

Exhibit A

Affidavit of Dorothy C. Jones

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

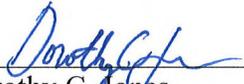
intent for many thousands of healthcare providers per vendor, and each vendor's network pricing was accompanied by a certified actuarial opinion. Further, the Plan would likely discover any misrepresentation of a vendor's provider network during the implementation period, which would greatly harm the 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]

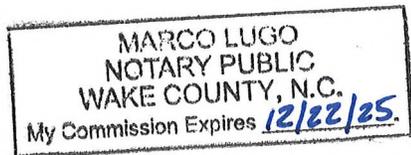
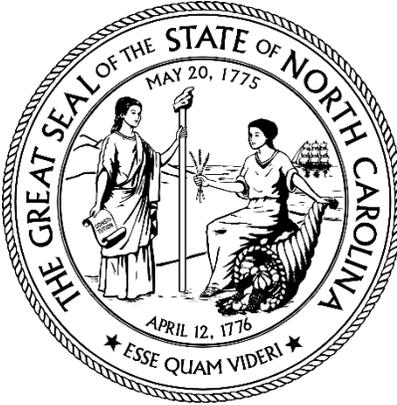


Exhibit B

Excerpts from RFP #270-20220830TPAS



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.

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1.0 VISION AND OVERVIEW OF THE STATE HEALTH PLAN

1.1 VISION

The North Carolina State Health Plan for Teachers and State Employees (Plan) seeks a Vendor that will provide superior third party administrative (TPA) services. Vendor must be willing to work with the Plan in meeting the mission and priorities set by the Treasurer and the Board of Trustees (Board). The Plan intends to be a leader in North Carolina known for providing cost-effective, quality health care programs for its membership.

To this end, several years ago, the Plan rolled out an initiative called the Clear Pricing Project (CPP) to promote affordable, quality care and increase transparency, predictability, and value for Plan Members. In the first phase of this project, the Plan developed a network of North Carolina providers, with reimbursement rates referenced to Medicare rates. The CPP providers were integrated with the TPA’s network to form a hybrid network called the North Carolina State Health Plan network. While this initiative was very successful, the Plan intends to reset and expand efforts to achieve the CPP objectives. While reference-based pricing continues to be a focus area, the Plan is also interested in incorporating alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation.

The Plan’s focus will continue to be on the key principles of transparent pricing, high quality care and service, and effective vendor partnerships. The Plan expects all Plan vendors to work in concert with Plan staff to fulfill its mission and vision while serving its Members. The Plan seeks a Vendor that will be:

- Flexible and Adaptable
- Collaborative with all CPP Initiatives
- Transparent
- Confident and Committed
- Responsive and Capable of Providing Superior Administrative and Technical Services

Vendor must demonstrate a dedication to providing a superior Customer Experience for all the services provided under the RFP which may require integration with other Plan vendors. Each Member touch point should be designed to be easily accessible and understandable. Vendor must have sufficient resources who are well educated on the Plan’s unique benefits and services to respond to Member, Employing Unit, and Plan inquiries in a timely fashion.

Finally, Vendor must provide quality services. Providing accurate information, processing claims with a high degree of accuracy, and delivering accurate reports and data files are all examples of the kind of dedication to quality that the Plan requires of its vendors. To demonstrate this dedication to excellence, Vendor must provide skilled project management and ongoing resources, deploy appropriate operational controls, maintain a strong program governance, conduct frequent audits, and accept appropriate performance guarantees to measure the success of these services.

1.2 OVERVIEW OF THE STATE HEALTH PLAN

State Health Plan

The Plan provides health care coverage to more than 742,000 teachers and school personnel, State employees, retirees, current and former lawmakers, State university and community college personnel, and eligible dependents. The services outlined in this RFP are focused on the approximately 582,000 self-funded Members. The mission of the State Health Plan is to improve the health and health care of North Carolina teachers, State employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

Governance

The Treasurer, Executive Administrator, and the Board are designated as fiduciaries for the Plan. The powers and duties of the Treasurer are set forth in statute at N.C.G.S. § 135-48.30(a) and include setting benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums subject to approval of the Board. The Board's powers and duties are set forth at N.C.G.S. § 135-22 and include approving large contracts, approving premium rates, copays and deductibles proposed by the Treasurer, and developing and maintaining a strategic plan. The North Carolina General Assembly determines member eligibility rules and provides State funding for the Plan.

The Board is required to be composed of at least one (1) of the following: an employee of a State department, agency, or institution; a teacher employed by a North Carolina public school system; a retired employee of a State department, agency, or institution; and a retired teacher from a North Carolina public school system. The Board must also include individuals with the following expertise: actuarial science, health economics, health benefits and administration, and health law and policy. The State Treasurer is an ex officio member of the Board and serves as its Chair, but only votes in the event of a tie. The Director of the Office of State Budget and Management serves as an ex officio nonvoting member. Two (2) members are appointed by the Governor. Two (2) members are appointed by the State Treasurer. Two (2) members are appointed by the North Carolina General Assembly upon the recommendation of the Speaker of the House of Representatives. Two (2) members are appointed by the North Carolina General Assembly upon the recommendation of the President Pro Tempore of the Senate.

Membership Statistics

The total membership as of April 30, 2022, is broken out as follows:

- 489,155 active employees and their dependents.
- 1,635 Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) participants and their dependents. COBRA requires most employers with group health plans to offer employees the opportunity to continue their group health care coverage temporarily under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status. COBRA rules apply to the State Health Plan pursuant to Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300bb-1 through 300bb-8.
- 248,977 Medicare and non-Medicare retirees and disabled members and their dependents.
- 3,093 Members and their dependents who are eligible for the Plan on a fully contributory basis who are invoiced for their premiums (direct bill members and surviving dependents) on a monthly basis.

The Plan offers two (2) Preferred Provider Organization (PPO) plans to its active employees and Non-Medicare retirees, described below, using the North Carolina State Health Plan Network for services incurred in North Carolina. Members who seek services outside of North Carolina have access to Blue Cross North Carolina's Blue Card network.

- The Enhanced PPO Plan (80/20) has higher premiums in exchange for lower copays, coinsurance, and deductibles. This plan includes the ability for the Subscriber to lower monthly Subscriber premium by attesting to being a non-tobacco user or a tobacco user willing to complete a tobacco cessation program.

- The Base PPO Plan (70/30) has lower premiums in exchange for higher copays, coinsurance, and deductibles. Like the Enhanced PPO Plan (80/20), the Base PPO Plan (70/30) includes the ability for the Subscriber to lower the monthly Subscriber premium by attesting to being a non-tobacco user or a tobacco user willing to complete a tobacco cessation program.

In 2022, the Plan offers three (3) health plan options for Medicare primary Members. These plans include the Base PPO Plan (70/30), which is also offered to Non-Medicare primary Members and administered through Blue Cross North Carolina, and two (2) Group Medicare Advantage (PPO) Plan options — offered through Humana— which include benefits and services such as access to the SilverSneakers® Fitness Program, a nurse help line and disease and case management services.

- Humana Group Medicare Advantage PPO Base Plan – 143,197
- Humana Group Medicare Advantage PPO Enhanced Plan – 17,977
- Base PPO Plan (70/30) – 35,987

The Plan offers a High Deductible Health Plan (HDHP) to employees determined by their Employing Units to be full-time employees in accordance with Section 4980H of the Internal Revenue Code and the employee does not qualify for coverage under subdivision (1), (5), (6), (7), (8), (9), or (10) of N.C.G.S. § 135-48.40(b). Eligibility is also subject to N.C.G.S. § 135-48.43.

- 572 HDHP Members

Plan Vendors

The Plan contracts with a number of vendors to provide third party administrative, pharmacy benefit management and other related services:

- Blue Cross and Blue Shield of North Carolina (BCBSNC) is the contracted TPA for Claims and Related Services for three (3) of the Plan’s self-funded plan options.
- The two (2) fully insured Medicare Advantage Plan designs are provided by Humana.
- CVS Health provides Pharmacy Benefit Management Services (PBM).
- Benefitfocus is the Plan’s eligibility and enrollment services (EES) vendor.
- iTEDIUM provides COBRA administration and billing services.

A listing of the Plan’s contracted vendors is available at www.shpnc.org, bottom of the page in the footer section, “SHP Contracted Vendors.”

2.0 GENERAL INFORMATION

2.1 REQUEST FOR PROPOSAL DOCUMENT

The RFP is comprised of the base RFP document, any attachments, and any addenda released before Contract award. All attachments and addenda released for this RFP in advance of any Contract award are incorporated herein by reference.

2.2 E-PROCUREMENT SOLICITATION

ATTENTION: This is NOT an E-Procurement solicitation. Paragraph #16 of ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS, paragraphs b), c), and d) do not apply to this solicitation.

2.3 NOTICE TO VENDORS REGARDING RFP TERMS AND CONDITIONS

It shall be Vendor’s responsibility to read the Instructions, the State’s terms and conditions, all relevant exhibits and attachments, and any other components made a part of this RFP and comply with all requirements and

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

ATTACHMENT A: PRICING

INSTRUCTIONS FOR DATA ACCESS and COST PROPOSAL

This section contains the submission requirements and instructions for worksheets and data files required to be submitted by Vendor.

Submission of Signed Non-Disclosure Agreement Required for Access to Attachment A: Pricing (Attachments/worksheets) and Data Files

Each Vendor must submit a signed **Attachment I: Non-Disclosure Agreement (NDA)** to the Plan in order to gain access to Attachment A: Pricing and data files. The NDA is included as part of the Minimum Requirements and must be submitted with the Minimum Requirement Responses.

The Plan will send the signed NDAs for all Vendors meeting Minimum Requirements to its Actuarial/Analytical and Health Benefits Consulting vendor, The Segal Company (Eastern States), Inc. ("Segal"). The Segal point of contact will provide Vendor's designated recipient a link to a SFTP system. The designated recipient may access the secure site and download the cost proposal worksheets and data files that will be used for the repricing exercise and other requirements within the cost proposal. Segal will not release any cost proposal worksheets and data files to any Vendor without a signed NDA.

For informational purposes, the Segal point of contact is as follows:

Stephen Kuhn
skuhn@segalco.com
617-424-7341

If issues arise, Segal and Vendor are permitted to communicate via email directly with one another regarding the transmission and receipt of documents through the Secure File Transfer system. Segal and Vendor must copy Vanessa.Davison@nctreasurer.com and SHPCContracting@nctreasurer.com on such emails. This communication is limited to technical support; all substantive questions shall be submitted pursuant to the Question and Answer process set forth in the RFP.

1.1 Network Access

The Plan seeks to have a provider network in place that best meets the program's long-term needs. This includes a broad provider network with the least disruption and with competitive pricing. This section will address access to the proposed network of healthcare providers.

1.1.1 Access Reports

Vendors are required to submit an accessibility report (Optum™, GeoAccess®, GeoNetworks, or comparable software) for the proposed provider network. Access must be reported by county.

Vendor will be required to provide a summary of participants with and without access to network providers/facilities within the established mileage parameters listed below:

Provider Type	Urban and Out-of-State	Suburban	Rural
Facilities			
Hospitals	1 within 20-miles	1 within 25-miles	1 within 35-miles
Ambulatory Surgical Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Urgent Care facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
Imaging Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Inpatient Behavioral Health Facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
Professional Services			
Primary Care			
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	2 within 10-miles	2 within 15-miles	2 within 20-miles
OB/GYN (female members, age 12 and older)	2 within 10-miles	2 within 15-miles	2 within 20-miles
Pediatrician (birth through age 18)	2 within 10-miles	2 within 15-miles	2 within 20-miles
Specialists			
Endocrinologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Urologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Cardiologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Dermatologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Allergist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Psychologist/Psychiatrist	2 within 20-miles	2 within 25-miles	2 within 35-miles
General Surgeon	2 within 20-miles	2 within 25-miles	2 within 35-miles
Hematologist/Oncologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Chiropractor	2 within 20-miles	2 within 25-miles	2 within 35-miles

The submitted access reports (mapping and accessibility analysis) must demonstrate provider availability for EACH provider group type listed in the table above. In the production of the reports, please note the following:

Vendor must utilize Optum™, GeoAccess®, GeoNetworks or comparable software.

- The access report must indicate, by county, those participants with access and those without access according to the provider network access standards listed above.
- The access reports should include providers under contract as of September 1, 2022 and may also include providers that have executed a legally-binding letter of intent or letter of agreement with Vendor.
- Vendor is required to provide separate reporting for each proposed provider network.

A census file will be provided in a format detailed in **Attachment A-1**. Vendors should use this file to support the accessibility report.

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:

- **Repricing by Service Category Summary – Attachment A-4:** Vendors should provide aggregate information on the contractual amount (aka, 'Allowed Amount') for each county and detailed service category, identified by the Service Category Codes in the repricing file.
- **Repricing by Provider Summary – Attachment A-5:** Vendors should provide aggregate allowed information for each provider listed.
- **Contract Improvements – Attachment A-6:** Vendors should identify any known contract improvements.

It is imperative that Vendors return data in the exact formats prescribed. Failure to do so may cause Vendor's proposal to be rejected. Attachments A-4 and A-5 should be financially identical to the detail data submitted and will be utilized to cross-check results and submissions.

Vendors must submit the complete repriced file along with any requested supporting documentation. Failure to comply may cause Vendor's proposal to be rejected.

1.3 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.

1.4 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.

1.5 Self-Funded Claims Projection

This section (**Attachment A-9**) allows Vendor to estimate the expected claim and administrative cost for the proposed provider network. Based on the claims experience provided in the repricing file, Vendor is asked to estimate the expected future costs under its medical management and pricing arrangements with providers. It is expected that Vendor will map the repricing data to the proposed network. This is to be Vendor's best estimate and should be performed as accurately as possible, in good faith.

The summary projection requires thoughtful inputs at a very high level, recognizing that a detailed projection would be performed differently for each Vendor. There are two (2) inputs required of Vendors:

- **Utilization Adjustment:** If Vendor feels that its medical management will alter current utilization, Vendor should enter the expected utilization adjustment percentage. An explanation of anticipated changes is required.
- **Allowed Adjustment:** The submitted/billed charge per service is included in the summary and requires Vendor to provide an adjustment to allowable charge per service. It is understood that this is not discounts alone and will represent movement between provider charges. The goal is to get to what Vendor believes to be its per-service cost in the proposed network.

This section provides an opportunity for Vendor to demonstrate the strength of its network.

1.6 Data Certification

There is a required certification (**Attachment A-10**) of all information submitted, including data, guarantees, pricing worksheets, etc. Vendor's actuary should sign the certification, but signature by either Vendor's CFO or CEO will also be accepted. Appropriate language can be provided by Vendor.

1.7 Attachments for Attachment A: Pricing

The following attachments taken together make up Attachment A: Pricing.

- Attachment A-1: Census File Format
- Attachment A-2: Network Access for Non-Medicare Membership
- Attachment A-3: Claims Repricing File Layout
- Attachment A-4: Repricing Summary - Service Category
- Attachment A-5: Repricing Summary - By Provider
- Attachment A-6: Contract Improvements
- Attachment A-7: Administrative Fees
- Attachment A-8: Network Pricing Guarantees
- Attachment A-9: Self-Funded Claims Projection
- Attachment A-10: Actuarial Certification

ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE

ATTACHMENT K: MINIMUM 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 K by only marking either "Confirm" or Does Not Confirm" as a response for each Minimum Requirement. Under no circumstances will narrative or text from Vendor be accepted as a response.

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.