

Message

From: Dee Jones [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=421FCFB9EC28424C96835AB1056C9150-DEE JONES]
Sent: 8/22/2022 8:19:02 PM
To: Caroline Smart [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1173c514153d4c7088e63f2c589feac1-Caroline Sm]; Matthew Rish [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=10bbde503a1d4c2093425c16c56d9727-Matthew Rish]; Kendall Bourdon [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=d1d44d46ecc245079732dcfc08e71ced-Kendall Bou]
CC: Dee Jones [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=421fcfb9ec28424c96835ab1056c9150-Dee Jones]
Subject: RE: Segal TPA Cost Scoring input

I tend to agree with the network, guarantees and admin fees.

Like we discussed last week, if we give 1 point for admin and guarantees and 3 points for network then that will enable us to rank the bidders in a 4,3,2,1 (assuming 4 bidders). Then doing the same with the Technical scores, then combining rankings for a total score with top scorers going to the board. If necessary, we take all bidders to the board.

Dee Jones

Executive Director
State Health Plan
Office: (919) 814-4407
Work Cell: (919) 215-2795

From: Caroline Smart <Caroline.Smart@nctreasurer.com>
Sent: Monday, August 22, 2022 4:06 PM
To: Matthew Rish <Matthew.Rish@nctreasurer.com>; Dee Jones <Dee.Jones@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>
Subject: RE: Segal TPA Cost Scoring input

I'm all about simplicity. I still think there are just three primary areas. Disruption and geo access will show up in pricing.

- Overall network (pricing)
- Guarantees
- Admin fees

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



SHP 0092243

Email correspondence to and from this address may be subject to the North Carolina Public Records Law. It may be subject to monitoring and disclosure to third parties, including law enforcement personnel, by an authorized state official.

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

From: Matthew Rish <Matthew.Rish@nctreasurer.com>

Sent: Monday, August 22, 2022 3:10 PM

To: Dee Jones <Dee.Jones@nctreasurer.com>; Caroline Smart <Caroline.Smart@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>

Subject: RE: Segal TPA Cost Scoring input

Thoughts?

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

www.SHPNC.org



E-mail correspondence to and from this address is subject to North Carolina's Public Records Act, N.C. Gen. Stat. Sec. 132, and may be disclosed to third parties. However Federal and State law protects personal health and other information that may be contained in this e-mail from unauthorized disclosure. If you are not the intended recipient, please delete this e-mail and any accompanying documents and contact the sender immediately. Unauthorized disclosure, copying or distribution of any confidential or privileged content of this e-mail is prohibited.

From: Matthew Rish

Sent: Thursday, August 18, 2022 5:01 PM

To: Dee Jones <Dee.Jones@nctreasurer.com>; Caroline Smart <Caroline.Smart@nctreasurer.com>; Kendall Bourdon <Kendall.Bourdon@nctreasurer.com>

Subject: Segal TPA Cost Scoring input

In follow up from yesterday's discussion, had a good conversation with Segal this afternoon. Charles, Tamara and I participated on our side. The input/comments:

- Other states use/have used the ranking method
- They can score components:
 - Network
 - Admin
 - Guarantees
 - Disruption
 - Geo Access
 - We don't need to use all components
 - Option to score the above components (should we choose to use those 5) as 5, 2, 1, 1, 1 as an example
 - Could breakout and look at the Network as Hospital and Professional
- We can then take the component score and apply as we see fit (e.g. the ranking method we discussed yesterday, or the 10 point method mentioned above, or another method)

SHP 0092244

- Notes:

- Given that the winner would have 2 years to negotiate the network with an additional 400+k Members, perhaps they're willing to put more at risk in the Guarantee section

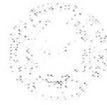
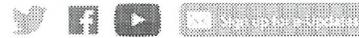
Happy to discuss further. Segal will have to us tomorrow the updated documents, which will not contemplate the above, of course. However, this would likely only update text in the documents, not layouts, tables, etc.

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
www.SHPNC.org



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

E-mail correspondence to and from this address is subject to North Carolina's Public Records Act, N.C. Gen. Stat. Sec. 132, and may be disclosed to third parties. However Federal and State law protects personal health and other information that may be contained in this e-mail from unauthorized disclosure. If you are not the intended recipient, please delete this e-mail and any accompanying documents and contact the sender immediately. Unauthorized disclosure, copying or distribution of any confidential or privileged content of this e-mail is prohibited.

SHP 0092245

APPX V1.0098



June 9, 2022

2021 ANNUAL AUDIT SUMMARY REPORT
North Carolina State Health Plan – BCBSNC
AUDIT PERIOD: January – December 2021



Healthcare Horizons Consulting Group, Inc.

800 S Gay St, Ste 1600, Knoxville, TN 37929

(800) 646-9987 or (865) 673-9927

HHAdmin@healthcarehorizons.com

HEALTHCAREHORIZONS.COM

SHP 0093927

APPX V1.0099

Table of Contents

Executive Summary.....	2
Consolidated Results by Issue from the 2021 Comprehensive Audits	3
Total 2021 Recoverable Dollars by Category.....	4
Total 2021 Disputed Dollars by Category	5
Notable Categories of Findings for 2021	7
Findings/Root Cause/Corrective Action	8
Conclusion	12
Appendix A - Yearly Targeted Audit Recoverable Dollars Comparison	13
Appendix B - Yearly Targeted Audit Disputed Dollars Comparison.....	14
Appendix C - Stratified Random Sample Yearly Trend.....	15
Appendix D - Weighted to Full Population Random Sample Yearly Trend.....	16

Executive Summary

The North Carolina State Health Plan (SHP) engaged Healthcare Horizons to perform comprehensive (targeted) and random sample audits on a quarterly basis for medical claims processed by Blue Cross and Blue Shield of North Carolina (BCBSNC). For 2021 paid dates, Healthcare Horizons received \$2,953,285,527 in medical claim payments for review. The purpose of the comprehensive audits was to identify claim errors resulting in incorrect payments and to assess underlying root cause contributing to any errors identified. The purpose of the random sample audits was to assess the accuracy of payments by BCBSNC based on a statistically valid random sample of claims selected by Healthcare Horizons.

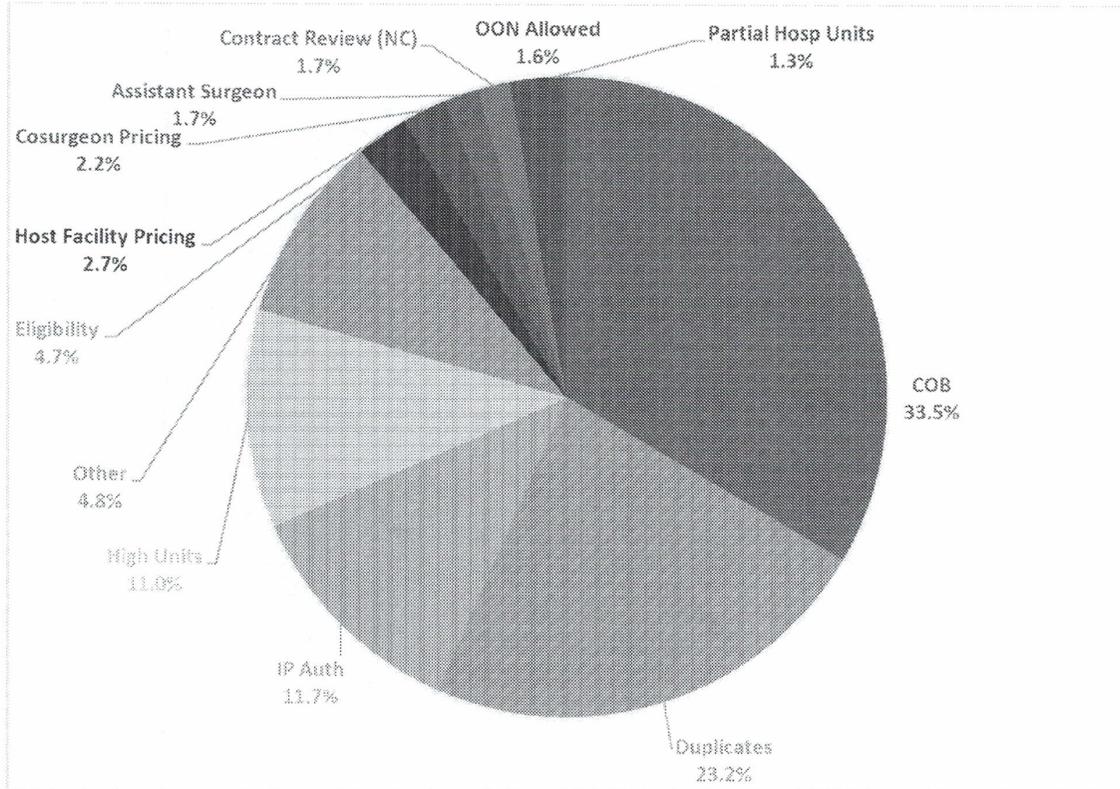
For each quarterly audit, Healthcare Horizons delivered 500 targeted and 500 random sample (1,000 in total) claims for review with BCBSNC. Healthcare Horizons performed virtual site visits with BCBSNC in order to review each claim and submit first pass questions. BCBSNC provided responses to each sample claim inquiry and worked with Healthcare Horizons to achieve final resolution on each item. Healthcare Horizons submitted detailed draft and final audit reports (inclusive of written response by BCBSNC) for each quarterly audit.

This executive summary quantifies the 2021 audit findings with additional report sections included to summarize key issues and compare audit results to 2019 and 2020.

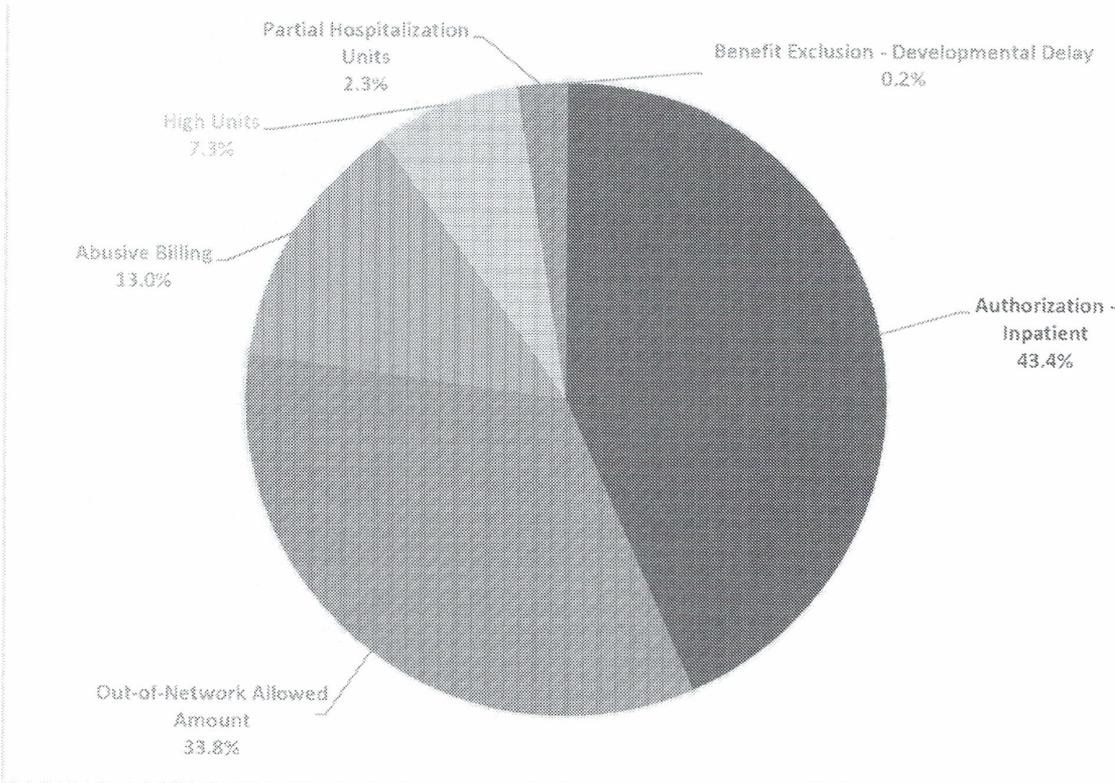
Consolidated Results by Issue from the 2021 Comprehensive Audits

Issue	Site Visit Agreed Recovery Amount	Site Visit Disputed but Recoverable Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Recovery Amount (Excluding Site Visit Disputed)
Other Insurance	\$19,332.70	\$85,359.30	\$0.00	\$344,515.60	\$449,207.60
Duplicates	\$295,050.86	\$84,832.69	\$0.00	\$0.00	\$379,883.55
Authorization - Inpatient	\$250,428.43	\$0.00	\$294,969.99	\$0.00	\$250,428.43
High Units	\$28,849.50	\$89,480.32	\$49,313.58	\$117,027.87	\$235,357.69
Secondary Payments	\$206,497.88	\$1,963.81	\$0.00	\$0.00	\$208,461.69
Eligibility	\$1,707.48	\$98,533.49	\$0.00	\$132.84	\$100,373.81
Overlapping Inpatient	\$54,198.85	\$29,538.90	\$0.00	\$0.00	\$83,737.75
Host Facility Pricing	\$0.00	\$56,830.66	\$0.00	\$0.00	\$56,830.66
Retiree Over 65 Medicare Coordination	\$38,655.27	\$10,594.35	\$0.00	\$7,124.51	\$56,374.13
Cosurgeon Pricing	\$18,000.00	\$29,300.00	\$0.00	\$0.00	\$47,300.00
Assistant Surgeon Pricing	\$12,233.50	\$24,971.20	\$0.00	\$0.00	\$37,204.70
Contract Review (NC)	\$35,420.98	\$0.00	\$0.00	\$0.00	\$35,420.98
Out-of-Network Allowed Amount	\$31,144.30	\$3,534.04	\$229,728.40	\$0.00	\$34,678.34
Medicaid Reclamation	\$30,719.42	\$0.00	\$0.00	\$0.00	\$30,719.42
Partial Hospitalization Units	\$2,960.00	\$23,889.41	\$15,869.90	\$0.00	\$26,849.41
ER with Admission	\$18,135.13	\$0.00	\$0.00	\$0.00	\$18,135.13
Outpatient During Inpatient	\$16,466.50	\$0.00	\$0.00	\$0.00	\$16,466.50
Surgery Bundle	\$13,600.00	\$0.00	\$0.00	\$0.00	\$13,600.00
Home Health During Inpatient	\$13,161.02	\$0.00	\$0.00	\$0.00	\$13,161.02
Multiple Procedure Reductions	\$5,011.85	\$4,806.91	\$0.00	\$0.00	\$9,818.76
Outpatient with Admission	\$9,135.89	\$164.05	\$0.00	\$0.00	\$9,299.94
Benefit Exclusion - Telehealth Facility Fee	\$538.02	\$499.21	\$0.00	\$6,122.92	\$7,160.15
Benefit Exclusion - Alternative Communication	\$0.00	\$5,140.00	\$0.00	\$0.00	\$5,140.00
Benefit Exclusion - Family Planning	\$3,386.36	\$1,102.20	\$0.00	\$0.00	\$4,488.56
Pre-Admission Testing	\$3,426.54	\$0.00	\$0.00	\$0.00	\$3,426.54
Observation	\$1,551.19	\$0.00	\$0.00	\$0.00	\$1,551.19
Clear Pricing Project - Facility Coinsurance	\$915.17	\$0.00	\$0.00	\$0.00	\$915.17
After Hours Charge	\$267.96	\$26.97	\$0.00	\$488.51	\$783.44
Once in a Lifetime	\$0.00	\$748.16	\$0.00	\$0.00	\$748.16
Benefit Exclusion - Hearing Aid	\$676.70	\$0.00	\$0.00	\$0.00	\$676.70
Medical Edits	\$0.00	\$342.44	\$0.00	\$0.00	\$342.44
Benefit Exclusion - Supplies	\$151.70	\$0.00	\$0.00	\$0.00	\$151.70
Benefit Exclusion - Genetic Testing	\$137.00	\$0.00	\$0.00	\$0.00	\$137.00
Surgery Global	\$0.00	\$66.00	\$0.00	\$0.00	\$66.00
Benefit Exclusion - Hypnosis	\$56.26	\$0.00	\$0.00	\$0.00	\$56.26
Benefit Exclusion - Developmental Delay	\$0.00	\$0.00	\$1,438.95	\$0.00	\$0.00
Abusive Billing	\$0.00	\$0.00	\$88,272.50	\$0.00	\$0.00
COVID-19 Patient Cost Share	-\$4,729.21	\$0.00	\$0.00	\$0.00	-\$4,729.21
Totals	\$1,107,087.25	\$551,724.11	\$679,593.32	\$475,412.25	\$2,134,223.61

Total 2021 Recoverable Dollars by Category



Total 2021 Disputed Dollars by Category





The quarterly random sample audit results are as follows:

1Q 2021	Stratified Sample	Weighted to Full Population
Processing Accuracy ¹	97.60%	97.44%
Payment Accuracy ²	97.80%	97.44%
Financial Accuracy ³	98.86%	98.45%

2Q 2021	Stratified Sample	Weighted to Full Population
Processing Accuracy ¹	98.40%	99.68%
Payment Accuracy ²	98.40%	99.68%
Financial Accuracy ³	99.39%	99.37%

3Q 2021	Stratified Sample	Weighted to Full Population
Processing Accuracy ¹	98.00%	99.01%
Payment Accuracy ²	98.00%	99.01%
Financial Accuracy ³	99.90%	99.70%

4Q 2021	Stratified Sample	Weighted to Full Population
Processing Accuracy ¹	98.60%	99.80%
Payment Accuracy ²	98.80%	99.80%
Financial Accuracy ³	99.06%	99.08%

¹ Percent of claims processed with no error

² Percent of claims processed with no financial error

³ Total dollars paid minus the absolute value of financial errors divided by total dollars paid expressed as a percentage

Healthcare Horizons has provided accuracy rates for both the stratified audit sample as well as weighted results extrapolated to the full claims population. Our understanding is that SHP performance guarantees are based upon audit sample error rates only.

Notable Categories of Findings for 2021

Notable categories of findings are listed below with further detail provided in the Findings/Root Cause/Corrective Action section of this annual audit summary report.

1. Secondary Payments
2. Duplicate Payments
3. DRG Readmissions
4. Eligibility
5. Partial Hospitalization Units
6. Medically Unlikely Units
7. Fee Schedule Pricing
8. Coordination of Benefits
9. Out-of-Network Allowed Amount Limitation
10. Family Planning Benefit Exclusion
11. Incidental Denials for Venipuncture and IV Administration
12. Assistant Surgeon Reductions
13. Inpatient Authorization Requirement
14. Inpatient Services Denied by Medicare for No Authorization
15. Abusive OON Billed Charge Case on IPP Case

Findings/Root Cause/Corrective Action

1. Secondary Payments

As secondary claim payments often require manual processor intervention, Healthcare Horizons tests high-dollar payments for accurate coordination based on rules for both Medicare and commercial primary coverage. The audits yielded a number of secondary payment calculation errors involving Medicare primary coordination. The root cause for these overpayments involved manual processor error as the secondary payments by BCBSNC were not limited to the remaining patient responsibility after Medicare primary processing. In terms of corrective action for the manual errors, BCBSNC has provided refresher training for its processors.

2. Duplicate Payments

Healthcare Horizons performs several iterations of duplicate payment testing with varying matching requirements to identify claims paid in error. These sample claims were included in the categories of duplicates, overlapping inpatient, and Medicaid reclamations. The primary BCBSNC response for duplicate payments cited manual processor error as the root cause. BCBSNC further indicated that feedback and additional training have been provided to the responsible claim processors. Healthcare Horizons identified two trends in the duplicate payment findings including payments in full for both original and corrected claims as well as duplicate payments to the provider and Medicaid (reclamation). BCBSNC may choose to increase training efforts for these particular claim types. Given the volume of claims processed by BCBSNC, the duplicate payments identified via the audits are not indicative of a systemic issue.

3. DRG Readmissions

As part of the North Carolina facility contract review, Healthcare Horizons observed language prohibiting payment for the same DRG for a readmission within a certain number of days. While a control is now in place, we found that the readmissions are not identified and assessed on a pre-payment basis. Finally, BCBSNC should consider contract language changes to deny readmissions for a related condition or complication versus only denying stays billed for the exact same DRG.

4. Eligibility

Healthcare Horizons utilized the eligibility history file from BCBSNC to test all claims for coverage on the service date of the claim. In our experience, retroactive eligibility terminations often result in historical claims that require recovery. The majority of claims identified by Healthcare Horizons were found to be previously identified for recovery via BCBSNC internal processes. As such, our impression is that BCBSNC has effective controls in place to identify and recover claims impacted by retroactive eligibility terminations.

5. Partial Hospitalization Units

Revenue codes 0912 (partial hospitalization for chemical dependency) and 0913 (partial hospitalization for psychiatric services) are intended to be billed once per day as they are typically reimbursed on a per diem basis. Healthcare Horizons identified claims billed and allowed in error with multiple units for the same service date by a limited number of providers. While BCBSNC cited provider billing error as the root cause, it was agreed that the claims were recoverable. In addition, BCBSNC updated its reimbursement policy, *Partial Hospitalization and Intensive Outpatient Programs*, on 11/16/2021 to advise providers that only one unit per service date is allowed.

6. Medically Unlikely Units

As part of our comprehensive audit process, the unit count billed for all procedure codes is compared to maximum daily unit criteria based on several industry resources. A number of instances were identified in which BCBSNC did not have a maximum unit limitation in place for a procedure code resulting in payment for medically unlikely units. In most cases, it was determined that a provider billing error occurred and BCBSNC requested a corrected claim submission. It is our understanding the Facets claims processing system that is effective beginning 2022 has a more robust set of edits related to medically unlikely units.

7. Fee Schedule Pricing

As part of our random sample audit process, Healthcare Horizons works to confirm fee schedule pricing and also reviews reasons for claim adjustments which may be cited as an error due to an “avoidable adjustment.” We encountered multiple scenarios in which adjustments were due to fee schedule pricing issues and the sample claims were part of the remediation project to correct the pricing (both underpayments and overpayments). These remediation projects often involved thousands of claims. Moving forward, the SHP should request notification of the remediation projects along with total claims and dollar impact as well as plans for root cause correction.

8. Coordination of Benefits

As part of our comprehensive audit process, Healthcare Horizons targets claims paid as primary by BCBSNC (no COB savings) for members that are likely to have other primary commercial or Medicare coverage. For Medicare, we review end stage renal disease members as well as retirees and COBRA participants that have reached the age of 65. For both Medicare and commercial coverage, we identify inconsistencies in the data by member for COB savings. In most instances, the findings related to missed coordination of benefits were due to retroactive notification of the other primary coverage. BCBSNC should ensure processes are in place to identify and adjust claims impacted by retroactive notification of other primary coverage.

9. Out-of-Network Allowed Amount Limitation

The plan documents for the SHP include an allowed amount limitation for non-emergency, out-of-network claims. The allowed amount is the maximum benefit payable by the plan and is defined as the lesser of the out-of-network provider's billed charge or an amount based on an out-of-network fee schedule as developed by BCBSNC. If a service is not included on the BCBSNC out-of-network fee schedule, the allowed amount will be the lesser of billed charge or an amount established by BCBSNC utilizing a methodology that is applied to in-network providers for comparable services. The majority of findings cited as disputed by Healthcare Horizons involved inter-plan processing (IPP) claims in which the out-of-state BCBS plan is passed billed charges for the out-of-network provider. BCBSNC disputes an error on these claims as they are unable to apply their own out-of-network fee schedule based on BlueCard guidelines. It is our understanding that the SHP and BCBSNC are reviewing all IPP limitations impacting administration of plan guidelines so that future audit direction can be provided to Healthcare Horizons.

10. Family Planning Benefit Exclusion

Per the plan document, family planning services including artificial insemination are not covered. It was determined that a benefits configuration error had occurred allowing payment for these non-covered services. BCBSNC corrected the configuration in June of 2021 and also created an impact report of all claims affected.

11. Incidental Denials for Venipuncture and IV Administration

As part of the random sample audit process, a number of claims were cited as an avoidable adjustment as BCBSNC failed to properly deny venipuncture and IV administration codes as incidental on outpatient facility claims. The adjustments observed by Healthcare Horizons served to correct the original overpayment. In terms of root cause, an automation issue occurred in August and September of 2021 that prevented the application of pre-payment edits. As a result, the claims were later adjusted via post-payment controls. BCBSNC was able to correct the Managed File Transfer issue preventing the automated pre-payment controls from being applied. Our impression was that all impacted claims were later processed with appropriate controls and edits, therefore, no additional impact analysis was requested.

12. Assistant Surgeon Reductions

Healthcare Horizons identified cases in which providers failed to bill the appropriate modifier (80, 81, 82, AS) that would have resulted in a payment reduction based on the assistant surgeon services rendered. This resulted in payment of the same full fee schedule rate as the primary surgeon. While BCBSNC disputed these claims as provider billing errors, they agreed the claims were recoverable. In terms of root cause correction, BCBSNC continues to conduct provider education regarding appropriate use of assistant surgeon modifiers.

13. Inpatient Authorization Requirement

BCBSNC is unable to enforce the inpatient authorization requirement for inter-plan processing (IPP) claims. Specifically, the plan document states that it is the member's responsibility to ensure that in-network providers outside of North Carolina request prior authorization for non-emergency inpatient facility services. BCBSNC disputes an error on these claims as they are unable to apply provider sanctions based on the IPP or BlueCard guidelines for these providers. It is our understanding that the SHP and BCBSNC are reviewing all IPP limitations impacting administration of plan guidelines so that future audit direction can be provided to Healthcare Horizons. In addition, available sanction amounts for certain IPP plans and providers were not correctly deducted for lack of authorization (manual errors). In terms of missing authorizations for North Carolina facilities, manual processor error resulted in the identification of overpayments. These instances included failure to recognize denied authorizations as well as cases in which Medicare coverage status was not fully validated (if Medicare is primary no authorization is required, however, an authorization is required if Medicare is secondary).

14. Inpatient Services Denied by Medicare for No Authorization

Healthcare Horizons requested plan intent clarification for processing secondary payments when the primary carrier denies a service due to the member or provider failing to follow primary plan guidelines such as an authorization requirement. In terms of Medicare, BCBSNC standard processing guidelines do not require a separate authorization for an inpatient admission when Medicare is primary. Upon further review, BCBSNC is modifying its policy to require a separate authorization review when Medicare denies for no authorization.

15. Abusive OON Billed Charge Case on IPP Case

An out-of-network surgeon from New York billed a total of \$103,850.00 for surgical procedures to remove spinal fusion devices due to an infection. The reimbursement of \$88,272.50 was based on a negotiated percent discount from billed charges. In comparison, the national Medicare fee for the procedures billed would amount to approximately \$2,000 which coincides with the out-of-network rate shown in the Blue² system (not utilized). We requested an evaluation of the reasonableness of the billed charge amounts along with a description of any controls in place to identify abusive billed charge amounts for services rendered when billed charges impact reimbursement. Based on the Medicare comparison provided, BCBSNC refunded the difference directly to the SHP. BCBSNC should monitor the reasonableness of billed charge amounts for IPP claims when reimbursement is at, or a percentage of, billed charges.

Conclusion

We recommend the following action items based on the 2021 audit findings:

- BCBSNC to continue processor feedback and training for manual errors identified – opportunities for automation should also be explored where feasible.
- The SHP and BCBSNC should address IPP limitations that prevent accurate administration of the plan design.

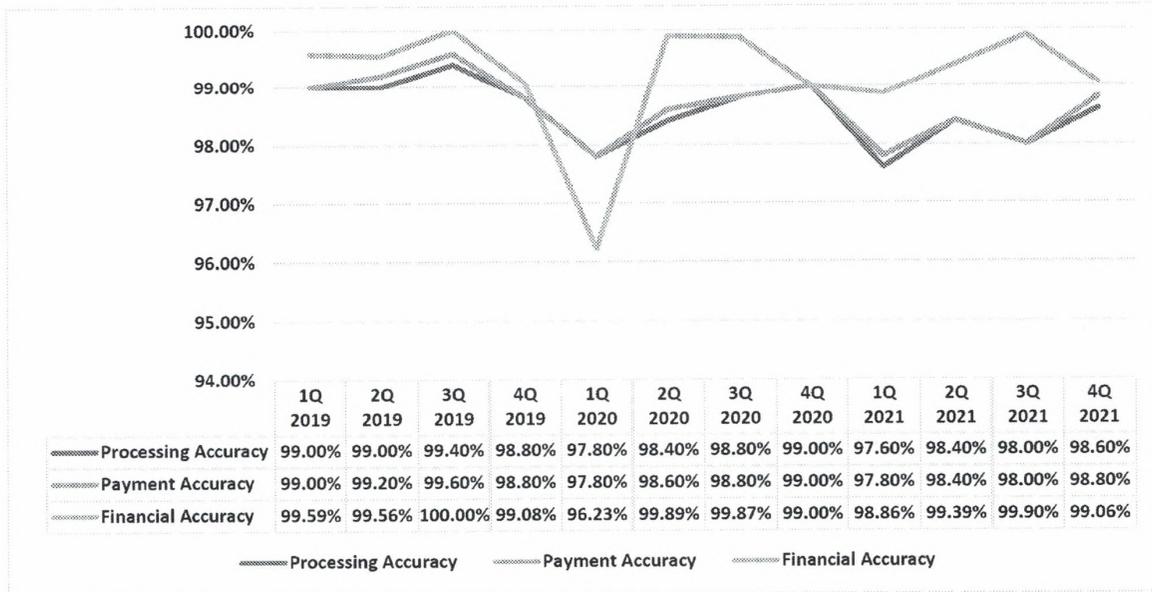
Appendix A - Yearly Targeted Audit Recoverable Dollars Comparison

Issue	2019 Recoverable	2020 Recoverable	2021 Recoverable
After Hours Charge	\$0.00	\$0.00	\$783.44
Assistant Surgeon Pricing	\$42,991.29	\$38,828.96	\$37,204.70
Authorization - Inpatient	\$0.00	\$12,207.16	\$250,428.43
Benefit Exclusion - After Hours Charge	\$0.00	\$166.26	\$0.00
Benefit Exclusion - Alternative Communication	\$0.00	\$82,198.57	\$5,140.00
Benefit Exclusion - Athletic Evaluations	\$0.00	\$672.02	\$0.00
Benefit Exclusion - Audiometry	\$0.00	\$79.15	\$0.00
Benefit Exclusion - Dental	\$90.84	\$76.91	\$0.00
Benefit Exclusion - Extracorporeal Shockwave	\$900.00	\$0.00	\$0.00
Benefit Exclusion - Family Planning	\$0.00	\$0.00	\$4,488.56
Benefit Exclusion - Genetic Testing	\$0.00	\$0.00	\$137.00
Benefit Exclusion - Grandchildren	\$3,657.56	\$0.00	\$0.00
Benefit Exclusion - Hearing Aids	\$22.50	\$15.50	\$676.70
Benefit Exclusion - Hypnosis	\$0.00	\$102.75	\$56.26
Benefit Exclusion - Supplies	\$29,708.30	\$166,223.91	\$151.70
Benefit Exclusion - Telehealth Facility Fee	\$0.00	\$186.79	\$7,160.15
Benefit Maximum - SNF	\$0.00	\$12,469.16	\$0.00
Clear Pricing Project - Facility Coinsurance	\$0.00	\$81,500.72	\$915.17
COBRA Over 65 Medicare Coordination	\$6,360.83	\$5,932.76	\$0.00
Contract Review (NC)	\$176,869.81	\$273,225.70	\$35,420.98
Cosurgeon Pricing	\$0.00	\$0.00	\$47,300.00
COVID-19 Patient Cost Share	\$0.00	\$0.00	-\$4,729.21
Duplicates	\$205,465.91	\$367,764.79	\$379,883.55
Eligibility	\$82,788.23	\$190,889.95	\$100,373.81
ER with Admission	\$0.00	\$0.00	\$18,135.13
High Units	\$5,277.64	\$154,469.35	\$235,357.69
Home Health During Inpatient	\$15,147.00	\$3,248.07	\$13,161.02
Host Professional Pricing	\$0.00	\$67,664.68	\$0.00
Host Facility Pricing	\$0.00	\$0.00	\$56,830.66
Medicaid Reclamation	\$11,220.73	\$9,425.84	\$30,719.42
Medical Edits	\$5,140.46	\$2,327.96	\$342.44
Missed Coinsurance	\$0.00	\$262.30	\$0.00
Multiple Procedure Reductions	\$25,272.01	\$9,515.27	\$9,818.76
Observation	\$0.00	\$1,552.32	\$1,551.19
Once per Lifetime	\$2,182.03	\$2,483.22	\$748.16
Other Insurance	\$91,661.19	\$68,530.06	\$449,207.60
Out-of-Network Allowed Amount	\$115,243.08	\$90,274.78	\$34,678.34
Outpatient During Inpatient	\$19,640.04	\$6,280.37	\$16,466.50
Outpatient with Admission	\$28,871.84	\$54,986.53	\$9,299.94
Overlapping Inpatient	\$111,917.45	\$77,236.81	\$83,737.75
Partial Hospitalization Units	\$0.00	\$0.00	\$26,849.41
Pre-Admission Testing	\$0.00	\$0.00	\$3,426.54
Professional Pricing	\$0.00	\$117,603.15	\$0.00
Retiree Over 65 Medicare Coordination	\$105,140.78	\$108,159.98	\$56,374.13
Secondary Payments	\$923,339.42	\$502,390.75	\$208,461.69
Surgery Bundle	\$0.00	\$0.00	\$13,600.00
Surgery Global	\$7,236.76	\$1,925.90	\$66.00
Totals	\$2,016,145.70	\$2,510,878.40	\$2,134,223.61

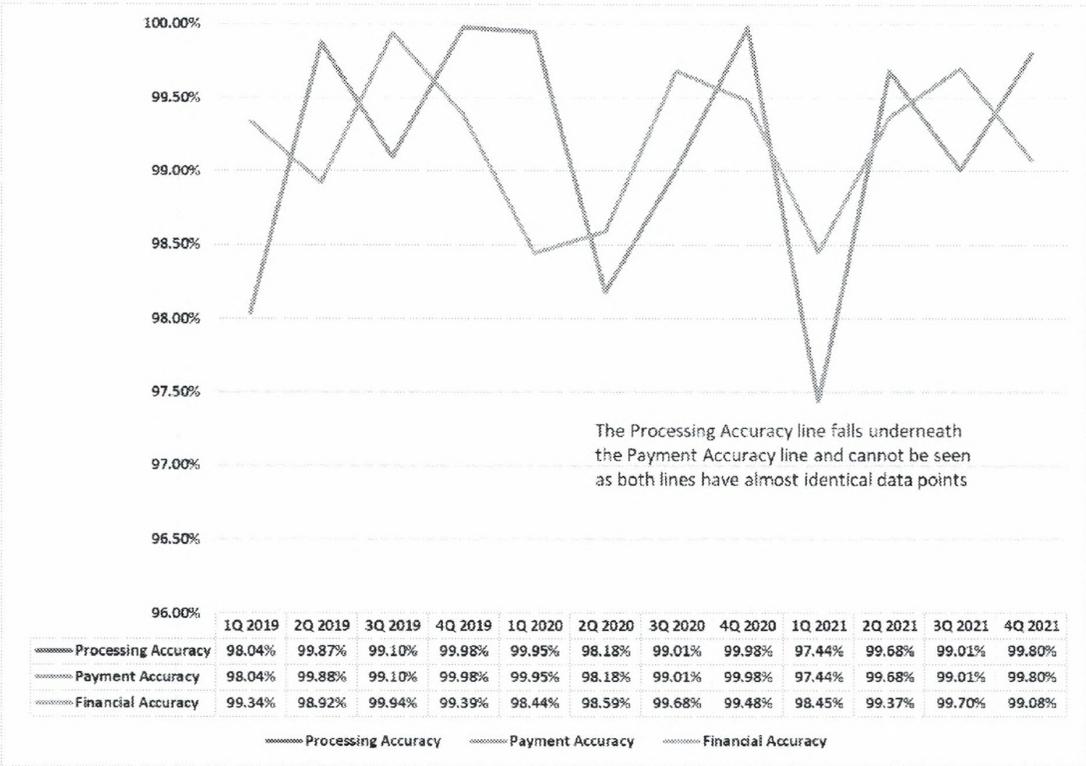
Appendix B - Yearly Targeted Audit Disputed Dollars Comparison

Issue	2019 Disputed	2020 Disputed	2021 Disputed
Abusive Billing	\$45,064.00	\$25,000.00	\$88,272.50
Assistant Surgeon Pricing	\$44,303.64	\$14,177.52	\$0.00
Authorization - Inpatient	\$277,258.62	\$1,576,511.10	\$294,969.99
Benefit Exclusion - After Hours Charge	\$0.00	\$69.36	\$0.00
Benefit Exclusion - Alternative Communication	\$12,730.15	\$0.00	\$0.00
Benefit Exclusion - Developmental Delay	\$0.00	\$0.00	\$1,438.95
Benefit Exclusion - Family Planning	\$612.06	\$0.00	\$0.00
Benefit Exclusion - Genetic Testing	\$48,222.33	\$32,091.08	\$0.00
Benefit Exclusion - Hypnosis	\$436.51	\$0.00	\$0.00
Benefit Exclusion - Routine Foot Care	\$141.22	\$0.00	\$0.00
Benefit Exclusion - Routine Vision	\$283.26	\$0.00	\$0.00
Benefit Exclusion - Sexual Dysfunction	\$69,118.74	\$0.00	\$0.00
Benefit Exclusion - Shoes	\$0.00	\$102.46	\$0.00
Benefit Exclusion - Supplies	\$51,162.76	\$0.00	\$0.00
Benefit Exclusion - Telehealth Facility Fee	\$255.00	\$46.15	\$0.00
Benefit Exclusion - Thermography	\$10.53	\$0.00	\$0.00
COBRA Over 65 Medicare Coordination	\$440.11	\$0.00	\$0.00
Contract Review (NC)	\$66,912.77	\$0.00	\$0.00
Duplicates	\$0.00	\$468.00	\$0.00
Eligibility	\$234.79	\$0.00	\$0.00
High Units	\$0.00	\$58,860.77	\$49,313.58
Never Event	\$58,922.64	\$0.00	\$0.00
Once in a Lifetime	\$2,511.09	\$0.00	\$0.00
Other Insurance	\$56,302.07	\$0.00	\$0.00
Out-of-Network Allowed Amount	\$114,578.07	\$135,769.59	\$229,728.40
Partial Hospitalization Units	\$0.00	\$0.00	\$15,869.90
Retiree Over 65 Medicare Coordination	\$60,693.59	\$0.00	\$0.00
Secondary Payments	\$0.00	\$38,091.29	\$0.00
Totals	\$910,193.95	\$1,881,187.32	\$679,593.32

Appendix C - Stratified Random Sample Yearly Trend



Appendix D - Weighted to Full Population Random Sample Yearly Trend





Staff: Dee Jones, Ted Brin, Sam Watts, Kendall Bourdon, Sharon, Beth, Frank, Caroline, Matt, Charles, Joel, Aaron, Ben.

Executive Session

- Kendall Bourdon, Director, Contracting and Compliance, presented to the Board on the Third-Party Administrative Services Request for Proposal #: 270-20220830TPAS (TPA RFP). Ms. Bourdon provided information on of the TPA RFP modernization strategy and process; the development of the TPA RFP; and the TPA RFP's implementation, evaluation, and scoring.
- Several members expressed appreciation for the changes made to the RFP process and the TPA RFP, as well as the provision of TPA RFP materials to the Board prior to the current meeting to enable a thorough review by Board members.
- Ms. Bourdon presented the evaluation, scoring, and results for the TPA RFP minimum requirements, technical proposals and cost proposals for Blue Cross Blue Shield of North Carolina (BCBS); UMR, Inc (UMR).; and Aetna Life Insurance Company (Aetna). Ms. Bourdon briefed the Board on the final scoring for BCBS, UMR, and Aetna.
- Dr. Robie expressed the importance to the Plan and its members of each of the technical requirements that were not confirmed by BCBS.
- Mr. Vernon asked why BCBS' proposed administrative fees were a low outlier when compared to the other bidders. Ms. Jones and Ms. Smart stated that in the current TPA contract what services are included in BCBS' administrative fee is limited. To operationalize Plan requirements, the Plan has had to request BCBS perform additional services not within those limited services. This has required the Plan to pay additional amounts to BCBS' initial administrative fee amount BCBS proposed in the 2019 TPA RFP. Under the current TPA contact with BCBS, the Plan is paying more for administrative fees than what the Plan was quoted in BCBS' 2019 proposal. Mr. Stevenson requested staff explain what services were included within each bidder's administrative fee. Staff provided a breakdown. Several members noted that BCBS' fee was lower because it did not include as many services as UMR and Aetna. Several Board members expressed concern that such BCBS' low outlier administrative fee was indicative of reduced staff support and service by BCBS to the Plan.
- Ms. Bourdon presented the TPA RFP Evaluation Committee's recommendation, based on TPA RFP's evaluation and the scoring methodology, to award the TPA services contract to Aetna. Ms. Bourdon then presented BCBS, UMR, and Aetna to the Board for its consideration and a determination by the Board of which party to award the contract.
- Mr. Fish asked what analysis had been done on network adequacy especially for rural areas. Staff discussed the network adequacy evaluation performed as part of the RFP's minimum requirements.
- Dr. Robie detailed provider claims experiences with each of the bidders.
- Ms. Hargett asked staff to describe what member disruption would occur if TPA vendors changed and what steps staff could take to minimize any disruption.
- The was discussion on cost and trend.

SHP 0075511

- Several members requested staff to explain the scoring of cost guarantees, the comparative value of each vendor's response, the risk each vendor was willing to take, and whether the Plan would benefit from each bidder's proposal.

Board Vote: Motion by Mr. Fish; second by Judge Duke; roll call vote was taken; unanimous vote to award the TPA contract to Aetna.

Chair Folwell called for a motion to move into public session.

Board Vote: Motion by Dr. Robie; second by Judge Duke; roll call vote was taken; unanimous vote by Board to move into public session.

~~8~~
under old process
BCMC would
not have been
presented re
BOT



SHP 0094284



Third Party Administrative Services RFP Debrief Meeting with Blue Cross NC

December 16, 2022



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

Background

- Intent of procurement: Secure a qualified vendor to provide superior third party administrative services.
- North Carolina General Statutes §135-48.22 and §135-48.33(a) require that the Board of Trustees approve the award of all Plan contracts with a value over \$3,000,000.
- The cost for this Contract will exceed \$3,000,000 and required the Board's approval for award.
- All three proposals were approved by the Attorney General's Office.
- Incumbent: Blue Cross Blue Shield of North Carolina (Current contract: 3/5/20 – 12/31/24).

Evaluation Process

- The Plan received Minimum Requirement Proposals from: Blue Cross and Blue Shield of NC (Blue Cross NC), Aetna, and UMR.
- All 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 reviewed the cost proposals and presented its findings, along with scoring, to the Evaluation Committee.

Evaluation Process

- The Plan requested clarifications from all three bidders throughout the evaluation process.
- The Plan decided not to request Oral Presentations for this RFP.
- 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.

Evaluation Process – Contract Modernization Strategy

- Streamline the TPA contract.
 - Restructure the Contract to avoid micromanaging every possible detail from the outset; allow the Plan to have flexibility and adaptability by using ADMs and BRDs to operationalize initiatives as needed.
 - Set the expectation that Vendor work in concert with the Plan to fulfill its mission and vision while serving its Members.
 - Scrutinized the scope of work to identify the Plan’s non-negotiable items and move those items to the Minimum Requirements.
 - Created new forms to receive the Minimum Requirements responses and Technical Requirements responses. These forms limited the Vendors’ responses to two options: “Confirm” or “Does Not Confirm.” This removed subjectivity from the evaluation and scoring and prevented Vendors from inserting descriptions, limitations, or qualifications potentially negating a confirmation.

Evaluation Process – Contract Modernization Strategy

- Fresh approach to the evaluation process.
 - Added advisory roles to the Evaluation Committee, such as including the Plan’s Executive Administrator in the evaluation meetings.
 - Revised the scoring methodology with a lens for maximizing objectivity:
 - Technical Requirements, because there were only two options, were scored zero (0) or one (1).
 - Every requirement held equal weight.
 - Revised the scoring of the cost analysis to reflect the import of the three (3) components—six (6) points for Network Pricing, two (2) points for Administrative Fees, and two (2) points for Pricing Guarantees.
 - Utilized a ranking methodology to weight Technical and Cost equally.
 - Ensured the Board, as the statutorily authorized fiduciaries of the Plan, are the decision-making body statutorily authorized to award the Contract.

Contract Technical Proposals Scoring

RFP Section	Title	Maximum Points	Vendor		
			Aetna	BCBSNC	UMR
5.2.1	Account Management	20	20	20	20
5.2.2	Finance and Banking	19	19	19	19
5.2.3	Network Management	28	28	27	28
5.2.4	Product and Plan Design Management	41	41	41	41
5.2.5	Medical Management Programs	18	18	18	18
5.2.6	Enrollment, EDI, and Data Management	40	40	39	40
5.2.7	Customer Experience	52	52	48	52
5.2.8	Claims Processing and Appeals Management	16	16	15	16
5.2.9	Claims Audit, Recovery, and Investigation	25	25	25	25
5.2.10	Initial Implementation and Ongoing Testing	3	3	3	3
5.2.11	Reporting	48	48	48	48
TOTAL TECHNICAL POINTS		310	310	303	310

Contract Technical Proposals – “Does Not Confirm”

- Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States. (5.2.3.2.b.iii.)
- 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. (5.2.6.2.b.xvi.)
- 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:
 - Electronic medical and health records. (5.2.7.2.b.xxiv.1)
 - Disease Management Nurse notes. (5.2.7.2.b.xxiv.2)
 - Case Management notes. (5.2.7.2.b.xxiv.3)
 - Health Coach notes. (5.2.7.2.b.xxiv.4)
- Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits. (5.2.8.2.b.v.)

Cost Analysis – Comparison

BAFO #1							
Network Pricing (Claims \$M)							
Vendor	2025	2026	2027	Total	Ranking	% Diff	Score
Aetna					3		6
BCBS	3,049.9	3,224.7	3,409.8	9,684.4	2	+ 0.47%	6
UMR					1		5

BAFO #1						
Vendor	Base Admin Fee (PSPM)			Total Cost (\$M)	Rank	Score
	2025	2026	2027			
Aetna					2	1
BCBS	13.53	14.21	14.92	223.3	3	2
UMR					1	0

- Disease Management Fees for Non-Medicare members were included
- One Time Credits for implementation, communication, etc. are incorporated into the Total Cost

Cost Analysis – Comparison

Vendor	Discount Guarantee			Max \$ At Risk (\$M)		
	2025	2026	2027	2025	2026	2027
Aetna						
BCBS	55.1%	55.6%	56.1%	2.7	2.8	2.9
UMR						

Vendor	Trend Guarantee			Max \$ At Risk (\$M)		
	2025	2026	2027	2025	2026	2027
Aetna						
BCBS	N/A	6.00%	6.00%	N/A	2.8	2.9
UMR						

Pricing Guarantees		
Vendor	Rank	Score
Aetna	2	1
BCBS	1	0
UMR	3	2

Cost Analysis – Expected Cost and Scoring

BAFO #1			
Combined 3-Year Cost (\$M)			
Vendor	Claims	Admin	Total
Aetna			
BCBS	9,684.4	223.3	9,907.7
UMR			
			0.0%

BAFO #1									
Vendor	Rankings			Points			Total		
	Claims	Admin	Guarantees	Claims	Admin	Guarantees			
Aetna	3	2	2	6	1	1	8		
BCBS	2	3	1	6	2	0	8		
UMR	1	1	3	5	0	2	7		

Cost Analysis – Total Contract Value (5-years)

Total Contract Value (\$M)						
Aetna BAFO #1						
	2025	2026	2027	2028	2029	Total
Claims						
Admin						
Total						17,521.9

Total Contract Value (\$M)						
BCBS BAFO #1						
	2025	2026	2027	2028	2029	Total
Claims	3,049.9	3,224.7	3,409.8	3,605.5	3,812.5	17,102.5
Admin	52.7	74.0	76.9	84.2	114.5	402.3
Total	3,102.6	3,298.7	3,486.8	3,689.7	3,927.0	17,504.8

Total Contract Value (\$M)						
UMR BAFO #1						
	2025	2026	2027	2028	2029	Total
Claims						
Admin						
Total						17,791.8

Final Scoring

	Maximum Points	Vendor		
		Aetna	BCBSNC	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

Recommendation and Board Vote

- Based upon its evaluation and scoring methodology, the Evaluation Committee recommended awarding the Contract to Aetna.
- All three proposals were presented for the Board's consideration.
- The Board accepted the Evaluation Committee's analysis, considered the recommendation, and voted to award this Contract to Aetna.
- The two-year implementation period for this Contract begins January 1, 2023, through December 31, 2024. The three-year initial service period for this Contract begins January 1, 2025 (*Open Enrollment, Fall 2024), through December 31, 2027, with the option to renew for two, one-year terms.

<p>STATE OF NORTH CAROLINA</p> <p>Department of State Treasurer</p>  <p>Refer <u>ALL</u> Inquiries to: Vanessa Davison Email: Vanessa.Davison@nctreasurer.com Copy to SHPCcontracting@nctreasurer.com</p> <p>See page 2 for submission instructions.</p>	<p>REQUEST FOR BEST AND FINAL OFFER (BAFO) #1 RFP # 270-20220830TPAS</p>	
	Offers will be received until: 11:59 PM ET, November 22, 2022	
	BAFO Issue Date: November 18, 2022 Description of goods/services: 851017- Health Administrative Services	
		Agency Requisition No. 270-20220830TPAS

NOTICE TO VENDOR Offers, subject to the conditions made a part hereof, will be received via email until 11:59 PM ET, November 22, 2022, for furnishing and delivering the goods and services as described herein. Refer to page 2 for submission instructions. Offers submitted in any other way in response to this Best and Final Offer (BAFO) will not be accepted. Offers are subject to rejection unless submitted on this form.

EXECUTION

In compliance with this BAFO, and subject to all the terms and conditions herein, those in the original Request for Proposal (RFP), dated August 30, 2022, (unless superseded herein) and in Vendor's proposal thereto, the undersigned offers and agrees to furnish and deliver any or all goods and services which are offered, at the prices agreed upon and within the time specified herein. Under penalty of perjury, the undersigned Vendor certifies that this offer has not been arrived at collusively or otherwise in violation of Federal or North Carolina law and this offer is made without prior understanding, agreement, or connection with any firm, corporation, or person submitting an offer for the same services, and is in all respects fair and without collusion or fraud.

Failure to execute/sign offer prior to submittal shall render offer invalid. Late offers are not acceptable.

VENDOR:	EMAIL:	
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING:	FAX NUMBER:	
AUTHORIZED SIGNATURE:	DATE:	

Offer valid for ninety (90) days from date of opening unless otherwise stated here: ____ days.

ACCEPTANCE OF BAFO

If the State accepts any or all parts of this offer, an authorized representative of the Department of State Treasurer shall affix her/his signature to the Vendor's response to this Request for BAFO. The acceptance shall include the response to this BAFO, any provisions and requirements of the original RFP that have not been superseded by this BAFO, and the provisions of Vendor's response to the original RFP that have not been superseded by this BAFO. These documents shall then constitute the written agreement between the Parties. In the event of conflict, the State's terms and conditions shall control. A copy of this acceptance will be forwarded to the successful Vendor(s).

<p>FOR STATE USE ONLY: Offer accepted and Contract awarded this ____ day of _____, 20__, as indicated on the attached certification, by _____</p> <p>(Authorized Representatives of NC Department of State Treasurer)</p>

SUBMISSION INSTRUCTIONS: Vendor shall submit its BAFO response via email to Vanessa.Davison@nctreasurer.com with a copy to SHPContracting@nctreasurer.com and SKuhn@segalco.com. Any files submitted shall not be password protected and shall be capable of being copied to other media.

SOLICITATION REQUEST FOR BEST AND FINAL OFFER (BAFO):

This request is to acquire a best and final offer from Vendor for **Third Party Administrative Services**. Your offer shall integrate the previous response to the RFP and any changes listed below. Any individual Vendor may receive a different number of requests for BAFOs than other Vendors.

The State encourages the Vendor to supply more competitive prices. Vendor should submit its most competitive prices in response to this Request for BAFO. The State reserves the right to accept the Vendor's original offer if deemed more advantageous to the State.

Note: This proposal is still in the evaluation period. During this period and prior to award, possession of the BAFO, original proposal response and accompanying information is limited to personnel of the Department of State Treasurer, and to agencies responsible for participating in the evaluation. Vendors that attempt to gain this privileged information or to influence the evaluation process (i.e. assist in evaluation) will be in violation of purchasing rules and their offer may not be further evaluated or considered.

Specific requests begin on next page. Vendor may copy requests onto additional pages, as needed, to provide sufficient space for its response.

1. The Plan requests that Vendor provide its best and final offer by completing Attachment A: PRICING - BAFO #1 in its entirety.
2. Vendor must provide its most competitive pricing as subsequent BAFOs may not follow.
3. Vendor must round all fees to two decimal places. Vendor shall not delete prepopulated formulas.

ATTACHMENT A: PRICING, BAFO #1

INSTRUCTIONS FOR BAFO #1 COST PROPOSAL

1.1 Administrative Fees

The proposed administrative fees must support all the services requested in Section 5.0 “Technical and Cost Proposal Requirements and Specifications” of this RFP. **Tables A-7.1 through A-7.3 must include all costs except actual claim payments for covered Members. Unspecified fees and expenses will not be paid by the Plan.**

Vendor must provide the monthly administrative fee per subscriber for each of the five (5) years in the contract period. An exhibit with detailed instructions is included in **Attachment A-7**.

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

Table A-7.1 also requests PMPM pricing for some additional, optional services, if the Plan authorizes the TPA to perform those services.

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

Note: Vendor must round all fees to two decimal places. Vendor must not delete prepopulated formulas.

1.2 Network Pricing Guarantees

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

Discount improvements guarantees will only be reflected in projected costs to the extent Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk.

**Summary of the Evaluation Process
Request for Proposal #270-20220830TPAS
Third Party Administrative Services**

A. Scope

The North Carolina State Health Plan for Teachers and State Employees (Plan) issued the Third Party Administrative Services RFP #270-20220830TPAS on August 30, 2022.

The Plan seeks a Vendor that will provide Third Party Administrative (TPA) Services for self-funded health claims and related services. Providing health benefits to Plan Members is the core of the Plan's mission; therefore, having the right Vendor partner is the key to success. The scope of work includes:

- Account Management
- Finance and Banking Requirements
- Network Management
- Product & Plan Design Management
- Medical Management
- Enrollment, EDI & Data Management
- Customer Experience
- Claims Processing & Appeals Management
- Claims Audit, Recovery & Investigation
- Initial Implementation and Ongoing Testing, and
- Reporting.

The Plan issued Addendum #1 on September 16, 2022, responding to questions submitted by interested Vendors and making changes to several areas in the RFP; Addendum #2 on October 14, 2022, responding to questions submitted by Vendors who met the Minimum Requirements; and Addendum #3 on October 31, 2022, providing a dial-in-number to the bid opening scheduled for November 7, 2022 at 10:00 a.m. ET.

B. Third Party Administrative Services Evaluation Committee

The Plan commissioned the following Evaluation Committee (EC) to objectively review and score each proposal in accordance with the pre-developed and pre-described criteria in the RFP and to make a recommendation for award based on fair and ethical review practices.

Core (Voting)

Caroline Smart
Chrissy Crute
Duane Maxie
Jen Zamudio
Beth Horner
Matt Rish
Tamara Williams

Advisory (Non-Voting)

Dee Jones
Charles Sceiford
Aaron Vodicka (Legal)
Joel Heimbach (Legal)

Contracting (Non-Voting)

Kendall Bourdon
Sharon Smith
Vanessa Davison
Kimberly Alston

Subject Matter Experts (SME) by Section

Renee Bourget*
Matt Rish

5.1 Minimum Requirements, item 4, Data Security
5.1 Minimum Requirements, item 5, Financial Stability

Aaron Vodicka 5.1 Minimum Requirements, items 9 and 10, Attachment G: Business Associate Agreement and Attachment H: HIPAA Questionnaire

*Note: Jennifer Braley will assist Renee as needed.

C. Vendor Conference Call

A conference call with interested Vendors was held at 10:00 a.m. ET on September 1, 2022, led by Kendall Bourdon and Treasurer Folwell, which provided a high level introduction and general instructions to potential bidders. The following four (4) Vendors participated on the call: Aetna Life Insurance Company, Blue Cross Blue Shield of North Carolina, Cigna Insurance Company, and UMR, Inc.

D. Minimum Requirements Proposal/Bid Opening

Minimum Requirements Proposals (MRPs) were opened in a public forum at the Plan at 10:00 a.m. ET on September 26, 2022.

MRPs were received from the following Vendors:

Vendor
Aetna Life Insurance Company (Aetna)
Blue Cross Blue Shield of North Carolina (Blue Cross NC)
UMR, Inc. (UMR)

Vanessa Davison, Contracting Agent, Kimberly Alston, Contracting Agent, and Sharon Smith, Senior Manager of Contracting conducted a cursory review of the MRPs in accordance with RFP section 2.6 and 2.7.

It was noted, and discussed with Kendall Bourdon, Director of Contracting and Compliance, that UMR's RFP ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT did not include a signature and the signature of Scott Hogan on UMR's ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION in both original submissions appeared not to be original nor digital. All three (3) MRPs were deemed eligible for release to the Evaluation Committee for evaluation.

E. Kickoff/Evaluation Meeting, September 27, 2022, 9:30 A.M. ET

During the kickoff meeting, Vanessa Davison provided an overview of the EC Members' roles and responsibilities, provided an overview of the evaluation process, announced names of Vendors who had submitted proposals, established ground rules for forthcoming meetings, provided an overview of the evaluation tool and the evaluation schedule, and provided an opportunity for disclosure of potential conflicts of interest. After the announcement of Vendors, potential conflicts were discussed and documented with the Director of Contracting and Compliance, but the relationships did not rise to the level of conflicts of interest.

MRPs were distributed to the EC and SMEs. The EC completed its evaluation of MRs # 1, 2, 3, 6, 7, 8, 11, and 12 for all three (3) Vendors and agreed that all Vendors met these MRs. The SMEs began evaluating MRs # 4, 5, 9, and 10.

F. Minimum Requirements Clarifications

During the evaluation of MRs, the following MR Clarifications were issued.

Vendor	Clarification	Date Issued	Topic
Aetna	#1	9/28/2022	MR #4 – Data Security, MR #10 – Attachment H: HIPAA Questionnaire, Q7.
Aetna	#2	9/29/2022	MR #4 – Data Security.
Aetna	#3	9/30/2022	MR #4 – Data Security.
Blue Cross NC	#1	9/28/2022	MR #4 – Data Security, MR #10 – Attachment H: HIPAA Questionnaire, Q15.
UMR	#1	9/28/2022	MR #4 – Data Security, MR #5 – Financial Stability, MR #9 – Attachment G: Business Associate Agreement, MR #10 – Attachment H: HIPAA Questionnaire, MR #12 – Attachment J: Minimum Requirements Submission Information form.
UMR	#2	9/29/2022	MR #5 – Financial Stability, MR #10 – Attachment H: HIPAA Questionnaire, Q15, Q16, Q21, Q22, and Q25.

G. Evaluation Meeting, September 30, 2022, 1:00 P.M. ET

After receiving clarification responses, the SMEs completed their evaluation of MRs # 4, 5, 9, and 10 and deemed that all three (3) Vendors met these MRs. The SMEs' review, analysis and conclusions of those responses were shared with the EC and the EC updated the scoring tool.

Caroline Smart made the motion to proceed forward with notifying each of the three (3) Vendors as well as Segal that all three (3) Vendors passed the MRs and will be given a link to the Secure File Transfer (SFT) workspace for access to Data and ATTACHMENT A: PRICING for submission of a Technical and Cost Proposal. Matthew Rish seconded the motion, and the EC unanimously approved the motion.

Vanessa Davison sent emails to Aetna, Blue Cross NC and UMR notifying each that they met the MRs.

Sharon Smith sent Segal the names of each Vendor meeting the MRs as well as each Vendor's ATTACHMENT I: NONDISCLOSURE AGREEMENT with the name and email address of the individual designated to receive Data and Attachment A: PRICING.

Segal sent the link to the SFT workspace to all three (3) Vendors to download the files.

H. Technical and Cost Proposal/Bid Opening

Technical and Cost Proposals were opened in a public forum at the Plan at 10:00 a.m. ET on November 7, 2022.

Technical and Cost Proposals were received from the following Vendors:

Vendor
Aetna Life Insurance Company (Aetna)
Blue Cross Blue Shield of North Carolina (Blue Cross NC)
UMR, Inc. (UMR).

Vanessa Davison, Contracting Agent, Kimberly Alston, Contracting Agent, and Sharon Smith, Senior Manager of Contracting conducted a cursory review of the three (3) Technical and Cost Proposals in accordance with RFP Sections 2.6 and 2.7. All three (3) Technical Proposals were deemed eligible for release to the Evaluation Committee.

I. Technical Proposal Evaluation Meeting, November 8, 2022, 9:45 A.M. ET

Technical Proposals and copies of the scoring tool were distributed to the EC. The EC reviewed the Technical Proposals from each Vendor and the scoring tool was updated for each technical requirement accordingly, 1 point for each “confirm” response, 0 points for each “does not confirm” response. The EC decided there was no need to issue any clarification to the three (3) Vendors regarding their technical proposals. Below are the points and rankings for the technical proposals.

Vendor	Final Technical Points	Final Technical Proposal Rank
Aetna	310	3
Blue Cross NC	303	1
UMR	310	3

J. Cost Analysis meeting, November 17, 2022, 1:30 P.M. ET

Segal presented its initial cost analysis of the three (3) cost proposals and subsequent scoring with the EC. Cost Proposals and Segal’s Cost Proposal Analysis (Draft, For Discussion Purposes As of 11/17/2022) were distributed to the EC. Maximum points attainable for each Vendor’s cost proposal was 10, six (6) points for Network Pricing, two (2) points for Administrative Fees and two (2) points Network Pricing Guarantees. Even after clarifications were sought and received from each Vendor (see chart below), Segal was still uncertain of Vendor’s intent in certain areas of their proposals and therefore recommended the Plan ask for additional clarifications to confirm the claims repricing responses used in the Network Pricing scoring as well as request better pricing using the Request for Best and Final Offer (BAFO) process. Discussion followed as to the timing and content of the request for clarifications and the BAFOs.

After Segal’s presentation, the EC continued to meet and discussed Segal’s recommendations.

Caroline Smart made the motion to issue a Request for BAFO to all three (3) Vendors requesting better pricing as well as clarifications regarding In-Network Discounts. Beth Horner seconded the motion, and the EC unanimously approved the motion.

Below are the preliminary points and rankings for the cost proposals; and the final technical proposal and preliminary cost proposal rank totals.

Vendor	Preliminary Cost Proposal Total Score	Preliminary Cost Proposal Rank
Allocated Points	10	
Aetna	5	2
Blue Cross NC	8	3
UMR	2	1

Vendor	Final Technical Proposal Rank	Preliminary Cost Proposal Rank	Final Technical Proposal and Preliminary Cost Proposal Rank Totals
Aetna	3	2	5
Blue Cross NC	1	3	4
UMR	3	1	4

K. Cost Clarifications

During the evaluation of cost proposals, the following clarifications were issued:

Vendor	Clarification	Date Issued	Topic
Aetna	#4	11/10/2022	Attachment A: Pricing – A-3 and A-6
Aetna	#5	11/18/2022	Attachment A: Pricing – In-Network Discounts
Aetna	#6	12/6/2022	General
Blue Cross NC	#2	11/10/2022	Attachment A: Pricing - A-3 and A-6
Blue Cross NC	#3	11/15/2022	Clarification #2
Blue Cross NC	#4	11/18/2022	Attachment A: Pricing – In-Network Discounts, Clarification #2 and #3
Blue Cross NC	#5	11/22/2022	Clarification #4
Blue Cross NC	#6	11/23/2022	Clarification #5
Blue Cross NC	#7	11/28/2022	Clarifications #2 through #6
BlueCross NC	#8	12/6/2022	General
UMR	#3	11/10/2022	Attachment A: Pricing
UMR	#4	11/15/2022	Clarification #3
UMR	#5	11/18/2022	Attachment A: Pricing – In-Network Discounts, Clarification #3 and #4
UMR	#6	12/6/2022	General

L. BAFO Cost Analysis Meeting, November 30, 2022, 10:00 A.M. ET

Request for BAFO #1 was issued to Aetna, Blue Cross NC, and UMR on November 18, 2022, with responses due no later than 11:59 p.m. ET on Tuesday, November 22, 2022. Vendors were required to complete Attachment A- 7: Administrative Fees and Attachment and A-8: Network Pricing Guarantees.

Copies of Vendor’s responses to Request for BAFO #1 and Segal’s “Cost Proposal Analysis - Reflects Clarifications and Best and Final Offers (BAFO #1) DRAFT for Discussion Purposes As of 11/29/2022” were distributed to the EC. Segal presented their second analysis reflecting responses to subsequent clarifications and BAFOs with the EC.

After Segal's presentation, the EC and Contracting updated the Master Scoring Tool with the numbers in Segal's BAFO #1 Cost Analysis and determined that Aetna received the highest technical and cost rank and Blue Cross NC and UMR tied.

Below are the points and rankings for the BAFO #1 cost proposals; and the final technical proposal and BAFO #1 cost proposal rank totals.

Vendor	BAFO #1 Cost Proposal Total Score	BAFO #1 Cost Proposal Rank
Allocated Points	10	
Aetna	8	3
Blue Cross NC	8	3
UMR	7	1

Vendor	Final Technical Proposal Rank	BAFO #1 Cost Proposal Rank	Final Technical Proposal and BAFO #1 Cost Proposal Rank
Aetna	3	3	6
Blue Cross NC	1	3	4
UMR	3	1	4

Caroline Smart made a motion to present all three (3) proposals (Aetna, Blue Cross NC and UMR) to the Plan's Board of Trustees at the December 14, 2022 meeting with the recommendation to award RFP #270-20220830TPAS to Aetna. Matt Rish seconded the motion, and the EC approved it unanimously.

M. Attorney General Office (AGO) Review

On December 8 and 9, 2022, the AGO reviewed and approved the proposals from Aetna, BlueCross NC and UMR.

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