what mandatory data, assurances, and requirements the Plan included or removed, how the Plan determined to score particular items, and the priority and weight that the Plan decided to place on specific requirements—was not reasonable. Actually, the Plan's decisions on structure, process, and award were logically connected to better achieving the objectives governing the Plan through this TPA RFP.

For example, the Plan decided to increase the weight for the score of the Cost Proposal to better align the scoring of the TPA RFP with the Plan's priority of reducing costs. In addition, within the Cost Proposal, Network Pricing was given the largest score because it reflects the highest cost to the Plan—in billions of dollars—while the Administrative Fee



and the Network Pricing Guarantees reflect smaller amounts of money—in hundreds of millions or millions of dollars.

2. BCBS' complaint about not being able to explain its answers

Regarding the complaint that the Plan did not provide BCBS an opportunity to explain its answers, it is true that the Plan decided to limit vendor answers to simple confirmations of ability to meet the Plan's requirements. This choice was made to align the Plan's RFP process, and specifically this TPA RFP process, with the goals of increasing objectivity in the analysis and ensuring that vendors are able and willing to work with the Plan to meet the TPA RFP requirements without qualification. The Plan's decisions on refining and restructuring its RFP process were based on a logical connection with the Plan's overarching objectives.

In addition, the effort to modernize the TPA RFP was specifically intended to eliminate explanations by bidding vendors that obscure and obstruct more than they reveal and clarify. For example, in the RFP for third-party administrative services issued in 2019, BCBS first stated "CONFIRMED in part, NOT CONFIRMED in part" to the Plan's requirement that its third-party administrator would "pay all claims, including non-network claims based on assignment of benefits." Requirement 5.2.12.2.b.i, 2019 TPA RFP. Later, in its explanation, BCBS described its limitations regarding this Plan requirement with this statement:

We do not confirm that we will pay all out-of-network claims based on assignment of benefits. In situations where we can negotiate a lower reimbursement in exchange for reimbursing the provider directly, we will do so. For all other out-of-network claims, we will reimburse the member directly. We have found that this policy is critical to our provider contracting ability and, ultimately, saves money for the Plan.

Requirement 5.2.12.2.b.iv, 2019 TPA RFP. Notwithstanding the reasons BCBS gave for how they wanted to handle claims payments, the fact is that the Plan has logical, considered reasons for its requirements, and asking vendors to clearly confirm their ability to meet such requirements is imminently reasonable. Avoiding equivocating explanations with the recently completed TPA RFP was *not* a failure to "proper[ly] exercise . . . its diligence," nor was the Plan's approach "illogical and arbitrary." Protest Letter, p. 10, 14. Instead, the Plan made a reasonable, careful effort to reduce the need for painstaking parsing in its evaluation of vendors' responses.

C. BCBS' problem with what "[t]he RFP does not explain"

The Plan first officially informed BCBS of its intent to issue the TPA RFP on June 15, 2022. The Plan then issued the TPA RFP on August 30, 2022. On September 1, 2022, BCBS participated in the Plan's call regarding the TPA RFP, where the Plan provided information



and answered vendor questions. The deadline to submit a response to the Minimum Requirements Proposal was September 26, 2022.

You complain in various places in your Protest Letter that the TPA RFP “does not explain” the scoring of the Cost Proposal and that “[t]he Plan has offered no justification” with respect to its weighting of the requirements in the Technical Proposal. Protest Letter, p. 5, 8–9.

But BCBS had ample opportunity to examine the Plan’s TPA RFP and its structure, process, and scoring prior to submitting its responses to the various Proposals. Like other vendors, BCBS was at liberty to ask questions, seek clarification, and request changes. BCBS did not raise *any* of the issues discussed in your Protest Letter during that time. By taking part in the TPA RFP, BCBS specifically and freely agreed to the TPA RFP and its structure, process, and scoring. Only now, after the Board has voted to award to Aetna the third-party administrative services contract beginning in 2025, is BCBS complaining about the TPA RFP’s structure, process, and scoring.

If BCBS had real concerns about the TPA RFP, and not fabricated ones, it had a responsibility to raise them during the process when it had multiple opportunities to do so. Raising these issues at this point is akin to Captain Renault’s faux shock in the movie *Casablanca*—you argue that you are surprised that the TPA RFP was structured and scored exactly as delineated in the TPA RFP.

D. Thoroughness and care exercised by the Plan

It is lawful, proper, and necessary for the Plan, the Treasurer, and the Board to implement a RFP to obtain more favorable terms for the Plan’s members and to align vendor relationships to better achieve the Plan’s strategic priorities.

Any implication that the Plan’s TPA RFP was not performed in good faith and in a fair manner does not align with the process as it actually occurred. The TPA RFP Evaluation Committee was commissioned to objectively review and score each proposal in accordance with the pre-developed criteria in the TPA RFP and to make a recommendation and presentation to the Board based on fair and ethical review practices. Those pre-developed criteria were created to achieve the objectives given to the Plan, already discussed above.

You assert that, in its pursuit of the Plan’s objectives, the Plan did not obtain sufficient information to make a reasonable decision, creating the false impression that the TPA RFP, its development, and its review were a cursory affair that only relied upon scant facts and a lack of knowledge, that “the Plan took a complex decision ... and tried to turn it into a checklist.” Protest Letter, p. 14. This dramatic language does not describe the Plan’s recently completed TPA RFP process.



In reality, the detailed, 209-page initial TPA RFP required vendors to provide substantial data to the Plan for review and a multitude of binding contractual assents (without qualification) to the Plan's essential requirements for its next third-party administrator. Specifically, the TPA RFP required submission of many mandatory items, such as (i) vendor network minimum requirements, (ii) an accessibility report of the vendor's proposed provider network, (iii) a summary of participants with and without access to network providers and facilities within established mileage parameters, and (iv) a list of each vendor's entire proposed provider network. Each vendor's proposed network was also tested through the claims repricing exercise of the Cost Proposal, described above. These and other items were requested, evaluated, and scored in accordance with the Plan's objectives to ensure that the Plan had the knowledge and assurances that its priorities and objectives would be met.

Finally, while we appreciate BCBS' stated concern regarding the disruptions that a change in third-party administrator may cause to the Plan's members, this is also something that the Treasurer, the Board, and the Plan have already carefully considered. Minimizing such disruptions is one reason why we are grateful for BCBS President and CEO Tunde Sotunde's repeated assurances of support and faithful work through the remainder of the current contract to State Treasurer Dale Folwell. In addition, this is why it matters so much to the Plan's members that the new third-party administrative services agreement will not begin for another two years: disruptions to members will be reduced by the Plan having adequate time for its implementation process. But the mere avoidance of disruption would mean that the Plan should never issue a new RFP for any services, and this would not be in keeping with the duties owed to the Plan's many members and other taxpayer like them.

CONCLUSION

Your Protest Letter also mentioned the two public records requests related to the TPA RFP submitted by BCBS on December 15 and 20, 2022. As BCBS is already aware, the deadline for all vendors to submit redacted versions of their materials just passed last week, on Monday, January 9, 2023. Thus, despite the apparent length of time since BCBS' public records requests, there have only been *seven* business days since the vendor submission deadline passed.

In addition, the Plan would not normally release procurement-related materials until after that procurement's "silent period" is lifted, which the Plan was forced to extend to cover responses to vendors' protest letters, including BCBS' own. Plan staff are still compiling the materials submitted by participating vendors, materials amounting to thousands of pages per vendor, even with the Plan's improved RFP process. Then, Plan staff must review and confirm the redactions to avoid sharing vendors' trade secret and confidential information. BCBS is already fully aware that fulfillment of these regular post-procurement public record requests usually takes multiple weeks, sometimes longer.



In this response to your Protest Letter, I have avoided an in-depth discussion of the implications of your statements about Aetna, that it was “motivated . . . to superficially ‘confirm’ its ability to meet each requirement *regardless* of its current capabilities or any limits on [its] ability to satisfy the requirement in the future.” Protest Letter, p. 10 (emphasis in original). If Aetna was untruthful when it confirmed its ability to meet all the Plan’s requirements, then the Plan will discover this during the next two years of implementation and during the term of the third-party administrative services contract. The Plan will then have contractual remedies to obtain and fiduciary responsibilities to uphold.

Regardless, a neutral examination of the facts shows that the Plan’s recently completed TPA RFP and its structure, process, scoring, and award were conducted carefully, professionally, in good faith, in a fair and reasonable manner, and in the best interest of the Plan’s members consistent with the Plan’s fiduciary responsibilities. Following its objectives, the Plan carefully considered the critical facts and arrived at decisions regarding RFP structure, process, scoring, and award that were logically connected with those objectives.

Your claim that the TPA RFP was arbitrary is without merit, and a meeting to further discuss BCBS’ protest of the award would serve no purpose. I understand BCBS’ disappointment at the award of the TPA RFP to Aetna and that this is not the outcome they desired; however, I am constrained to consider the facts and law as they exist.

I nonetheless desire to thank BCBS for their participation in the TPA RFP process—each bidder increases competition, which moves the Plan closer to achieving its overall goals of reducing the Plan’s costs, improving the Plan’s solvency, and lowering dependent premiums, all to maintain the Plan’s sustainability for this and the next generation of those who teach, protect, or otherwise serve. I have appreciated this opportunity to engage in a factual, thoughtful, and transparent review of the Plan’s contracting process for the third-party administrative services contract going into effect two years from now, and I welcome BCBS’ future bids on RFPs.

Sincerely,



Sam Watts
Interim Executive Administrator
North Carolina State Health Plan