

Blue Cross Blue Shield of North Carolina (Blue Cross NC)
 RFP # 270-20220830TPAS
 Third Party Administrative Services
 November 23, 2022

Request for Clarification #6

Regarding Blue Cross NC's response to Clarification #5, the Plan requests Blue Cross NC to clarify the following by responding via email no later than 11:59 A.M. ET on Monday, November 28, 2022 to Vanessa Davison, vanessa.davison@nctreasurer.com, SHP Contract, shpcontracting@nctreasurer.com, and Stephen Kuhn, SKuhn@segalco.com.

1. Your response to Clarification #5 indicated, "When calculating 2023 discounts, both the billed trend and the allowed trends are considered to create the expected 2023 discount". Your response clearly indicates a portion of the discount improvement is simply the result of trending charges to 2023.

We are attempting to isolate the contract improvements from the claims trends which was the objective in the discount accumulation exhibit provided in Clarification #4 and referenced in Clarification #5.

What percent of the 2.8% improvement (from the 51.2% to 54.0%) is from the billed charge trends versus only contracted improvements?

Answer:

The 54.0% discount was based on both allowed charges and billed charges in 2023. We believe the purpose of the repricing exercise was to provide a projected discount assuming the same exact claims experience incurred in 2023. Your clarification "What percent of the 2.8% improvement (from the 51.2% to 54.0%) is from the billed charge trends versus only contracted improvements?" indicates that you are looking for a "discount-like" calculation of 2023 allowed charges versus 2021 billed charges. This calculation will produce a lower discount than our 2021 figure of 51.2% (2021 allowed charges vs 2021 billed charges) as 2023 allowed charges are higher than 2021 allowed charges. The only way for a discount to increase year over year while excluding the corresponding billed charge increases would be for the allowed charges to have negative trend at the provider level, year over year. This would imply that a carrier is able to negotiate lower fees with providers statewide year over year, which is not consistent with our historical experience in North Carolina.

If the request is to restate the 54.0% discount with a calculation based on 2023 allowed charges and 2021 billed charges, then the following provides the components required for this clarification.

- Discount when comparing 2021 allowed charges vs. 2021 billed charges = 51.2%
 - Apply 2023 known contracts and pricing
- Discount comparing 2023 allowed vs. 2021 billed = 50.2%
 - Apply billed charge trend from 2021 thru 2023
- Discount when comparing 2023 allowed vs. 2023 billed = 54.0%



To summarize the 2.8% difference is composed of:

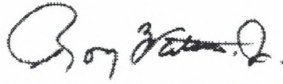
- 1) Contractual improvements of 2.0% between 2021 and 2023. This yields a -1% adjustment to the discount calculation.
- 2) Billed charge trends between 2021 and 2023 which yields a +3.8% adjustment to the discount calculations

Sign Clarification:

Offeror:

Blue Cross Blue Shield of North Carolina

Authorized Signature:



Name and Titled (Typed):

Roy Watson, Vice President Group and State Segment

Date:

11/28/22

Blue Cross Blue Shield of North Carolina (Blue Cross NC)
RFP # 270-20220830TPAS
Third Party Administrative Services
November 28, 2022

Request for Clarification #7

Regarding Blue Cross NC's response to the RFP and responses to the subsequent clarifications, the Plan requests Blue Cross NC to clarify the following by responding via email no later than 11:00 A.M. ET on Tuesday, November 29, 2022 to Vanessa Davison, vanessa.davison@nctreasurer.com, SHP Contract, shpcontracting@nctreasurer.com, and Stephen Kuhn, SKuhn@segalco.com.

1. The instructions provided in the RFP requested Vendors 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 (e.g., November 1, 2022). The RFP did not request Vendors provide estimated/projected discounts for 2023. Please note that the near-future contract improvements are only applicable in instances where discounts are increasing due to improved contract pricing (not assumed increases in billed charges).

Based on Blue Cross NC's responses to date, you have indicated a discount of 51.2% during 2021 and a projected 2023 discount of 54.0%. The Plan would deduce that your current discount at the time of your repricing is greater than the 51.2%, but lower than the 54.0%.

Your responses have also indicated that the majority of the improvement is due to increases in billed charges. You have indicated estimate discount improvements of approximately 1.5% to 2.0% per year (51.2% in 2021, 54.0% in 2023, 57.8% in 2025). As such, is your current discount at the time of the repricing (e.g., November 1, 2022) approximately 52.7% (1.5% improvement for 10 months)?

The Plan requests Blue Cross NC to confirm or revise to match its current discount at the time of its repricing.

Answer:

Confirmed. The current discount at the time of the repricing (e.g., November 1, 2022) is approximately 52.7%. The 2023 discount considering known/signed contract rates is expected to be 54.0%. The 2021 achieved discount experienced by the Plan is 51.2%. Therefore, the actual achieved discount as of November 2022 would be approximately 52.7%.



Sign Clarification:

Offeror: Blue Cross Blue Shield of North Carolina

Authorized Signature:

A handwritten signature in black ink, appearing to read "Roy Watson".

Name and Titled (Typed):

Roy Watson, Vice President Group and State Segment

Date:

11/29/22

Proposal Number: 270-20220830TPAS

CONFIDENTIAL

Vendor: Blue Cross Blue Shield of North Carolina

Date: October 14, 2022

RFP Number: 270-20220830TPAS

RFP Description: Third Party Administrative Services

Addendum Number: 2

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Vanessa Davison

Opening Date / Time: November 7, 2022 @ 10:00 a.m. ET

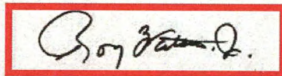
INSTRUCTIONS:

1. This Addendum is issued in response to questions submitted.
2. Return two (2) properly executed originals of this Addendum Number 2 with your Technical and Cost Proposal. Failure to sign and return this Addendum Number 2 may result in the rejection of your proposal.

Execute Addendum Number 2. RFP Number 270-20220830TPAS:

Vendor: Blue Cross Blue Shield of North Carolina

Authorized Signature: _____



Name and Title (Print): Roy Watson

Vice President of Group and State Segment

Date: November 2, 2022

ADDENDUM #2



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ATTORNEYS' EYES ONLY

Blue Cross NC_0000633

No.	Reference	Vendor Question	Answer
1.	1.1, page 8	Would the Plan consider the awarded vendors narrow network as a potential solution to the Clear Pricing Project (CPP) in the future?	The Plan will evaluate network options during the implementation of the Contract. While a narrow network may be an option at some point, the Plan has a commitment to the independent providers that joined CPP; therefore, continuing to support these providers is important to the Plan.
2.	1.2, page 10	Can the State Health Plan provide the current self-funded administration fees and identify what programs are included in the fees?	The base administrative fees for the Plan include claims, customer service, ID cards, utilization review, medical management, network access, appeals, group premium billing, enrollment and EDI reconciliation, outbound Data Files, secure Member portal, audits, standard and custom reports, self-service analytical tool, actuarial support for benefits and programs, information-technology-data management, provider network, management, and services.
3.	2.4 RFP SCHEDULE, page 12	Will a finalist meeting for each vendor be held during the BAFO window or at some other time?	The Plan did not include finalist meetings in the RFP Schedule and does not anticipate the need to add a finalist meeting to the schedule at this time.
4.	2.6 c) ii, page 13	Due to the size, should the completed claims repricing files we received from Segal via the SFTP link on 9/30/22 (NCSHP_Medical_RFP_Medical_File_Part1.zip and NCSHP_Medical_RFP_Medical_File_Part2.zip) be uploaded back to the same SFTP link, and not be included in electronic format in our hard copy/USB proposal response?	<p>Yes, Vendor should upload its response to Attachment A-3 to the Segal SFTP workspace where Vendor accessed the RFP data files and attachments.</p> <p>In addition to uploading the response to the Segal SFTP workspace, all cost proposal attachments are required to be submitted in hard copy and USB per Section 2.7.2 "Technical and Cost Proposal Contents." However, note that Section 2.6.3 "Technical and Cost Proposal Submission" states that individual attachments, exhibits, and/or supporting documentation greater than 50 pages in length may be submitted in electronic copy only on flash drives. If so, the hard copy responses must specifically identify the file names and location of the individual attachments, exhibits, and/or supporting documentation.</p>

5.	2.7.2, page 14, 2.6.3 page 15 and 5.3, page 74	Should the technical proposal as laid out in section 2.7.2 just have a page in letter d) referring to a separate cost proposal binder, in which all cost items should be contained?	Confirmed. In accordance with the order of preference laid out in Section 2.7.2 "Technical and Cost Proposal Contents," a page in d) as a marker for the cost proposal indicating a separate binder including all cost items is acceptable.
6.	2.7.2, page 16	Can you confirm "ATTACHMENT B: INSTRUCTIONS TO VENDORS" only needs to be included in the proposal in whole, and does not need to be signed?	Correct. Attachment B: "Instructions to Vendors" does not require a signature. Vendor is required to submit a copy of Attachment B: "Instructions to Vendors" in accordance with RFP Section 2.7.2 "Technical and Cost Proposal Contents."
7.	2.7.2, page 16	Will the Plan permit vendors to include a Cover Letter and/or Executive Summary highlighting their offering?	No. The Plan will not review nor evaluate as part of the Contract, if awarded, any Cover Letters or Executive Summaries.
8.	4.15 Conflict of Interest, Page 32	Please confirm if the information requested in section 4.15 is required upon award, or if it should be included with our RFP response?	The obligation to make certain disclosures under Section 4.15 "Conflict of Interest" is created upon the signing of the Execution Page. Therefore, any information rising to the level of a necessary disclosure under Section 4.15 "Conflict of Interest" should be submitted with the RFP Response.
9.	4.18 page 33, and Attachment B, #9, page 86	Can you confirm the Certificate of Authority to Transact Business (and any other required licenses or certificates) would need to be provided upon award, and should not be included with our proposal response?	Correct. The provisions of Section 4.18 "Registration and Certification" requiring a Certificate of Authority to Transact Business is a condition of Contract award. It should not be included with proposal responses, but Vendors must be prepared to furnish any necessary documents at the point of award.
10.	5.1.4 (c), page 38	Please describe the customization anticipated for incentive Plan Design features.	The current Plan Design features include a copay incentive as referenced in Requirement 5.1.4.b. There are also copay incentives for CPP specialists and mid-tier providers. These are outlined as Wellness Incentives in the Plan's Benefit Booklet. The Plan may also develop additional incentives or value based benefit designs in the future.
11.	5.2.1.1, page 44	What custom Product Solutions will be needed to support the Plan?	The Plan intends to evaluate Vendor's network and product offerings during the implementation of the Contract.

			Any customizations will be determined at that time and evaluated on an annual basis.
12.	5.2.2 Finance and Banking Technical Requirements b ii, page 47 and exhibit 1 on page 121	Can the Claims Overpayment recoveries be deposited into one account, or do they need to be separated into different accounts based on different agencies or other needs?	Claim Overpayment recoveries can be deposited into one account.
13.	5.2.2 Finance and Banking Technical Requirements b iii, page 47 and Exhibit 11 page 120-121	The Diagram indicates DST will do positive pay reconciliation and receives cleared items from the bank. Is this diagram applicable to this health care business? From RFP pg. 47, "iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable." Will DST do a parallel reconciliation with the contractor and/or the bank? If so, would DST then require updates for stops and voids from the contractor? Does DST decision positive pay exception items at the bank or does contractor handle exceptions? Does DST send cleared items to the contractor in order that the contractor can reconcile in parallel and identify stale dated escheatable items?	This diagram is applicable. Department of State Treasurer (DST) Accounting will do a parallel reconciliation of disbursing accounts using the reconciliation sent by Vendor. DST Accounting requires information for stops and voids from Vendor via the weekly disbursement report. In addition, DST Accounting requires a separate report on any return items that will be included subsequently with the weekly disbursement report. DST Banking is responsible for decisioning positive pay exception items on a daily basis. DST Banking makes available cleared items in order to aid Vendor in reconciliation and identification of stale dated escheated items.
14.	5.2.2 Finance and Banking Technical Requirements b x, xi, page 47	Does the Plan wish to review individual claims for payment approval or is the entire batch approved in total? Will the State cap disbursements based on an aggregate amount? If a batch or individual claims are held, who decides which claims are held? How is Late Claim Interest handled for claims the state holds?	The disbursement request is approved in total. If the Plan has to limit the weekly disbursement, the Plan will provide Vendor with the amount to be disbursed and Vendor can determine which claims to release. Vendor is only responsible for late payment penalties as a result of Vendor's action, inaction, or system failure.
15.	5.2.2 Finance and Banking Technical Requirement s xix, page 48	Can you define what "settlement" means, as used in this item? How often does it occur in the current contract that you have an ad hoc settlement to the member?	As noted in Requirement 5.2.8.2.a.iii, the Plan must follow N.C.G.S. § 135-48.24. This applies to both claims and enrollment appeals; therefore, the Plan may reach a financial "settlement" with a Plan Member as a result of this process. On average the Plan reaches a settlement with a Member every 45 – 60 days.
16.	5.2.2.2 Finance and	(Inline check processing) Our check production begins with blank, security enhanced check stock.	This process is acceptable to the Plan. During the implementation of

	Banking, page 46-Banking Services link. And page 47 item iii in reference to Check Stock and preprinted contents	Upon it, the relevant customer and banking information, including MICR, is printed in real time. Please confirm this is acceptable versus preprinted stock that would include NC specific details.	the Contract, the Plan would require a test check that could be approved prior to production.
17.	5.2.3.2.b.iii	Please define "payment rules" and "utilization management."	Payment rules are intended to capture the specific requirements Vendor has implemented to consistently administer claims. If Vendor, for example, requires prior authorization for a service to be covered, this "payment rule" should apply to services incurred in North Carolina as well as any other state. The penalty for not following the rule should be the same too. If, for example, the network provider is responsible for obtaining the prior authorization, that should be the rule in every state, not just North Carolina. The same is true for utilization management. If there are medical necessity, appropriateness, and efficiency of the use of certain services, the same criteria should be applied in all states.
18.	5.2.3.2.b.iii	Please confirm that the definitions of "payment rules" and "utilization management" apply to all locations, including outside of North Carolina.	Confirmed. See response to Question #17 above.
19.	5.2.3.2 (b) v, page 49	Can virtual visits be billed through the claims wire?	All claims must be funded through the weekly disbursement process.
20.	5.2.4.2 (a) iii, page 51	Can you provide a sample of a value-based incentive plan and any other concepts you may be considering or implementing in the future?	The Plan is currently developing a capitation pilot program with a provider group. This will be a retrospective program layered on top of fee for service. If successful, the Plan anticipates expanding that program. The Plan also anticipates deploying other, yet to be determined, value-based and/or incentive programs in the future.
21.	5.2.4.2.b.viii	Please provide an example of an integration request the Plan may be considering.	If the Plan's current pilot program with a provider, described in the response to Question #20 above, is successful, a future phase may require integration

			with the Plan's TPA. That is all yet to be determined.
22.	5.2.4.2 (b) ix, page 52	Is the HRA offered to anyone enrolled in both the Enhanced or Basic PPO plans today?	The Plan does not currently offer an HRA, but may decide to do so again in the future.
23.	5.2.4.2 (b) ix, page 52	Do the Employer funds on the HRA pay upfront?	While Members earn funds "upfront," the account would be virtual; which means the Plan would pay the claims from the HRA as they are incurred.
24.	5.2.4.2 (b) ix#14, page 52	Does the plan have any specifications on the HRA that might be offered with the Enhanced PPO copay based plan (80/20)?	The Plan does not have any specifications about the HRA at this time.
25.	5.2.5.2 (b) ii, page 53 5.2.5.2 (b) viii, page 54	Will SHP allow TPA's to bill services behavioral Health capitation through the claims wire? Are Radiology utilization management services allowed to be processed through the claims wire or invoice? Are any fees paid to access networks outside NC?	All claims should be paid via the weekly disbursement. A determination about whether the Plan will support a capitated payment will have to be determined during the implementation of the Contract. Vendor should include any PSPM or PMPM fees for utilization management programs in Attachment A-7: Administrative Fees. The Plan does not currently pay separate network access fees.
26.	5.2.5.2 (b) ii, page 53	Please provide a copy or a sample of any current clinical policies that have been customized or concepts you may be considering implementing in the future?	While the Plan does not currently have any custom clinical policies, the Plan has implemented new benefits, such as applied behavioral analysis, that at the time were not a standard benefit of the TPA and therefore required a custom medical policy. Additionally, the Plan has exclusions that may impact a Vendor's clinical policies. It would be the Vendor's responsibility to administer the claims and policies in accordance with the Plan's benefit booklet.
27.	5.2.5.2 (b) vii, page 53	Can you provide an overview of the specific types of wellness programs and services you are looking for as a part of the bid to support plan members?	The Plan does not have a specific type of wellness program requirement. The Plan expects Vendor to include some wellness programs as part of its standard offering.
28.	5.2.5.2 (b) x, page 54	What is the scope of conditions and health risks to be covered as part of the Disease Management health coaching program?	The Plan has not defined the Disease Management program for this Contract.

29.	5.2.5.2 (b) x, page 54	How does the Plan want the services delivered: 1:1 telephonic, group coaching or digitally?	The Plan does not have a specific requirement about how the services will be delivered.
30.	5.2.5.2 (b) x, page 54	Are there expectations for the vendor to provide coaching services onsite? If so, in which locations?	There are no on-site coaching service requirements.
31.	5.2.5.2 (b) x, page 54	Will the Plan allow for disease management services to be charged on a per engagement basis?	If disease management services are being offered as an Additional Service, the Plan will consider fees on a per engagement basis.
32.	5.2.6 Enrollment, EDI and Data Management 5.2.6.2 Services, b, ii item 4; page 57	Confirm what vendor connections and types of data are being requested to be use for API's?	While the Plan has utilized APIs in the past, the Plan does not currently have any APIs in place. As a reminder, Vendor will have to integrate with the Plan's EES vendor's systems.
33.	5.2.6 Enrollment, EDI and Data Management 5.2.6.2 Services, b, items xxxiii, xxxiv, xxxv & xxxvi; page 58	1095-B forms are used by fully insured carriers for all size business and self-funded groups with fewer than 50 full-time employees and/or full-time equivalents. Confirm if these items are applicable to this RFP.	Many of the Employing Units enrolled on the Plan have less than 50 employees; therefore, 1095-B forms are applicable.
34.	5.2.7.2 (b) v and 5.2.7.2 (b) vi, page 59	To protect the privacy of members, it is our practice to redacted sensitive PHI information from recorded calls. Will this process meet the Plan's requirements?	Vendor shall provide copies of non-redacted recorded calls in response to this Requirement as the Plan expects to receive all information related to calls.
35.	5.2.7.2 (b) xii, page 60	Please elaborate on the number of unique digital platform experiences you will require for your wellness program. How many different wellbeing incentives are being administered? For example, do state employees receive a different experience from state colleges, employer groups or local governments?	The Plan does not require a specific number of digital platform experiences in support of wellness programs, but the Plan expects there to be some standard digital offerings. There are currently no wellbeing incentives for Plan Members.
36.	5.2.7.2.b.xxi	Please describe the type of online forums and live chat groups that would be on the member portal.	The Plan is not currently hosting online forums or live chats but has successfully utilized these in the past to engage Members in wellness challenges. The Plan would like to engage in these types of activities in the future.

37.	5.2.7 Customer Experience 5.2.7.2 Services, b, xxiii item 4; page 61	Confirm how many single sign-on (SSO) connections will be requested to build the State's vendor partnerships?	At a minimum, there will be an SSO between the Plan's EES vendor and the TPA, and an SSO between the Plan's PBM vendor and the TPA. Some type of integration will be required between the Plan's EES vendor and the TPA's PCP Selection tool, as outlined in Requirement 5.2.6.2.a.xxi.
38.	5.2.7.2. (b) xxxi, page 62	Can you please describe how many onsite wellness events you anticipate having annually?	In 2022, there has been one onsite wellness event. There are currently no wellness events planned for 2023.
39.	5.2.8.2 (b) xiv, page 63	Can you confirm EOB Election would be done at the employee/family level, rather than the individual level?	Correct. EOB Election will be done at the employee/family level, rather than the individual level.
40.	5.2.8 Claim Processing and Appeals Management 5.2.8.2 Services, b, xvi; page 64	Can you describe or give examples of the "gate-keeper" rules?	Currently, Plan Members can select a PCP, but they are not required to use that PCP. At some point, the Plan may decide to tighten up the PCP selection requirements in such a way that the Member would be required to select and utilize the PCP.
41.	5.2.9.2 (b) xxiv, page 66 5.2.8.2 (b) viii, page 63	It is typical for a TPA to subcontract with vendors for recovery for claims that may have been overpaid, fraudulent, paid in error, misdirected including subrogation. When recoveries are made, the vendor charges a fee for those services. The fee is based on the recovery savings and billed through an invoice or claim wire. Can the TPA bill for those services through an invoice process or through the claims wire? Other services that may be billed through invoice or claims wire may include: -Subrogation -Coordination of Benefits -Third Party Claims and Code Review -Out of Network claims review negotiation of charges -Radiology Utilization Management -Behavioral Health	Any fees that Vendor intends to invoice to the Plan must be outlined in the Cost Proposal, Attachment A-7 and billed on a monthly basis as part of the administrative fees.
42.	5.2.11 Reporting 5.2.11.2 Services, b, viii items 2 b & c; page 69	Confirm if items b & c should read country or county?	Requirements 5.2.11.2.b.viii.2) b) and c) appropriately read "country".

43.	Phase II - General Question	Can you clarify the scoring metrics for each of the required attachments A-L?	Attachment A: "Pricing" and Attachment L: "Technical Requirements Response" will be scored in accordance with RFP Section 3.4 "Evaluation Criteria." There are no points allocated to Attachments B through K. However, Attachment B: "Instructions to Vendors" and Attachment F: "Supplemental Vendor Information" are required to be submitted in accordance with RFP Section 2.7.2 "Technical and Cost Proposal Contents." Attachments C, D, E, G, H, I, J, and K were submitted in response to RFP Sections 2.7.1 "Minimum Requirements Proposal Contents" and 5.1 "Minimum Requirements."
44.	Attachment A	Please confirm that no component of the cost proposal may be redacted.	Correct. Vendors are required to submit a non-redacted cost proposal for evaluation.
45.	Attachments and execution pages	Please confirm that the plan will accept digital signatures on the technical and cost proposals as was accepted on the minimum requirements.	Correct. Digital signatures are acceptable and binding for all forms requiring signatures, including the Execution Pages, as stated in response to Question #18 in Addendum #1.
46.	Attachment A - Pricing	Please provide a detailed description of your current clinical care management programs.	The Plan does not have detailed descriptions of the current clinical management programs. These programs are managed by the Plan's TPA and change from time to time.
47.	Attachment A - Pricing	Can you please share what the State's medical trend has been over the past few years?	The trend rates listed below are based on incurred dates of service in the respective calendar years. Obviously, COVID-19 had a big impact. The average over this time period is 6.3% for medical trend. 2017: 3.5% 2018: 5.0% 2019: 3.8% 2020: 2.9% 2021: 16.2%
48.	Attachment A - page 81	Can you confirm additional quotes for alternate/narrow networks will not be accepted as part of this RFP?	Correct. Additional quotes for alternative/narrow networks will not be accepted at this time.
49.	Attachment A - Pricing	What does the Plan consider an eligible not considered record? (For example, TIN, dental RX, mental health, chiropractic, RAPL, claim, etc.)	All records in the data file are eligible claims to be considered. If Vendor is not able to reprice a claim, Vendor

	1.1 Network Access		should indicate "NA" in the "NetStatus" field, \$0 in the "ContAmt" field, and the reason for not repricing the claim in the "ContType" field.
50.	Attachment A - Pricing 1.1 Network Access	What percentage of network disruption will the Plan find satisfactory?	The Plan has not established a disruption percentage.
51.	Attachment A 1.1.1, page 82	Can the Plan provide a zip code listing of which members they would like the Geo Access reports run for OB/GYNs (female members, age 12 and older) and Pediatricians (members, birth through age 18) or guidance on what starting date bidders should base the age on?	Vendors should use 10/1/2022 to calculate the age of all Members.
52.	Attachment A 1.1.1, page 82	Do bidders need to provide full geo access reports, in addition to completing the Network Access Urban, Network Access Suburban and Network Access Rural tabs? Can you confirm actual maps are not required?	Yes, Vendor needs to provide full geo access reports, in addition to completing the Network Access Urban, Network Access Suburban, and Network Access Rural tabs. Vendor needs to complete the exhibits provided in Attachment A-2 and provide documentation that the access reports were run consistent with the parameters requested in Attachment A: "Pricing" of the RFP, which includes mapping.
53.	Attachment A 1.1.3, page 83	Can you confirm providers requested in the "Provider Listing" tab should be our North Carolina broad network?	Vendor's broad network should be used.
54.	Attachment A, 1.2.1, page 83	Is it acceptable to provide our response to the repriced claims file with just these four fields in the final file: -SG_ROWID (Unique record identifier) -NetStatus (Network Status) -ContAmt (Network Contracted Amount) -ContType (Type of Network Contract)	Yes, it is acceptable for Vendor to return the claims repricing files with only these four (4) fields. -SG_ROWID (Unique record identifier) -NetStatus (Network Status) -ContAmt (Network Contracted Amount) -ContType (Type of Network Contract)
55.	Attachment A - Pricing 1.2.1 Claims Repricing File	Due to the confidentiality of the repricing exercise and the limited number of people with access to that information, is possible for our designated recipient to return the repricing exercise results through the Segal SFTP site?	Yes. Vendor should upload its response to Attachment A-3 to the Segal SFTP workspace where Vendor accessed the RFP data files and attachments. In addition to uploading the response to the Segal SFTP workspace, all cost proposal attachments are required to

			be submitted in hard copy and USB per Section 2.7.2 "Technical and Cost Proposal Contents." However, note that Section 2.6.3 "Technical and Cost Proposal Submission" states that individual attachments, exhibits, and/or supporting documentation greater than 50 pages in length may be submitted in electronic copy only on flash drives. If so, the hard copy responses must specifically identify the file names and location of the individual attachments, exhibits, and/or supporting documentation.
56.	Attachment A - Pricing 1.2.1 Claims Repricing File	What is the Plan's evaluation process specific to the review of the repricing (Attachments A) with the qualified vendors? Will there be any question/answer, clarifications or other types of exchanges during the review process in order for the State to fully understand the network value put forth by the vendor? If so, how will those exchanges be handled?	Attachment A: "Pricing" will be evaluated and scored in accordance with RFP Section 3.4.c) "Evaluation Criteria – Cost Proposal." The Plan will communicate with Vendors as needed through the written request for clarification process.
57.	Attachment A-1.2.1, page 84	Will Contract improvements indicated in Exhibit A-6 be considered in the network pricing scoring, or are they informational-only?	Responses to Attachment A-6, along with all pricing attachments, will be considered in the evaluation of proposals.
58.	Attachment A-1.3 Administrative Fees, page 84	Should bidders provide pricing for on Flexible Spending Accounts (healthcare and dependent care) and/or Limited Purpose Flexible Spending Account, in addition to the HRA and HSA pricing?	No. Vendor should not provide pricing for Flexible Spending Accounts.
59.	Attachment A 1.6, page 85	Can you confirm a typed signature is acceptable for Attachment A10 Actuarial Certification?	No. Typed signatures are unacceptable. Vendor shall either provide wet signatures, preferably in blue ink, or digital signatures, as stated in response to Question #19 in Addendum #1.
60.	Attachment A-3	What is the intention of the table with the Medicare control totals? Attachment A-3 includes a tab called Medicare Summary which shows control totals. The data files don't appear to have a way to identify those same charges? Are the Medicare charges included in the 15M line data sample?	The "Medicare Summary" tab includes informational data on the Medicare primary lives and claims Vendor is expected to administer as part of this Contract. The data in the "Medicare Summary" tab are not control totals and these Medicare claims are not included in the claim data files provided for claims repricing.
61.	Attachments A-3 and A-6	Please confirm the claim time period to be used for the repricing analysis is incurred January 2021 through December 2021, paid through June 2022.	The claims data provided for repricing represents incurred January 1, 2021, through December 31, 2021, paid

		Please confirm the instructions on attachment A-6 indicate that we should use results on attachment A-3 to illustrate contract improvements for 2025.	through June 30, 2022. In its response to Attachments A-3, A-4, and A-5, Vendor is expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, <u>at the time of the repricing</u> . Vendor's response to Attachment A-6 should reflect anticipated improvements in its reimbursement arrangements from after the claims repricing analysis (i.e., not reflected in the claims repricing) to January 1, 2025.
62.	Attachment F - Supplemental Vendor Information	We would like to better understand the states expectations on HUB certified tier-2 suppliers. How can we demonstrate integrating our current initiatives as we build tier-2 suppliers in partnership with the State?	Attachment F: "Supplemental Vendor Information" is not a scored document, rather it is intended for informational purposes only. Responses should reflect current relationships, and responses may be amended or revised over the life of the Contract.
63.	Attachment F - Supplemental Vendor Information	What is the numerical points value for Attachment F: Supplemental Vendor Information?	There are no points allocated for Attachment F: "Supplemental Vendor Information"; however, Vendor is required to complete and submit Attachment F: "Supplemental Vendor Information" in accordance with Section 2.7.2 "Technical and Cost Proposal Contents."
64.	Attachment L, page 118	Can you confirm that the Attachment L- Technical Requirements Response Document that was posted to the Ariba site only needs to be returned in the Hard Copy/UBS submission once complete, and does not need to be reposted to the Ariba site?	Correct, Vendor should not upload its completed Attachment L: "Technical Requirements Response" into Ariba. Vendor is required to submit its completed Attachment L: "Technical Requirements Response" in accordance with RFP Sections 2.6.3 "Technical and Cost Proposal Submission" and 2.7.2 "Technical and Cost Proposal Contents."
65.	Addendum #1, in whole	Can you confirm that a signed copy of Addendum #1 does not need to be re-included with our response, since we included in the Minimum Requirements response?	Correct, Vendor does not need to include a signed copy of Addendum #1 in its Technical Requirements response in addition to its Minimum Requirements response.