

# **STATE OF NORTH CAROLINA**

**Department of Health and Human Services**

**Division of Health Benefits**

**Request for Proposal #: 30-180090**

**Enrollment Broker Services**

**Date of Issue: March 2, 2018**

**Proposal Opening Date: April 13, 2018**

**At 2:00PM ET**

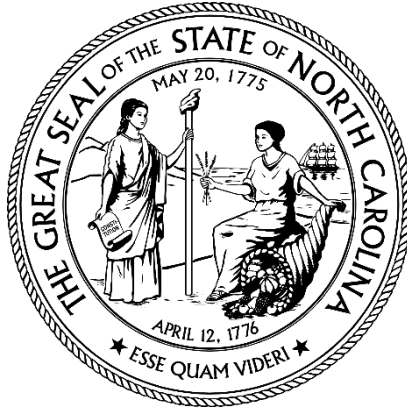
**Direct all inquiries concerning this RFP to:**

**Ken Dahlin**

**Contract Specialist**

**Email: [ken.dahlin@dhhs.nc.gov](mailto:ken.dahlin@dhhs.nc.gov)**

**Phone: (919) 855-4054**



## STATE OF NORTH CAROLINA

### Request for Proposal #

**30-180090**

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For internal State agency processing, please provide your company's Federal Employer Identification Number or alternate identification number (e.g. Social Security Number). Pursuant to North Carolina General Statute 132-1.10(b) this identification number shall not be released to the public. **This page will be removed and shredded, or otherwise kept confidential**, before the procurement file is made available for public inspection.

**This page is to be filled out and returned with your Proposal.**

**ID Number:**

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Federal ID Number or Social Security Number

---

Offeror Name



**STATE OF NORTH CAROLINA**  
**Department of Health and Human Services**

**Refer ALL Inquiries regarding this RFP to:**

Ken Dahlin  
Contract Specialist  
ken.dahlin@dhhs.nc.gov  
(919) 855-4054

**Request for Proposal # 30-180090**

**Proposals will be publicly opened:** April 13, 2018 @ 2:00PM ET

**Contract Type:** Agency Specific

**Commodity No. and Description:** 948-07 – Health Administration Services

**Using Agency:** Department of Health and Human Services,  
Division of Health Benefits

**Requisition No.:** n/a

**EXECUTION**

In compliance with this Request for Proposal, and subject to all the conditions herein, the undersigned Offeror offers and agrees to furnish and deliver any or all items upon which prices are proposed, at the prices set opposite each item within the time specified herein. By executing this proposal, the undersigned Offeror certifies that this proposal is submitted competitively and without collusion (G.S. § 143-54), that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934 (G.S. § 143-59.2), and that it is not an ineligible Contractor as set forth in G.S. § 143-59.1. False certification is a Class I felony. Furthermore, by executing this proposal, the undersigned certifies to the best of Offeror's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal or State department or agency. As required by G.S. § 143-48.5, the undersigned Offeror certifies that it, and each of its subcontractors for any Contract awarded as a result of this RFP, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system. G.S. § 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By execution of any response in this proposal, you attest, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization. **Failure to execute/sign proposal prior to submittal shall render proposal invalid and it WILL BE REJECTED.**

**Late proposals will not be accepted.**

OFFEROR:		
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:
PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE		
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF OFFEROR:		FAX NUMBER:
OFFEROR'S AUTHORIZED SIGNATURE:	DATE:	EMAIL:

Offer valid for at least **180** days from date of proposal opening unless extended by the State in writing. After this time, any withdrawal of offer shall be made in writing, effective upon receipt by the agency issuing this RFP.

**ACCEPTANCE OF QUOTE**

If any or all parts of this proposal are accepted by the State of North Carolina, an authorized representative of the Department of Health and Human Services shall affix his/her signature hereto and this document and all provisions of this Request for Proposal along with the Offeror's proposal, and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Offeror

**FOR STATE USE ONLY:** Offer accepted and Contract awarded this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, as indicated on the attached certification, by \_\_\_\_\_  
(Authorized Representative of NC Department of Health and Human Services)

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## I. INTRODUCTION

### A. Vision for NC's Medicaid Transformation

In September 2015, the North Carolina General Assembly (General Assembly) enacted North Carolina Session Law 2015-245, which was amended by Session Laws 2016-121 and 2017-57, directing the transition of North Carolina's Medicaid program from a fee-for-service model to a managed care model. The law requires the North Carolina Department of Health and Human Services (Department or DHHS), through the Division of Health Benefits (DHB), to implement a Medicaid managed care program that advances high-value care, improves population health, engages, and supports providers, and establishes a sustainable program with predictable costs. The Department's goal is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

As part of Medicaid managed care, the Department will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs. As directed by the General Assembly, the Department will delegate the direct management of certain health services, including physical health, behavioral health and pharmacy services, and financial risks to entities called Prepaid Health Plans (PHPs). PHPs will receive a monthly, actuarially sound, capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure, for example, that PHPs have adequate provider networks, deliver clinical quality, or other aspects of a successful Medicaid managed care program.

The following is an overview of the beneficiaries eligible for managed care, types of managed care plans North Carolina will offer, and the timeline for managed care implementation. The Department will work with the General Assembly to enact changes in the authorizing legislation to ensure the implementation of a managed care program that best meets the needs of beneficiaries, providers, and other stakeholders. Detailed information about the proposed design of North Carolina's implementation of Medicaid managed care and 1115 demonstration waiver application is available at <https://ncdhhs.gov/NC-medicaid-transformation>.

1. Beginning with the launch of managed care, most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs. There will be limited exceptions to mandatory enrollment for certain populations that may be better served outside of Medicaid managed care. These populations may be "exempt" from Medicaid managed care in that the beneficiary may choose to enroll in either fee-for-service or Medicaid managed care, or "excluded" in that they are required to remain enrolled in fee-for-service and do not have the option to enroll in Medicaid managed care.
  - a. Exempt populations include members of federally recognized tribes.
  - b. Excluded Populations
    - i. As provided in Session Law 2015-245, as amended by Session Laws 2016-121 and 2017-57, the following populations will be excluded:
      - (i) Beneficiaries dually eligible for Medicaid and Medicare;

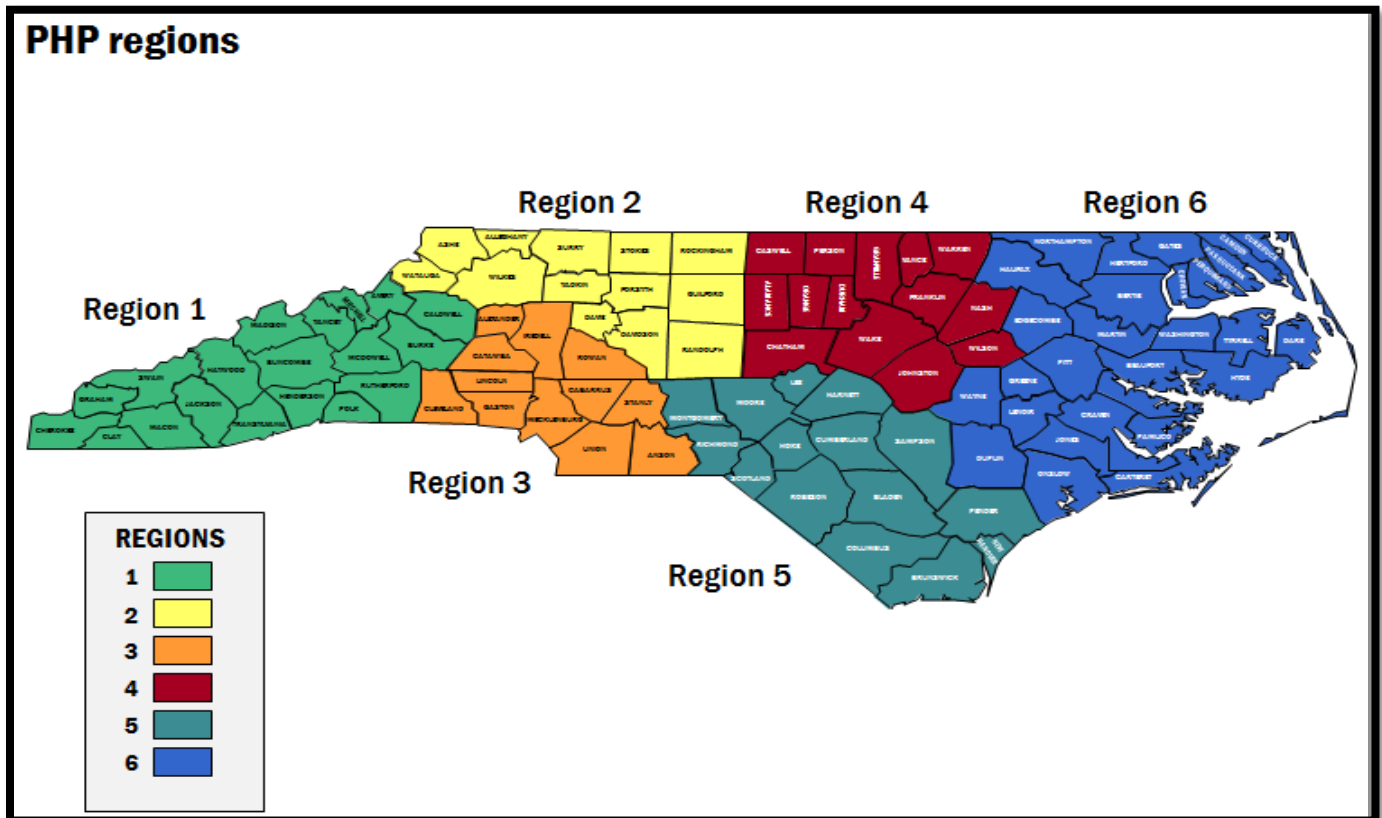
- (ii) Program of All-Inclusive Care for the Elderly (PACE) beneficiaries;
    - (iii) Medically needy beneficiaries;
    - (iv) Beneficiaries only eligible for emergency services;
    - (v) Presumptively eligible beneficiaries, during the period of presumptive eligibility; and
    - (vi) Health Insurance Premium Payment (HIPP) beneficiaries;
  - ii. The Department is seeking legislative authority to exclude the following populations who are contemplated under current statute as managed care:
    - (i) Family planning program beneficiaries; and
    - (ii) Beneficiaries who are prison inmates.
  - iii. The Department is seeking legislative authority to delay mandatory enrollment until the launch of BH I/DD Tailored Plans:
    - (i) Beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder, or an intellectual / developmental disability as defined within this RFP.
2. To ensure consumer choice, leverage the experience and commitment of Medicaid providers in North Carolina, and maximize opportunities for innovation, the Department will establish statewide and regional contracts with two types of PHPs: commercial plans (CPs) and provider-led entities (PLEs).
- a. **Statewide Contracts.** Under State law, the Department will award three (3) statewide contracts to PHPs.
  - b. **Regional Contracts.** Under State law, the Department may award up to twelve (12) regional contracts in six (6) regions to PLEs. PLEs must cover a region in its entirety, and may bid for more than one region, provided the regions are contiguous.
3. Consistent with Session Law 2015-245, as amended by Session Laws 2016-121 and 2017-57, providers with a history of serving Medicaid beneficiaries may seek to own and operate risk-bearing Medicaid managed care plans (PLEs) and participate as a PHP in the Medicaid managed care program. Managed care plans sponsored by providers may either offer plans on a regional basis under one of the regional contracts or a statewide plan under one of the statewide contracts. The Department has defined six (6) managed care program regions within North Carolina. See *Table 1 – List of Counties by PHP Region* for the counties included in each of the six (6) PHP regions, and *Figure 1 – Map of PHP Regions* that illustrates the PHP regions in map format.

**Table 1 – List of Counties by PHP Region**

<b>PHP Regions</b>	<b>Counties</b>
<b>Region 1</b>	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
<b>Region 2</b>	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
<b>Region 3</b>	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union

<b>Region 4</b>	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
<b>Region 5</b>	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
<b>Region 6</b>	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

**Figure 1 – Map of PHP Regions**



4. The Department is seeking legislative authority to permit contracts with PHPs to offer two (2) types of products to meet the diverse needs of the North Carolina Medicaid and NC Health Choice Population.
  - a. Standard Plans: Plans that will serve most North Carolina Medicaid and NC Health Choice beneficiaries, including adults and children. These plans will provide integrated physical health, behavioral health, and pharmacy services at the launch of North Carolina’s Medicaid managed care program.
  - b. Tailored Plans: Plans that will be specifically designed to serve special populations with potentially unique health care needs. The Department is proposing to launch a Behavioral Health and Intellectual / Development Disability Tailored Plan (BH I/DD TP) no later than two (2) years after the launch of standard plans. As proposed, BH I/DD TPs will provide integrated physical health, behavioral health, I/DD, and

pharmacy services to beneficiaries with significant behavioral health (BH) disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injury (TBI).<sup>1</sup> The Department may create additional Tailored Plans for other high-needs populations, such as individuals dually eligible for Medicare and Medicaid.

5. The Department consulted with the State's only federally recognized tribe, the Eastern Band of Cherokee Indians (EBCI), and jointly concluded that Tribal members will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. The Department and EBCI will continue to collaborate on the development of a "tribal option" that considers and addresses the unique cultural, behavioral health and medical needs of the EBCI. The tribal option may not initially be a full-risk health plan; however, EBCI and the Department are considering the feasibility of a future full-risk or partial-risk arrangement. Additionally, EBCI and the Department are exploring options for EBCI members who may elect to participate in non-tribal option PHPs. Current estimates indicate there are approximately four-thousand (4,000) EBCI members enrolled in NC Medicaid.
6. The transition of high-need populations to Medicaid managed care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. The Department believes that certain targeted populations with complex health care needs should be allowed more time to make the transition to Medicaid managed care. This means phasing in the mandatory enrollment of some vulnerable populations after the Medicaid managed care program is fully established. To avoid care disruption during the transition period, special populations will continue to have access through the fee-for-service program. The Department will continue to work with the General Assembly to implement this proposal to allow the timeline and processes described below and in *Table 2 – Estimated Comprehensive Managed Care Enrollment by Cohort Based on NC DHHS Proposed Phase in Schedule*. More detailed enrollment estimates for special populations is included in ATTACHMENT I: NC MEDICAID AND HEALTH CHOICE HISTORICAL ENROLLMENT.

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<sup>1</sup> More information about Tailored plans is available at: [https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan\\_ConceptPaper\\_20181109.pdf?CkZhWxchGeNGBa2wXQsrSwWPrqi41aVP](https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQsrSwWPrqi41aVP) (last updated on Nov. 9, 2017)

**Table 2** – Estimated Comprehensive Managed Care Enrollment by Cohort Based on NC DHHS Proposed Phase in Schedule<sup>2</sup>

	Based on SFY 2016 Historical Enrollment		
Population Cohort with Proposed Timing for Comprehensive Managed Care Enrollment	Estimated Average Members by Group	Estimated Average Members by Cohort	Cohort as Percent of Total Members
Year 1: Standard Plan - Aged, Blind, Disabled	140,000	1,525,000	73%
Year 1: Standard Plan - All Other	1,385,000		
Year 3: Tailored Plan - Non-Duals	85,000	135,000	6%
Year 3: Tailored Plan - Duals	27,000		
Year 3: Foster Children	23,000		
Year 5: Non-Dual LTSS	5,000	217,000	10%
Year 5: Full Duals (Non-TP)	212,000		
Excluded: Family Planning	103,000	208,000	10%
Excluded: Medically Needy	23,000		
Excluded: Other	82,000		
<b>Total</b>	<b>2,085,000</b>	<b>2,085,000</b>	<b>100%</b>

7. Additionally, the Department is planning for a regional phase-in approach for the cross-over population in Year 1 to ensure successful implementation of the managed care program. North Carolina Medicaid and NC Health Choice beneficiaries would be transitioned from the fee-for-service program into the managed care program on a regional basis. The Department is planning for a two (2) phase approach – with two (2) corresponding open enrollment periods for each subset of the cross-over population. At or soon after PHP contract award, the Department will determine which regions will be selected for Phase 1 and Phase 2 managed care roll out depending on several factors including, but not limited to, the number of beneficiaries in the regions, a goal of including a mix of predominantly “urban” and “rural” regions in Phase 1, a mix of commercial plans and provider led entities PHPs. If possible, the Department will select contiguous regions to minimize beneficiary or provider confusion. Phase 2 is anticipated to occur in the remaining regions three to five (3-5) months after initial launch.

<sup>2</sup> Exhibit prepared Feb. 8, 2018, by the NC DHHS Division of Health Benefits based on “Population Profiles,” released Nov. 9, 2017,

Notes:

- Estimates are based on SFY 2016 historical experience and do not include projected enrollment growth.
- Timing for managed care enrollment is proposed and subject to change.
- Tailored plan population estimates are subject to change based on legislation and data availability.
- “Non-dual LTSS” includes CAP/C, CAP/DA and individuals with a nursing facility stay of 90 days or more.
- “Excluded: Other” is primarily comprised of partial dual eligible enrollees.
- See source documentation for calculation methodology, assumptions and limitations.

8. While the Department is permitted by S.L. 2015-245 as amended up to eighteen (18) months after approval of the 1115 demonstration waiver and any additional necessary waivers and State Plan Amendments to begin PHP contracts and complete initial PHP enrollment, the Department anticipates releasing the PHP Request for Proposal (RFP) for commercial plans and provider led entities in the spring of 2018 for an effective date of July 1, 2019. The PHP RFP will focus on standard plans and will be awarded to three (3) qualified PHPs to operate statewide and up to twelve (12) qualified provider led entities to operate on a regional basis.

## B. Vision for Beneficiary Experience within Medicaid Transformation

1. **Administratively Streamlined Eligibility Approach:** The Department is committed to providing Medicaid and NC Health Choice applicants and their families with a simple, streamlined eligibility and enrollment process that ensures the timely and accurate determination of Medicaid eligibility. County Department of Social Service (DSS) offices will continue to process and determine eligibility for potential beneficiaries until real-time eligibility determination is fully implemented for all populations. At managed care launch, the Department's plan is starting the implementation of a series of technical and process changes with the goal of making significant improvements to the beneficiary's overall experience as they interact with the Department. These changes will be implemented on both the Department's systems, as well as on partner systems. The Department will contract with an Enrollment Broker and leverage the Enrollment Broker's Plan Selection Tool which must allow beneficiaries to receive an eligibility determination in real-time in NC FAST or ePASS, and be redirected in real-time to the plan selection system. The Enrollment Broker will work with the Department to implement state management such that users can be transitioned from one IT system to another without the need for the user to provide a user id and password, and with the appearance of a single IT system and user interface. The Enrollment Broker's Tool must tailor the presentation of plans available to the beneficiary based on a variety of factors, including the beneficiary's location or unique health care needs, the PHP's provider network, and the beneficiary's history with a PHP; all of which are targeted at allowing beneficiaries to select a PHP which best suits their needs. The Department will work with the Enrollment Broker to define the plan selection factors, data transmission interfaces, application program interfaces (APIs), and security requirements to facilitate the exchange of beneficiary PHP selection information between systems.
2. **Choice Counseling:** To support beneficiary education and PHP choice support during the transition to managed care, the Department is focused on ensuring that beneficiaries have the necessary information to make an informed decision in selecting a PHP to meet their needs. The Department will collaborate with the selected Enrollment Broker to provide choice counseling and support PHP and AMH/PCP selection. The Enrollment Broker will be required to integrate with the Department's Medicaid eligibility and enrollment system, known as NC FAST, for choice counseling purposes and interact with NC's 100 county Departments of Social Services, the EBCI and DHHS offices to provide seamless eligibility and enrollment experience for beneficiaries.

As the Department improves the beneficiary experience as mentioned above and builds infrastructure to support a streamlined eligibility and enrollment process, the Enrollment Broker may be expected to integrate with additional systems such as ePASS, state eligibility, MMIS, or other systems not yet identified. The Department anticipates implementing the streamlined Medicaid eligibility and enrollment process as early as the implementation of the managed care program with continued enhancements rolling out over the term of the Enrollment Broker Contract.

3. Ombudsman Program: The Department will develop an Ombudsman Program to aid Medicaid managed care beneficiaries, especially during transition to managed care. The Ombudsman Program is anticipated to begin at a minimum of six (6) months prior to the launch of the managed care program.
4. Multiple Points of Entry: Beneficiaries must be directed to the appropriate source for education, enrollment, and ombudsman services regardless of where the beneficiaries' search begins. Entities with regular beneficiary contact will be able to provide the direction to the appropriate sources, which may include PHPs, local Departments of Social Services (DSS) offices, EBCI PHHS office(s), local health departments, LME-MCOs, beneficiary call centers and the Department's Medicaid website.

#### C. Pending State Law Changes

The Department is working closely with the General Assembly on necessary changes to state law to support the transformation of the Medicaid and NC Health Choice programs, and future managed care program operations. The Department has written this RFP based on the assumption that such changes will be enacted prior to Contract Award. Requirements within this RFP dependent upon and impacted by potential changes in state law requested by the Department have been identified and noted as such throughout the RFP. Proposals submitted by the Offeror in response to this RFP will be evaluated based on the Offeror's demonstrated ability to perform the requirements as contained herein. In the event some or all the changes are not enacted at the time of Contract Award, the Department will negotiate with the Offerors or Contractor adjustments to the requirements to ensure alignment with existing law, regulations, and the Department's authority to contract for the stated services and requirements herein.

## II. GENERAL PROCUREMENT INFORMATION & NOTICE TO OFFERORS

### A. General Procurement Information

#### 1. Definitions

- a. **ARC:** Annual Right to Change. Time at which the member may elect to remain enrolled in his or her current PHP or change to another PHP. In North Carolina, the annual right to change will be linked to the beneficiaries' annual redetermination.

- b. **Auto-Assignment:** Automated process by which the Department enrolls a beneficiary into a PHP if the beneficiary has not selected a PHP within a specified time defined by the Department.
- c. **ACD:** Automated Call Distribution System. An automated system that disperses incoming calls for all member and potential member calls answered at the Enrollment Broker call center to appropriate call center staff.
- d. **Advanced Medical Home (AMH):** Primary care practices which provide comprehensive primary and preventive care services to PHP enrollees, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high risk populations.
- e. **AVRS:** Automated Voice Response System. An automated system that allows members to perform self-service activities and resolve simple inquiries without the need to interact with an agent. The AVRS interacts with the member through voice prompts and recognition of numeric prompts.
- f. **Authorized representative:** An individual or organization authorized under state law to act on behalf of a beneficiary, including but not limited to, a network provider or legal guardian.
- g. **BAA:** Business Associate Agreement. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the contract between a HIPAA-covered entity and HIPAA Business Associate. The BAA protects personal health information (PHI) according to HIPAA guidelines.
- h. **Behavioral Health I/DD Tailored Plan (BH I/DD TP):** The Behavioral Health Intellectual / Developmental Disability Tailored Plan is a plan specifically designed to provide targeted care for individuals with intellectual and/or developmental disabilities.
- i. **Beneficiary:** An individual who is eligible to receive North Carolina Medicaid benefits but who may or may not be enrolled in the managed care program.
- j. **Beneficiary support system:** A system led by the Enrollment Broker, as required under 42 C.F.R. § 438.71, in collaboration with the Department, PHPs and Ombudsman program, which supports beneficiaries before, during and after enrollment in an MCO including outreach and education. The beneficiary support system includes assistance for enrollees in understanding managed care and in navigating the grievance and appeal process within the PHP, as well as appealing adverse benefit determinations by the PHP to a State fair hearing.
- k. **Call Back Requests:** The number of after-hours requests for an outbound call back to be handled on the next business day. This must be included in call center reports.
- l. **Calls Handled:** The number of inbound calls answered by a live call center agent. This must be included in call center reports.
- m. **Calls Offered:** The number of inbound calls received by the call center. These calls include abandoned calls, answered calls, calls diverted to a queue, calls where the caller receives a busy signal, calls sent to voicemail, and calls handled by the AVRS that are not directed to a call center agent. This must be included in call center reports.

- n. **Calls Short Abandoned:** The number of inbound calls offered but that are disconnected by the caller within three (3) seconds and are neither a Call Handled nor a self-service call. This must be included in call center reports.
- o. **CAP/C:** Community Alternatives Program for Children. A North Carolina Medicaid 1915(c) waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
- p. **CAP/DA:** Community Alternatives Program for Disabled Adults. A North Carolina Medicaid 1915(c) waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement.
- q. **Carolina Cares:** A health care program described in pending North Carolina House Bill 662 (2017-2018 Legislative Session) intended to address the needs of citizens of North Carolina committed to a healthy lifestyle who are ineligible for Medicaid due to their income levels but who are otherwise unable to afford health insurance.
- r. **Choice Counseling:** The provision of information and services designed to assist beneficiaries in making PHP enrollment decisions. It includes answering questions and identifying factors to consider when beneficiaries are choosing among managed care plans and primary care/advanced medical home providers. Choice Counseling does not include making recommendations for or against enrollment into a specific PHP.
- s. **Clarification:** In the context of the procurement of the Enrollment Broker contract, a written response from an Offeror that provides an answer or explanation to a question posted by the Department about that Offeror's proposal. Clarifications are incorporated into the Offeror's proposal as part of the response.
- t. **CMS:** The federal Centers for Medicare & Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, Children's Health Insurance Program (CHIP), and health insurance portability standards.
- u. **Contract Effective Date:** The date the Contract is fully executed by the Parties.
- v. **Contractor:** The Offeror awarded the Contract to be NC Medicaid's Enrollment Broker and perform the services and requirements defined herein.
- w. **CP:** Commercial Plan. A type of prepaid health plan defined in North Carolina Session Law 2015-245 as any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to members on a prepaid basis except for enrollee responsibility for copayments and deductibles, and holds a PHP license issued by the North Carolina Department of Insurance.
- x. **Cross-over population:** Refers to current North Carolina Medicaid and NC Health Choice members that are enrolled in the fee-for-service program that will transition to managed care beginning in the year 2019. The Department will transition approximately 1.5 million beneficiaries from the fee-for-service program on June 30, 2019 to the managed care program on the PHP effective date of July 1, 2019 (or

a date determined by the Department).<sup>3</sup> Those beneficiaries transitioned to managed care on that date are referred to as the “cross-over population.”

- y. **Cultural Competency:** The ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of the individuals are met. This includes the ability to interact effectively with people of different cultures helps to ensure the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competency means to be respectful and responsive to the health beliefs and practices and cultural and linguistic needs of diverse populations groups.
- z. **CVO:** Credentialing Verification Organization.
- aa. **Department or DHHS:** The North Carolina Department of Health and Human Services, which is responsible for managing the delivery of health and human related services for all North Carolinians, especially its most vulnerable citizens, which includes children, elderly, people with disabilities and low-income families. The Department works closely with health care professionals, community leaders and advocacy groups, EBCI, local, state, and federal entities; and many other stakeholders.
- bb. **DHB:** Division of Health Benefits. The division within the Department responsible for implementing Medicaid transformation and administering the transformed Medicaid and NC Health Choice programs as described in Session Law 2015-245, as amended.
- cc. **DMA:** Division of Medical Assistance. The division within the Department currently responsible for managing the North Carolina Medicaid and NC Health Choice programs.
- dd. **DMH/DD/SAS:** Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The division that provides quality support to achieve self-determination for individuals with intellectual and/or developmental disabilities, and quality services to promote treatment and recovery for individuals with behavioral or substance use disorders.
- ee. **DSS:** Department of Social Services. These are the federally mandated county administered social service systems that provide a range of direct services addressing poverty, family violence and exploitation. There are 100 county DSS offices in NC.
- ff. **EB:** Enrollment Broker. An individual or entity that performs choice counseling or enrollment activities for beneficiaries enrolling in prepaid health plans.
- gg. **EBCI Public Health and Human Services (PHHS):** The office of the Executive Branch of Tribal Government delegated the responsibility for planning and operations of social services and public health services for EBCI members living on and off trust lands. In addition to the direct responsibilities of developing policy and procedures, this Office also handles all day to day operations of the 24 programs within the Division. These offices include eligibility determination and assistance

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<sup>3</sup> Pending the approval of North Carolina’s amended 1115 waiver application.

for federal, state and tribal social service programs, child care, senior services, veterans' services, domestic violence services, juvenile justice services, women's wellness, home health and public health.

- hh. **Eligibility:** A series of requirements that determine whether an individual is eligible for Medicaid benefits.
- ii. **Employment Supports Provider:** LTSS provider that delivers services for individuals with I/DD that help those individuals find and maintain a job as defined as supported employment under the 1915(b)(3), Innovations waiver, and state funded BH and I/DD services.
- jj. **Enrollment:** The process through which a beneficiary selects or is auto-assigned to a PHP to receive Medicaid benefits through the managed care program.
- kk. **ePASS, Citizen Portal:** ePASS is the State's citizen self-service portal that provides access to information on State programs. The portal includes online screening and applications for Food and Nutrition Services (formerly Food Stamps) as well as Medical Assistance (Medicaid and NC Health Choice or CHIP). ePASS also hosts the secure inbox for recipients. The State may rebrand ePASS as part of Medicaid Transformation, however all references and requirements related to ePASS must remain.
- ll. **ESB:** Enterprise Service Bus. The primary data exchange mechanism for NC FAST and the Medicaid Transformation program. The ESB is a service-oriented platform that leverages NIEM standards. It also orchestrates large file transfers using File Transfer Edition (FTE).
- mm. **Family Member:** Any household member who is on Medicaid/NCHC and included in Managed Care.
- nn. **FFS:** Fee-for-Service. A payment model in which providers are paid for each service provided.
- oo. **Foster Care:** Means, as defined in G.S. § 131-D-10.2(9), "the continuing provision of the essentials of daily living on a twenty-four (24) hours basis for dependent, neglected, abused, abandoned, destitute, orphaned, undisciplined or delinquent children or other children who, due to similar problems of behavior or family conditions, are living apart from their parents, relatives, or guardians in a family foster home or residential child-care facility. The essentials of daily living include but are not limited to shelter, meals, clothing, education, recreation, and individual attention and supervision". For purposes of Medicaid managed care, foster care also includes children in adoptive placement and former foster children up to age twenty-six (26).
- pp. **Head of Household (HOH):** The head of a household consisting of one or more PHP members. The HOH is the only member in that household who can choose a Local Management Entity/Managed Care Organization, Prepaid Health Plan, and Primary Care/AMH Provider for all household members.
- qq. **HIPAA:** Health Insurance Portability and Accountability Act of 1996.
- rr. **Implementation Plan:** Comprehensive schedule of events, tasks, deliverables, and milestones developed and executed by the Contractor to ensure successful

implementation and launch of Enrollment Broker services to support the launch of North Carolina's Medicaid Managed Care program.

- ss. **Innovations waiver:** The 1915 (c) portion of the 1915(b)/(c) waiver that serves people who are at risk for institutional care in an intermediate care facility for people with intellectual disabilities. This program gives people the opportunity to live in a community setting instead of an institution or group home.
- tt. **IPS:** The State of North Carolina's Interactive Purchasing System.
- uu. **KPI:** Key Performance Indicator.
- vv. **LME/MCO:** Local Management Entity/Managed Care Organization. A local management entity that is paid a capitated rate by the Department to provide mental health, developmental disability, and substance use services to Medicaid beneficiaries pursuant to a combination of a section 1915(b) and a section 1915(c) waiver. For the Medicaid population, these entities are recognized under CMS Medicaid managed care rules and are known as a Prepaid Inpatient Health Plans (PIHP). LME/MCOs also manage federal block grant, State, local and county funds for other behavioral health services.
- ww. **Lock-in period:** The period during which a member is not allowed to change plans "without cause" until his or her redetermination.
- xx. **LTSS:** Long-Term Services and Supports. Includes institutional care and home- and community- based long-term services and supports provided to individuals with functional limitations or chronic illnesses who need assistance to perform activities of daily living (e.g., eating, bathing, dressing), along with the instrumental activities of daily living (e.g., preparing meals, managing medication, housekeeping).
- yy. **Maximum Abandoned Call:** The longest time an inbound caller waits before disconnecting without reaching a live call center agent or self-service option. This is measured in seconds. This must be included in call center reports.
- zz. **Maximum Call Answer Time:** The longest time an inbound caller waits before reaching a live call center agent. This is measured in seconds. This must be included in call center reports.
- aaa. **Medicaid:** The joint federal-state health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities.
- bbb. **Medical Care Advisory Committee (MCAC):** A federally required advisory group comprised of governor-appointed members from NC's thirteen (13) state congressional districts and seven (7) at-large members which advises the state Medicaid agency on health and medical care services.
- ccc. **Members:** Beneficiaries specifically enrolled in and receiving benefits through the North Carolina managed care program.
- ddd. **MCO:** Managed Care Organization. Defined in 42 C.F.R. § 438.2 as an entity that has, or is seeking to qualify for, a comprehensive risk contract and meets specified requirements, including the solvency standards of 42 C.F.R. § 438.116.
- eee. **MMIS:** The Department's Medicaid Management Information System.
- fff. **NCDOL:** The North Carolina Department of Insurance.

- ggg. **NC FAST:** North Carolina Families Accessing Services through Technology. The Department's integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
- hhh. **N.C.G.A.:** North Carolina General Assembly
- iii. **N.C.G.S., G.S.:** North Carolina General Statute.
- jjj. **NCID:** North Carolina Identify Management. This is the State's centralized Identity and Access Management System. <https://www.ncid.nc.gov>
- kkk. **NC Mediation Network:** A network of community mediation centers which offers dispute resolution services including mediation opportunities for Medicaid beneficiaries whose services have either been denied or reduced by LME-MCOs.
- lll. **NCTracks:** The Department's multi-payer Medicaid Management Information System (MMIS). The system establishes a centralized repository for recipient and provider information across the Divisions circle of services and programs. It also adjudicates claims for DMA, DMH/DD/SA, Division of Public Health, and Office of Rural Health.
- mmm. **NC Health Choice:** The program that extends health care coverage to children ages six (6) through eighteen (18) whose family income exceeds Medicaid financial eligibility criteria but is at or below two-hundred percent (200%) of the federal poverty level. The federally-recognized name for this program is the Children's Health Insurance Program (CHIP).
- nnn. **NIEM:** National Information Exchange Model. A model that enables efficient information exchange across diverse public and private organizations. It is the XML canonical model used within the Department's Enterprise Service Bus (ESB).
- ooo. **North Carolina Session Law 2015-245, Session Law 2015-245 as amended by S.L. 2016-121 and S.L. 2017-57:** The Medicaid Transformation and Reorganization Act enacted on September 23, 2015, authorizing the transition of the Medicaid and NC Health Choice programs to a managed care delivery system.
- ppp. **Offeror, Vendor:** Supplier, bidder, proposer, firm, company, corporation, partnership, individual or other entity submitting an offer in response to this RFP.
- qqq. **Ombudsman Program:** A new Department program to be established to provide education, advocacy, and issue resolution for Medicaid beneficiaries whether they are in the managed care program or the fee-for-service program. This program is separate and distinct from the Long-Term Care Ombudsman Program.
- rrr. **Open Enrollment Period:** Sixty (60) day period prior to implementation of North Carolina's Medicaid Managed Care program during which the cross-over population will be able to actively select a PHP with the support of the Enrollment Broker.
- sss. **PACE:** Program of All-Inclusive Care for the Elderly. A federal program that provides a capitated benefit for individuals age fifty-five (55) and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

- ttt. **PCP:** Primary Care Provider. A provider trained to give basic care and typically seen first for most health problems. The PCP makes sure that each beneficiary gets care needed to keep them healthy, and may coordinate referrals to other doctors and health providers when needed.
- uuu. **PHI:** Protected Health Information. Any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity (or a Business Associate of a Covered Entity) and can be linked to a specific individual.
- vvv. **PHP:** Prepaid Health Plan. As defined in Session Law 2015-245, a PHP is an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of covered services.
- www. **PII:** Personal Identifiable Information. Any data that could potentially identify a specific individual. Any information that can be used to distinguish one person from another and can be used for de-anonymizing anonymous data that can be considered PII.
- xxx. **PLE:** Provider-Led Entity. As defined in Session Law 2015-245, as amended by Session Laws 2016-121 and 2017-57, a PLE is “[a]n entity that meets all of the following criteria: (1) a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated plan offered by the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services or Medicaid and NC Health Choice providers; (2) a majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program; and (3) holds a PHP license issued by the North Carolina Department of Insurance.”
- yyy. **Qualified interpreter:** An interpreter who can provide remote interpreting service or an on-site appearance for an individual with limited English proficiency. The interpreter must adhere to generally accepted interpreter ethics principles including client confidentiality, demonstrate proficiency in speaking and understanding both spoken English and at least one other spoken language, and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.
- zzz. **Real-time:** Real-time refers to the synchronous exchange of data between IT systems resulting in immediate access to or update of data on which resides in another IT system. In most cases, this will be accomplished using web services.
- aaaa. **SAML:** Security Assertion Markup Language. This is the State’s preferred standard for the implementation of identify and access management.
- bbbb. **Self-Service Calls:** The number of inbound calls resolved by the call center AVRS and not by a live call center agent. This must be included in call center reports.
- cccc. **SP:** Standard Plan. A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most Medicaid and NC Health Choice beneficiaries.

- dddd. **TBI waiver:** Traumatic Brain Injury waiver. A proposed 1915(c) waiver that would provide home- and community-based services to individuals with TBI, if approved by CMS.
- eeee. **With cause disenrollment:** Type of disenrollment in which member may request to change from one PHP to another based on for cause reasons such as moving outside a PHP's region.
- ffff. **Without cause disenrollment:** Type of disenrollment in which member may request to change from one PHP to another during the ninety (90) days after PHP enrollment. Also referred to as the 90-day choice period.

2. Instruction to Offerors

- a. *READ, REVIEW, AND COMPLY:* It shall be the Offeror's responsibility to read this entire document and review all enclosures and attachments specified herein, regardless of whether appearing in these Instructions to Offerors or elsewhere in this RFP document.
- b. *EXECUTION:* Failure to sign the Execution page (page iii of v of the RFP) in the indicated space or return all attachments, completed and signed where required, will render the proposal non-responsive and it shall be rejected.
- c. *INFORMATION AND DESCRIPTIVE LITERATURE:* Offeror shall furnish all information requested as part of this RFP. Each Offeror shall submit with their proposal detailed narratives, diagrams, exhibits, examples, sketches, descriptive literature, complete specifications, etc. to support the services and products offered.
- d. *RECYCLING AND SOURCE REDUCTION:* It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable, and less toxic to the extent that the purchase or use is practicable and cost-effective. The State also encourages and promotes using minimal packaging and the use of recycled/recyclable products in the packaging of commodities purchased. However, no sacrifice in quality of packaging will be acceptable. The Offeror remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Offerors are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.
- e. *SUSTAINABILITY:* To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all proposals meet the following:
- i. All copies of the proposal are printed double sided;
  - ii. All submittals and copies are printed on recycled paper with a minimum post-consumer content of 30%;
  - iii. Unless necessary, all proposals and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable; and

- iv. Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.
  - f. *HISTORICALLY UNDERUTILIZED BUSINESSES*: Pursuant to G.S. § 143-48 and Executive Order 150 (1999), the Department invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled.
  - g. *MISCELLANEOUS*: Masculine pronouns shall be read to include feminine pronouns, and the singular of any word or phrase shall be read to include the plural and vice versa.
  - h. *INFORMAL COMMENTS*: The Department shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the Department during the competitive process or after award. The Department is bound only by information provided in this RFP and in formal Addenda issued.
  - i. *COST FOR PROPOSAL PREPARATION*: Any costs incurred by Offeror in preparing or submitting proposals are the Offeror's sole responsibility. The Department will not reimburse any Offeror for any costs incurred prior to award.
  - j. *OFFEROR'S REPRESENTATIVE*: Each Offeror shall submit with its proposal the name, title, email address, physical address, and telephone number of the person(s) with authority to bind the firm and answer questions or provide clarification concerning the firm's proposal.
  - k. *INSPECTION AT OFFEROR'S SITE*: The Department reserves the right to inspect, at a reasonable time, the equipment/item, plant, or other facilities of a prospective Offeror prior to Contract award, and during the Contract term as necessary for the Department determination that such equipment/item, plant or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.
  - l. *TRAVEL EXPENSES*: All travel expenses associated with the performance of the Contract *must be* included in the Offeror's Cost Proposal. Separately stated or invoiced travel expenses *will not* be reimbursed.
3. Request for Proposal
- a. This RFP is comprised of this RFP document in its entirety, addenda that may be released before contract award, the Offeror's proposal with their proposal, clarifications, and any Best and Final Offers (BAFOs) that are duly incorporated herein by reference. It shall be the Offeror's responsibility to read the Instructions, Terms and Conditions, specifications, requirements, exhibits and attachments, and any other components made a part of this RFP, and comply with all instructions and directives herein. The Offeror is responsible for

obtaining and complying with all Addenda and other changes that may be issued relating to this RFP.

- b. All additional, modified, or conflicting terms and conditions submitted on or with the Offeror's proposal *shall be disregarded* and shall not be considered a part of any contract arising from this RFP. Except as provided below in II.A.3.c., any attempt to delete or avoid the force of the previous sentence shall render the Offeror's proposal invalid, and the proposal shall not be considered.
- c. If the Offeror has questions, issues, or exceptions regarding any term, condition, instruction, or other component within this RFP, those *must be submitted* on a separate page titled "Request for Proposed Modifications to the Terms and Conditions." The Department, in its sole discretion, may consider any proposed modifications identified by the Offeror. Where necessary, any modification(s) to the terms and conditions agreed upon by the Department may be incorporated as part of a BAFO or Contract Amendment after award. Other than through this process, the Department rejects and shall not be required to evaluate or consider any additional or modified terms, conditions, or instructions included in the Offeror's proposal.
- d. This applies to any language appearing in or attached to the RFP document as part of the Offeror's proposal that purports to vary any terms and conditions, or Offerors' instructions therein to render the proposal non-binding or subject to further negotiation. Offeror's proposal to this RFP shall constitute a firm offer. **By execution and delivery of a proposal to this RFP, the Offeror agrees that any additional or modified terms and conditions, including Instructions to the Offeror, whether submitted purposely or inadvertently, or any purported condition to the offer, shall have no force or effect, and will be disregarded. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject Offeror's proposal.**

4. Request for Proposal (RFP) functionality

- a. This RFP serves two functions:
  - i. Define the specifications of the services being sought by the Department; and
  - ii. Provide the requirements and terms of any contract resulting from this procurement.
- b. All Terms and Conditions (T&Cs) in this RFP shall be enforceable as Contract Terms. The use of phrases such as "shall", "will", "must", "required" and "requirements" are intended to create enforceable Contract conditions. In determining whether proposals should be evaluated or rejected, the Department will take into consideration the degree to which Offerors have proposed or failed to propose solutions that are responsive to the Department's needs as describe in this RFP.

5. Right Reserved

Offerors are cautioned that this is a Request for Proposals, not a request to contract, and the Department reserves the unqualified right to reject all offers deemed failing to meet minimum requirements, not responsive, incomplete, or non-compliant with the

requirements described herein; or when such rejection is deemed to be in the best interest of the Department.

The Department may also:

- a. Waive any formality;
- b. Waive any undesirable, inconsequential, or inconsistent provisions of this RFP;
- c. If the responses to this solicitation demonstrate a lack of competition, or offers are found non-responsive, negotiate directly with one or more Offerors; and
- d. Not award, or if awarded, terminate any contract if the Department determines adequate Department funds are not available.

6. Right to Cancel Request for Proposal

The Department reserves the right to cancel this Request for Proposal at any time. Notice of Cancellation will be posted on the State's Interactive Purchasing System.

7. Changes in RFP Specifications

- a. Offerors are cautioned that the requirements of this RFP can only be altered by written Addendum issued by the Department, and that oral communications from whatever source(s) are of no effect.
- b. The Department reserves the right to modify any specification contained herein without modifying the timelines in this RFP. Any modification to specifications will be specified in an Addendum posted to IPS.

8. Contract Award

Upon conducting a comprehensive, fair, and impartial evaluation of the proposals received in response to this RFP, the Department reserves the right to award the contract(s) resulting from this RFP to a single or multiple Offerors. Upon award, the Department will sign the "Acceptance of Proposal" found at the bottom of the Execution of Proposal section, thus resulting in the formation of the Contract(s). Within two (2) business days after notification of award, the Offeror must register in NC E-Procurement @ Your Service. See <http://vendor.ncgov.com>.

9. Required Proposal Documents

Offerors are required to return and complete the following documents where indicated and return all listed with their response.

- a. Completed and signed EXECUTION PAGE, along with the entire body of this RFP, and signed receipt pages of any addenda released in conjunction with the RFP.
- b. Completed and signed ATTACHMENT A: MINIMUM REQUIREMENTS TABLE.
- c. Technical Proposal to address all requirements and specifications identified within this RFP. Offerors should include detailed narratives, diagrams, exhibits, examples, samples, descriptive literature, complete specifications, etc. to demonstrate their ability to fulfill each requirement and specification. This must be marked as ATTACHMENT B: TECHNICAL PROPOSAL.
- d. Cost Proposal. This must be marked as ATTACHMENT C: COST PROPOSAL.

- e. Completed ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL.
- f. Completed and signed ATTACHMENT E: LOCATION OF WORKERS UTILITZED BY CONTRACTOR.
- g. Completed and signed ATTACHMENT F: BUSINESS ASSOCIATE AGREEMENT.
- h. Completed and signed ATTACHMENT G: CERTIFICATION OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY.
- i. Completed ATTACHMENT H: OFFEROR'S CLIENT REFERENCES.
- j. ATTACHMENT I: NC MEDICAID AND HEALTH CHOICE HISTORICAL ENROLLMENT.
- k. ATTACHMENT J: PROPOSED MANAGED CARE ELIGILBTY AND ENROLLMENT PROCESS FLOWS.
- l. ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM.
- m. ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS.
- n. ATTACHMENT M: ANTICIPATED CONTRACT REQUIREMENTS AND IMPLEMENTATION SCHEDULE.
- o. ATTACHMENT N: BUSINESS CONTINUITY MANAGEMENT PROGRAM.

10. Proposal Submission

Sealed responses of the Offeror's proposal, subject to the conditions made a part hereof and the receipt requirements described herein, must be received at the address indicated below.

MAILING ADDRESS FOR DELIVERY OF PROPOSAL VIA U.S. POSTAL SERVICE	OFFICE ADDRESS FOR DELIVERY BY ANY OTHER MEANS, SPECIAL DELIVERY, OVERNIGHT DELIVERY, OR BY ANY OTHER CARRIER
PROPOSAL NUMBER: 30-180090 Attn: Ken Dahlin Department of Health and Human Services Office of Procurement and Contracts 2008 Mail Service Center Raleigh, NC 27699-2008	PROPOSAL NUMBER: 30-180090 Attn: Ken Dahlin Department of Health and Human Services Office of Procurement and Contracts 801 Ruggles Drive Raleigh, NC 27603

Offeror **must** deliver the following simultaneously to the address identified in the above by **April 13, 2018 at 2:00 PM EST**:

- a. One (1) signed, original executed response;
- b. Three (3) copies of the signed, original executed response;
- c. One (1) copy of the signed, original executed response on CD, DVD, or flash drive marked **RFP 30-180090**; and
- d. One (1) electronic copy of the signed, original executed response *redacted* in accordance with G.S. § 132, the Public Records Act, on a separate CD, DVD, or flash drive marked **RFP 30-180090 - Redacted**. For the purposes of this RFP, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Offeror and meets the definition of Confidential Information set forth in G.S. § 132-1.2. If the response does not contain

Confidential Information, Offeror should submit a signed statement to that effect as ***RFP 30-180090 - Redacted***.

The electronic copies of the response must not be password protected.

**IMPORTANT NOTE:** It is the responsibility of the Offeror to have the above documents and electronic copies physically in the Office provided above by the specified time and date of opening, regardless of the method of delivery. This is an absolute requirement. The time of delivery will be marked on each proposal when received, and any proposal received after the submission deadline **will not be accepted or evaluated.**

All risk of late arrival due to unanticipated delay, whether delivered by hand, U.S. Postal Service, courier or other delivery service or method, is entirely on the Offeror. Note that the U.S. Postal Service generally does not deliver mail to the street address above, but to the State's Mail Service Center stated above. The Offeror is cautioned that proposals sent via U.S. Mail, including Express Mail, may not be delivered by the Mail Service Center to the Department's Purchasing Office on the Due Date and time to meet the proposal submission deadline. The Offeror is urged to take the possibility of delay into account when submitting a proposal.

11. Confidentiality

- a. As provided for in the North Carolina Administrative code (NCAC), including but not limited to 01 NCAC 05B.
- b. 0210, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature. In accordance with these and other applicable rules and statutes, such material shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by G.S. § 132, **must be clearly marked as such and reflected in the redacted copy submitted on RFP 30-180090 - Redacted as applicable.** By submitting a redacted copy, the Offeror warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked **Confidential** and/or **Redacted** meet the requirements of G.S. § 132. The Offeror must identify the legal grounds for asserting that the information is confidential, including the citation to state law. **However, under no circumstances shall price information be designated as confidential.**
- c. Except as otherwise provided above in 11.a., pursuant to G.S. § 132-1, et seq., information or documents provided to the Department in response to this RFP are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, G.S. § 132-1.2. Redacted copies provided by Offerors to the Department may be released in response to public record requests without notification to the Offeror.

- d. During the period spanning the issuance of the RFP and Contract award, possession of proposals, accompanying information, and subsequent negotiations are limited to personnel of the Department and any third parties involved in this procurement process. Any attempt on behalf of an Offeror to gain such confidential information, or to influence the award process in any way, is a violation of North Carolina purchasing laws and regulations, and shall constitute sufficient grounds for disqualification of Offeror's offer from further evaluation or consideration at the sole discretion of the Department.
- e. The Department may serve as custodian of Offeror's confidential information and not as an arbiter of claims against Offeror's assertion of confidentiality. If an action is brought pursuant to G.S. § 132-9 to compel the Department to disclose information marked confidential, the Offeror agrees that it will intervene in the action through its counsel and participate in defending the Department, including any public official(s) or public employee(s). The Offeror agrees that it shall hold the Department, State of North Carolina, and any official(s) and individual(s) harmless from all damages, costs, and attorneys' fees awarded against the Department in the action. The Department agrees to promptly notify the Offeror in writing of any action seeking to compel the disclosure of Offeror's confidential information. The Department shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The Department shall have no liability to Offeror with respect to the disclosure of Offeror's confidential information ordered by a court of competent authority pursuant to G.S. § 132-9 or other applicable law.
- f. The Offeror agrees to use commercial best efforts to safeguard and protect any data, documents, files, and other materials received from the Department or an appropriate State entity during performance of any contractual obligation from loss, destruction, or erasure. The Offeror agrees to abide by all facilities and security requirements and policies of the Department or designated areas where work is to be performed. All Offeror personnel shall abide by such facilities and security requirements and shall agree to be bound by the terms and conditions of the Contract.
- g. The Offeror warrants that all its employees and any approved third-party contractors or subcontractors are subject to a non-disclosure and confidentiality agreement enforceable in North Carolina. The Offeror will, upon request by the Department or an appropriate State entity, verify and produce true copies of any such agreements. Production of such agreements by Offeror may be made subject to applicable confidentiality, non-disclosure, or privacy laws; if Offeror produces satisfactory evidence supporting exclusion of such agreements from disclosure under the N.C. Public Records laws in G.S. § 132-1 *et seq.* The Department or appropriate State entity may, in its sole discretion, provide a non-disclosure and confidentiality agreement for the Offeror's execution. The Department or appropriate State entity may exercise its rights as necessary or proper, in its discretion, to comply with applicable security regulations or statutes including, but not limited to 26 U.S.C. 6103 and IRS Publication 1075, (Tax Information Security Guidelines for Federal, State, and Local Agencies), HIPAA, 42 U.S.C. 1320(d) (Health

Insurance Portability and Accountability Act), any implementing regulations in the Code of Federal Regulations, and any future regulations imposed upon the Department pursuant to future statutory or regulatory requirements.

- h. The Offeror agrees and specifically warrants that it, its officers, directors, principals and employees, and any subcontractors, shall hold all information received during performance of the Contract in the strictest confidence and shall not disclose the same to any third party without the express written approval of the Department or appropriate State entity. The Offeror shall protect the confidentiality of all information, data, instruments, studies, reports, records, and other materials provided to it by the Department or maintained or created in accordance with this Contract. No such information, data, instruments, studies, reports, records, and other materials in the possession of Offeror shall be disclosed in any form without the prior written consent of the Department or appropriate State entity. The Offeror will have written policies governing access to and duplication and dissemination of all such information, data, instruments, studies, reports, records, and other materials.
- i. All project materials, including software, data, and documentation created during the performance or provision of services hereunder that are not licensed to the Department or other State entity, or are not proprietary to the Offeror are the property of the State of North Carolina, and must be kept confidential or returned to the Department, or destroyed. Proprietary Offeror materials shall be identified to the Department by the Offeror prior to use or provision of services hereunder and shall thereby remain the property of the Offeror. Derivative works of any Offeror proprietary materials prepared or created during the performance of provision of services hereunder shall be subject to a perpetual, royalty free, nonexclusive license to the Department and State.

12. Offeror Questions Concerning this RFP

Written questions concerning this RFP will be received until **March 8, 2018** at 2:00 PM EST. They must be sent via email to [Ken.Dahlin@ddhs.nc.gov](mailto:Ken.Dahlin@ddhs.nc.gov). Please insert “**Questions RFP 30-180090**” as the subject of the email. The questions should be submitted in the format below.

RFP Citation (i.e. Section & page number)	Offeror Question	Department Response (*to be completed by the Department and posted to IPS on <b>March 19, 2018</b> )
1.		
2.		

The Department will prepare responses to all written questions submitted by the stated deadline and post an Addendum to IPS. Offerors are cautioned that contacting anyone other than **Ken Dahlin** may be grounds for rejection of said Offeror’s response.

13. Falsified Information

The Department may initiate proceedings to debar an Offeror from participation in the bid process and from contract award as authorized by North Carolina law if it is determined that the Offeror has withheld relevant or provided false information.

14. Administrators for the Contract

The contract administrators are the persons to whom notices provided for in this contract shall be given, and to whom matters relating to the administration of this contract shall be addressed. Either party may change its administrator or his/her address and telephone number by written notice to the other party. **The Offeror must complete the table below providing the Contractor's Contract Administrator's information.**

a. ***For the Department***

*Contract Administrator for all contractual issues listed herein:*

Name & Title	Kimberley Kilpatrick, Contract and Compliance Specialist, Division of Health Benefits
Address 1 Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7015
Fax Number	919-832-0225
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov

*Contract Administrator regarding day to day activities herein:*

Name & Title	Debra Farrington, Senior Program Manager, Division of Health Benefits
Address 1 Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7025
Fax Number	919-832-0225
Email Address	Debra.Farrington@dhhs.nc.gov

*Department's Federal (HIPAA), NC State and NC DHHS Compliance Coordinator for all privacy and security matters herein:*

Name & Title	Pyreddy Reddy, DHHS CISO
Address 1	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	<a href="mailto:Pyreddy.Reddy@dhhs.nc.gov">Pyreddy.Reddy@dhhs.nc.gov</a>

**b. For the Offeror**

*Contract Administrator for all contractual issues listed herein:*

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

*Contract Administrator regarding day to day activities herein:*

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

*HIPAA or Compliance Officer for all privacy matters herein:*

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

15. Important Events and Schedule

The Department will make every effort to adhere to the following schedule. The Department reserves the right to adjust the schedule and will post an Addendum on the Interactive Purchasing System (IPS) website.

**RFP SCHEDULE**

<b>Action</b>	<b>Responsible Party</b>	<b>Date</b>
Issue RFP	Department	March 2, 2018
Deadline to Submit Offeror Questions to the Department	Offerors	March 8, 2018
Response to Offeror Questions	Department	March 19, 2018
Submission of Offer	Offerors	April 13, 2018
Offer Evaluation	Department	April 13 – May 31, 2018
Contract Award	Department	May 31, 2018
Contract Effective Date	Department and selected Offeror	The date Contract is fully executed by the Parties

**B. RFP Evaluation Process**

The Evaluation Process will commence on the date and time responses are unsealed as defined in this RFP. The Department will utilize the phases, evaluation method and scoring/weighting criteria stated herein for the evaluation of each Offeror's proposal.

1. Evaluation Phases

*Phase 1* – The Department will review each Offeror's proposal to validate that all required proposal documents are included and completed, and all Instructions to Offerors have been followed. Failure to adhere to these requirements may render the Offeror's response incomplete and may be grounds for rejection during Phase 1.

*Phase 2* – The Department will determine if Minimum Requirements are met as required in ATTACHMENT A: MINIMUM REQUIREMENTS TABLE. If the Offeror does not provide the required information, or the Department determines that the Offeror does not meet the Minimum Requirements, that Offeror's response shall be excluded from further consideration and evaluation during Phase 2.

*Phase 3* – The Department will create an Evaluation Committee to review the Offeror's Technical Response and Cost Proposal. The Department reserves the right to request clarifications from any Offeror, and such clarifications must be submitted in writing to

the Offeror to respond. However, the Department *is not required* to request clarifications from any Offeror. Each Offeror should exercise due diligence to ensure their response is clear and addresses all requirements of this RFP.

*Phase 4* – The Department reserves the right to enter into negotiations with any Offeror to establish a favorable contract that is in the best interest of the Department. Such negotiations may result in modifications to the Offeror’s Technical Response and/or Cost Proposal.

*Phase 5* - The Evaluation Committee will make an Award Recommendation. Upon approval of the recommendation by the Department, the Notice of Award will be issued with the Department executing the Contract with the successful Offeror.

2. Evaluation Method

A one-step process shall be used. The Offeror’s Technical Response and Cost Proposal will be evaluated simultaneously. Qualified responses will be evaluated, and acceptance will be made in accordance with Best Value procurement practices.

3. Scoring, Criteria, and Overall Weights

- a. The Department will evaluate the Offeror’s proposal for completeness and reasonableness and to determine if it complies with the instructions described in the RFP.
- b. The Offeror’s response will be evaluated and scored on several factors. The Technical Response, including the written response, clarifications, oral presentations (if requested by the Department), and the Cost Proposal will be scored based on an overall weighted point scale developed by the Department.
- c. The proposal with the lowest cost for a particular section that is scored will receive the total number of points allocated for that section. Other proposals will be assigned a portion of the score using the formula:

Total number of points allocated for cost proposal section multiplied by  
(lowest cost proposal divided by overall proposed cost) for the proposal  
section being evaluated.

- d. Scoring of proposals will reflect the following weights/percentages:

Minimum Requirements *	Scoring Weight/Percentage
Agree to Terms & Conditions	Meets/Does Not Meet
Financial Stability and Legal Action Disclosure	Meets/Does Not Meet
Experience:	
Enrollment broker services for Medicaid program with at least 400,000 beneficiaries	Meets/Does Not Meet

Call Center support for choice counseling and enrollment broker services for open enrollment population of at least 400,000	Meets/Does Not Meet
Integration with existing Medicaid program eligibility and customer service systems	Meets/Does Not Meet
<i>* Offerors receiving a "Does Not Meet" score will be disqualified</i>	

	Scoring Weight/Percentage
<b>Technical Proposal</b>	
Qualifications, Experience and Federal Requirements	4.0%
NC Medicaid and Health Choice Enrollment	1.0%
Member Appeals of Disenrollment	4.0%
Beneficiary Support Under Managed Care	4.0%
Beneficiary Grievances	4.0%
Member Outreach, Education and Materials	4.0%
Language Accessibility and Cultural Competency	2.0%
Call Center Support	4.0%
Enrollment Services Website and PHP Selection Tool	3.0%
Beneficiary Management Platform	2.0%
Consolidated Beneficiary Facing Provider Directory	4.0%
Mailing Requirements	1.0%
Enrollment Information System Integration	4.0%
Staffing and Key Personnel	4.0%
Account Management	1.0%
Training	2.0%
Fraud Waste and Abuse	3.0%
Performance Reporting and Delivery Requirements	1.0%
Reconciliation	4.0%
Security and Audit Requirements	1.0%
Business Continuity Plan	2.0%
Member Enrollment Satisfaction Survey	2.0%
Readiness Review	2.0%
Implementation Plan	3.0%
System Interface Plan	3.0%
Use Scenarios	4.0%
References	2.0%
<b>Total Technical Proposal</b>	<b>75.0%</b>
<b>Cost Proposal</b>	<b>25.0%</b>
<b>Total</b>	<b>100.0%</b>

### C. Contract Term

The Contract awarded pursuant to this RFP shall be effective upon execution by the Parties. The Contract Term is the period beginning on the Effective Date through December 31, 2020. The Department reserves the option, at its discretion, to extend the Contract for up to three (3) additional one (1) year periods, or a shorter period as required by the Department.

### D. Responding to the Scope of Work

#### 1. Consideration

For consideration, each proposal must clearly demonstrate all the requirements stated within this RFP. The Department reserves the right to reject proposals deemed incomplete, non-responsive or non-compliant with the RFP requirements. The Offeror must demonstrate it will comply with the requirements scope of work within this RFP, and must provide a detailed description to demonstrate its ability to fulfill each requirement.

#### 2. Responses to Scope of Work Requirements

The proposal must meet all minimum requirements of this RFP, including the completion and return of all attachments as indicated. The proposal must clearly articulate and address all requirements of this RFP. The Offeror must provide a detailed narrative description with supporting information that may include diagrams, exhibits, examples, sketches, descriptive literature, etc.

For some requirements, the Offeror may need to provide an affirmative statement to the question or requirement by, at a minimum, inserting the word CONFIRM in its proposal.

The Offeror must describe any limitations, qualifications or contingences impacting the ability to perform as required by the RFP. If limitations are not identified, the Offeror must perform as defined within this RFP.

The Offeror must not include any assumptions in its proposal. The Offeror should seek clarity on any questions or concerns during the defined Question/Answer period.

#### 3. Qualifications and References

The Department requires a contractor with a proven history of providing Enrollment Broker services, choice counseling and plan selection for Medicaid beneficiaries to support NC's Medicaid Transformation to a Managed Care model.

- a. To demonstrate the Offeror is qualified to meet the on-going demands of the Department, the Offeror must provide:
  - i. A description of the company, its operations, and ownership; and
  - ii. A description of any related expertise in the services required as part of this RFP, including the details of the experience and number of years providing the services.

- b. To support the Offeror's financial stability necessary to perform the services of this RFP, the Offeror must submit the required documents and information marked as ATTACHMENT G: CERTIFICATION OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY.
  - c. To support the Offeror's ability to provide a high level of quality services, the Department requires client references. These clients will be contacted and asked to respond to questions developed by the Department regarding Offeror's performance of services similar to those outlined in this RFP. The Offeror must provide a reference to meet each of the specific requirements stated in ATTACHMENT H: OFFEROR'S CLIENT REFERENCES.
4. Investigation and Inspection
- The Department may make such reasonable investigations or readiness reviews to determine the ability of the Offeror to perform the services, and the Offeror must furnish to the Department all such information and data within requested timeframes. The Department reserves the right to inspect Offeror's physical facilities, including any located outside of North Carolina prior to award and at any time during the contract period to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, the Offeror fails to satisfy the Department that the Offeror is properly qualified to carry out the obligations of the contract and to provide the required services.
5. Cost Proposal
- a. The Offeror must provide a proposal for the cost of the services required within this RFP and defined in its proposal by completing ATTACHMENT C: COST PROPOSAL. The cost proposal must provide all-inclusive, turn-key costs for services provided under the Contract, including all direct and indirect costs and any other expenses. The Department reserves the right to reject proposals deemed incomplete or non-compliant with this requirement.
  - b. The Department reserves the right to negotiate costs with one or more Offerors prior to Contract Award.
  - c. At any time during the Contract Term, the Department reserves the right to negotiate payment to the Offeror because of an increase or decrease in population, federal or state regulatory changes, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes, including but not limited, to the inclusion of additional populations into the managed care program, such as dual eligible or upon legislative action regarding Carolina Cares.

## E. Contract Terms and Conditions

- 1. **ACCESS TO PERSONS AND RECORDS:** Pursuant to G.S. § 147-64.7 and G.S. § 143-49(9), the Department, the State Auditor, appropriate State or federal officials, and their respective authorized employees or agents are authorized to examine all books, records, and accounts of the Contractor as far as they relate to transactions with any department, board, officer, commission, institution, or other agency of the State of

North Carolina pursuant to the performance of the Contract or to costs charged to the Contract. The Contractor shall retain any such books, records, and accounts for a minimum of three (3) years after the completion of the Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must duly adhere to such changes or additions.

2. **ADVERTISING:** Contractor agrees not to use the existence of this Contract or the name of the Department or State of North Carolina as part of any commercial advertising or marketing of its products or services. A Contractor may inquire whether the Department is willing to act as a reference by providing information directly to other prospective customers. The Department is under no obligation to serve as a reference.
3. **AFFIRMATIVE ACTION:** The Contractor will take affirmative action in complying with all Federal and State requirements concerning fair employment and employment of people with disabilities and concerning the treatment of all employees without regard to discrimination because of race, color, religion, sex, national origin, or disability.
4. **AMENDMENTS:** This Contract may be amended only by written amendments duly executed by the Department and the Contractor.
5. **ASSIGNMENT:** No assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted.

However, upon written request approved by the Department and solely as a convenience to the Contractor, the Department may:

- a. Forward the Contractor's payment check directly to any person or entity designated by the Contractor; and
- b. Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check.

In no event shall such approval and action obligate the Department to anyone other than the Contractor, and the Contractor shall remain responsible for fulfillment of all Contract obligations. Upon advance written request, the Department may, at its discretion, approve an assignment to the surviving entity of a merger, acquisition or corporate reorganization, if made as part of the transfer of all or substantially all the Contractor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of this Contract.

6. **AVAILABILITY OF FUNDS:** All payments to Contractor are expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the Department for the purposes set forth in the Contract. If the Contract or any Purchase Order issued hereunder is funded in whole or in part by federal funds, the Department's performance and payment shall be subject to and contingent upon the continuing availability of said federal funds for the purposes of the Contract or Purchase Order. If the term of the Contract extends into fiscal years after that in which it is approved, such continuation of the Contract is expressly contingent upon the appropriation, allocation,

and availability of funds by the N.C. General Assembly for the purposes set forth in this RFP. If funds to effect payment are not available, the Department will provide written notification to the Contractor. If the Contract is terminated under this paragraph, the Contractor agrees to take back any affected Deliverables and software not yet delivered under the Contract, terminate any Services supplied to the Department under the Contract, and relieve the Department of any further obligation thereof. The Department shall remit payment for Deliverables and Services accepted prior to the date of the previously mentioned notice in conformance with the payment terms.

7. **CHANGE IN CORPORATE STRUCTURE:** In cases where Contractor(s) are involved in corporate consolidations, acquisition or mergers, the Parties may negotiate agreements for the transfer of contractual obligations and the continuance of contracts within the framework of the new corporate structure.
8. **COMPLIANCE WITH LAWS:** Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business and performance in accordance with this contract, including those of federal, state, and local departments and agencies having jurisdiction and/or authority.
9. **COPYRIGHT:** North Carolina Public Records Laws requires all documents created for public transactions/business shall become public records, therefore, no deliverable items produced in whole or in part under this Contract shall be the subject of an application for copyright by or on behalf of the Contractor, except as otherwise provided herein. The State shall own all deliverables that the Contractor is required to deliver to the Department pursuant to this RFP, except as provided herein. Contractor shall not acquire any right, title, and interest in and to the copyrights for goods, all software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products provided by the State to Contractor. The State shall, upon payment for the Deliverables in full in accordance with the payment terms of the Contract, own copyrighted works first originated and prepared by the Contractor for delivery to the State. The State hereby grants Contractor a royalty-free, fully paid worldwide, perpetual, nonexclusive, irrevocable license for the Contractor's business use, to non-confidential Deliverables first originated and prepared by the Contractor for delivery to the State. Contractor shall maintain ownership of all pre-existing intellectual property that it provides to the State as part of the Deliverable(s), and the State shall have a royalty-free, fully paid, worldwide, perpetual, non-exclusive, irrevocable license to use such intellectual property solely for its operations. The intellectual property terms of this Contract do not: (i) affect Contractor's ownership of all other intangible intellectual property (e.g., processes, ideas, know how) that Contractor has developed in the course of performance hereunder, (ii) prevent Contractor from selling similar services elsewhere, or (iii) prevent Contractor from marketing, licensing or selling any and all intellectual property it develops hereunder to other customers, provided no State confidential information is used or disclosed in the process.

The Contractor shall take reasonable steps to provide deliverables under the Contract in such a manner to avoid the necessity for challenging the production of such deliverables pursuant to the North Carolina Public Records Law. In the event Contractor believes that any deliverable necessarily includes information that would be exempted from disclosure by the North Carolina Public Records Law, Contractor shall draft the deliverable in such a way that the deliverable can be produced with a minimum of redaction. In any event, the burden shall be on Contractor to defend at its expense any claim that information within the deliverable is exempt from production under the North Carolina Public Records Law. Subject to this requirement, the State agrees to use reasonable efforts to safeguard and protect from disclosure materials received from Contractor and appropriately identified as Contractor Confidential Information.

10. **DEFAULT:**

- a. If, through any cause, the Contractor shall fail to fulfill in timely and proper manner the obligations under this Contract, the Department shall have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. In case of default by the Contractor for any reason, the Department may procure substitute services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. Default or Termination for Cause may be cause for debarment.
- b. In addition, in the event of default by the Contractor under this Contract or upon the Contractor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against the Contractor, the Department may immediately cease doing business with the Contractor, immediately terminate this Contract for cause, and act to debar the Contractor from doing future business with the State.
- c. If Contractor fails to deliver or provide correct Services or other Deliverables within the time required by the Contract, the Department shall provide written notice of said failure to Contractor, and by such notice require performance assurance measures pursuant to G.S. § 143B-1340(f). Contractor is responsible for the delays resulting from its failure to deliver or provide services or other Deliverables.
- d. Should the Department fail to perform any of its obligations upon which Contractor's performance is conditioned, Contractor shall not be in default for any delay, cost increase or other consequences resulting from the Department's failure. Contractor will use reasonable efforts to mitigate delays, costs or expenses arising from assumptions in the Contractor's offer documents that prove erroneous or are otherwise invalid. Any deadline that is affected by any such failure in assumptions or performance by the Department shall be extended by an amount of time reasonably necessary to compensate for the effect of such failure.
- e. Contractor shall provide a plan to cure any delay or default if requested by the Department. The plan shall state the nature of the delay or default, the time required for cure, any mitigating factors causing or tending to cause the delay or default, and such other information as the Contractor may deem necessary or proper to provide.

11. **DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION:** The Contractor's failure to

fully and timely comply with the terms of this section, including providing reasonable assurances satisfactory to the State, may constitute a material break of the Contract. The Contractor shall disclose any current litigation or potential criminal activity as defined in the section in ATTACHMENT G: CERTIFICATON OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY.

- a. The Contractor shall notify the State in its offer, if it, or any of its subcontractors, or their officers, directors, or key personnel who may provide Services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception. The Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding involving the Contractor or any subcontractor, or any of the forgoing entities' then current officers or director during the term of the Contract or any Scope Statement awarded to the Contractor.
- b. The Contractor shall notify the State in its offer, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments against it or its subcontractors during the three (3) years preceding its offer, or which may occur during the term of any awarded to the Contractor pursuant to this solicitation, that involve (1) Services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.
- c. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity and such contractor shall be prohibited from entering into a contract for goods or Services with any department, institution or agency of the State
- d. All notices under subsection A, B and C herein shall be provided in writing to the State within thirty (30) calendar days after the Contractor learns about any such criminal or civil matters; unless such matters are governed by the other stated terms and conditions annexed to the solicitation. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Contractor may rely on good faith certifications of its subcontractors

addressing the foregoing, which certifications shall be available for inspection at the option of the State.

- 12. DISPUTE RESOLUTION:** The Parties agree that it is in their mutual best interest to resolve conflicts and disputes informally. A claim by the Contractor shall be submitted in writing to the Department's Contract Administrator for decision. A claim by the Department shall be submitted in writing to the Contractor's Contract Administrator for decision. The Parties shall negotiate in good faith and use all reasonable efforts to resolve all dispute(s). During the period where the Parties are attempting to resolve a dispute, each shall proceed diligently to perform their respective duties and responsibilities under this Contract. If a dispute cannot be resolved by the Parties within thirty (30) days after delivery of notice, either Party may elect to exercise any other remedies available under this Contract, or at law. However, all performance sanctions and assessment of damages will be governed in accordance with the requirements and process defined in Section IV Contract Performance and Sanctions.
- 13. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE:** This RFP and any documents incorporated specifically by reference represent the entire Contract between the Parties and supersede all prior oral or written statements or agreements. The Order of Precedence is:
- a. Any amendments executed by the Parties, in reverse chronological order;
  - b. Best and Final Offers or negotiation documents, in reverse chronological order, if any;
  - c. Written clarifications, in reverse chronological order, if any;
  - d. Addenda to the RFP, in reverse chronological order, if any; and
  - e. This RFP in its entirety; and
  - f. Offeror's proposal.

In the event of a conflict between or among the Contract Documents, the term in the Contract with the highest precedence shall prevail. All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the Contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

- 14. FORCE MAJEURE:** Neither Party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations because of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.
- 15. GENERAL INDEMNITY:** The Contractor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses

accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Contractor in performance of this Contract and that are attributable to the negligence or intentionally tortious acts of the Contractor, provided that the Contractor is notified in writing within sixty (60) days that the State has knowledge of such claims. The Contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Contractor goods and/or services to the State. The representation and warranty in the preceding sentence shall survive the termination or expiration of this Contract

16. **GOVERNING LAWS:** This Contract is made under and shall be governed, construed, and enforced in accordance with the laws of the State of North Carolina, without regard to its conflict of laws or rules.
17. **GOVERNMENTAL RESTRICTIONS:** In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.
18. **INDEPENDENT CONTRACTORS:** Contractor and its employees, officers and executives, and subcontractors, if any, shall be independent Contractors and not employees or agents of the Department. The Contract shall not operate as a joint venture, partnership, trust, agency, or any other similar business relationship.
19. **INSURANCE:** During the term of the Contract, the Contractor, at its sole cost and expense, shall provide commercial insurance coverage of such type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:
  - a. **Worker's Compensation** - The Contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of \$500,000.00, covering all of Contractor's employees who are engaged in any work under the Contract. If any work is sublet, the Contractor shall require the subcontractor to provide the same coverage for any of his employees engaged in any work under the Contract.
  - b. **Commercial General Liability** - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$2,000,000.00 Combined Single Limit.
  - c. **Automobile** - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used relating to the Contract. The minimum combined single limit shall be \$500,000.00 for bodily injury and property

damage; \$500,000.00 for uninsured/under insured motorist; and \$5,00.00 for medical payment.

- d. **REQUIREMENTS** - Providing and maintaining adequate insurance coverage is a material obligation of the Contractor and is of the essence of this Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Contractor shall always comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this Contract. The limits of coverage under each insurance policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract.

**20. INTELLECTUAL PROPERTY INDEMNITY:** Contractor shall hold and save the Department, State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or unpatented invention, articles, device, or appliance delivered relating to this contract.

**21. NOTICES:** Any notices required under the Contract must be delivered to the Contract Administrator for each Party. Unless otherwise specified in the Contract, any notices shall be delivered in writing by U.S. Mail, Commercial Courier or by hand,

**22. PAYMENT AND INVOICE TERMS:**

- a. The Contractor must submit one (1) invoice per month, no later than the 20<sup>th</sup> calendar day of the month, unless the Department approves another date.
- b. A hard copy of invoices with the information required as stated herein must be submitted to the following:
- DHHS Division of Health Benefits  
ATTENTION: Stephan Demeritte  
802 S. Boylan Avenue  
1950 Mail Service Center  
Raleigh, NC 27699-1950
- c. An electronic copy of the invoice must be submitted to [Stephan.Demeritte@dhhs.nc.gov](mailto:Stephan.Demeritte@dhhs.nc.gov), who may be reached at 919-527-7012.
- d. The invoice must be dated and reflect the fees and charges defined in the Contract for services or deliverables provided in the immediate preceding month, and include sufficient supporting documentation for the Department to validate the services and charges.
- e. Services invoiced on a Per Member Per Month (PMPM) basis shall be based on actual enrollment provided by the Department. The Contractor agrees that enrollment is to be based on the report without exception.

- f. The Parties shall mutually agree to an invoicing and reimbursement schedule for any one-time implementation fees charged in accordance with the Cost Proposal, except the Department shall not make payment for any one-time fees prior to the date services for the applicable component of the Scope of Work are fully implemented, unless otherwise agreed to by the Department.
- g. Payment will only be made for services and/or deliverables accepted by the Department in accordance with the Contract requirements, Cost Proposal and actual implementation dates.
- h. The Contractor is responsible for all payments to subcontractors under the Contract.
- i. Payment terms are Net not later than thirty (30) days after receipt of a correct invoice as verified by the Department.
- j. In the event the invoice is not correct, and the Department requires changes, the payment terms are Net not later than thirty (30) days after receipt of the correct invoice as resubmitted by the Contractor.
- k. The Department reserves the right to dispute an invoice after payment and require the Contractor to include a credit on the subsequent month's invoice to resolve disputes.
- l. Any reductions based on sanctions, liquidated damages, or other performance issues, etc. may be withheld from the Contractor's invoices. Contractor shall provide a credit memo for such reductions within ten (10) days, upon request.

**23. PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES:** Contractor warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for obtaining any Contract or award issued by the State and its Departments and other agencies or entities. The Contractor further warrants that no commission or other payment has been or will be received from or paid to any third-party contingent on the award of any Contract by the State, except as shall have been expressly communicated to the Department's Office of Procurement, Contracts and Grants in writing prior to acceptance of the Contract or award in question. Everyone signing the required sections of this RFP warrants that he or she is duly authorized by their respective Party to sign the Contract and bind the Party to the terms and conditions of this RFP. The Contractor and their authorized signatory further warrant that no officer or employee of the State has any direct or indirect financial or personal beneficial interest, in the subject matter of the Contract; obligation or Contract for future award of compensation as an inducement or consideration for making the Contract. Subsequent discovery by the State of non-compliance with these provisions shall constitute sufficient cause for immediate termination of all outstanding contracts. Violations of this provision may result in debarment of the Contractor(s) as permitted by 9 NCAC 06B.1206, or other provision of law.

**24. PROJECT MANAGEMENT:** All project management and coordination on behalf of the Contractor shall be through a single point of contact. The Contractor must provide that single point of contact.

- 25. PROTEST PROCEDURES:** If an Offeror wishes to protest a Contract resulting from this solicitation that is awarded by the Department, an Offeror shall submit a written request addressed to contact identified in Section II.A.10 Proposal Submission. The protest request must be received in the proper office within thirty (30) consecutive calendar days from the date of the Contract award. Protest letters **shall** contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party's claims. **Note:** Contract award notices are sent only to the Offeror awarded the Contract, and not to every person or firm responding to a solicitation. Proposal status and Award notices are posted on the Internet at <https://www.ips.state.nc.us/ips/>. All protests will be handled following the process defined in the North Carolina Administrative Code, 01 NCAC 05B .1519, but will be administered by Department of Health and Human Services personnel.
- 26. RECORDS RETENTION:** All records and data held by the Contractor as it relates to this Contract shall be retained and maintained as required by North Carolina law and federal law. However, if any litigation, claim, negotiation, audit, disallowance action or other action involving this contract has been started before the expiration of the legally required retention period, the records must be retained until completion of the action and resolution of all issues which arise from it.
- 27. SECURITY AND BACKGROUND CHECKS:** The Department reserves the right to conduct a security background check or otherwise approve any employee or agent provided by the Contractor, and to refuse access to or requires replacement of any such personnel for cause, including but not limited to, technical or training qualification, quality of work or change in security status or non-compliance with the Department's security or other requirements.
- 28. SEVERABILITY:** If a court of competent authority holds that a provision or requirement of the Contract violates any applicable law, each such provision or requirement shall be enforced only to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of the Contract shall remain in full force and effect. All promises, requirement, terms, conditions, provisions, representations, guarantees and warranties contained herein shall survive the expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable federal or State statute, including statutes of repose or limitation.
- 29. SITUS:** The place of this Contract, its situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in Contract or tort, relating to its validity, construction, interpretation, and enforcement shall be determined.
- 30. SOVEREIGN IMMUNITY:** Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the Department and State under applicable law.

**31. SUBCONTRACTORS:** The Contractor may subcontract the performance of required services with resources under this Contract only with the prior written consent of the Department's contracting authority. Upon request, the Contractor shall provide the Department with complete copies of any contracts made by and between the Contractor and all subcontractors. The selected Contractor remains solely responsible for the performance of its subcontractors. Subcontractors, if any, shall adhere to the same standards required of the selected Contractor and this Contract. Any contracts made by the Contractor with a subcontractor shall include an affirmative statement that the Department is an intended third-party beneficiary of the Contract; that the subcontractor has no contract with the Department; and that the Department shall be indemnified by the Contractor for any claim presented by the subcontractor. Notwithstanding any other term herein, Contractor shall timely exercise its contractual remedies against any non-performing subcontractor and, when deemed appropriate by the Department, substitute another subcontractor.

**32. TAXES:** Any applicable taxes shall be invoiced as a separate item and in accordance with this paragraph and applicable laws.

- a. G.S. § 143-59.1 bars the Secretary of Administration from entering into Contracts with Contractors if the Contractor or its affiliates meet one of the conditions of G.S. § 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under G.S. § 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the Contractor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the proposal document the Contractor certifies that it and all its affiliates, (if it has affiliates), collect(s) the appropriate taxes.
- b. All agencies participating in this Contract are exempt from Federal Taxes, such as excise and transportation. Exemption forms submitted by the Contractor will be executed and returned by the using agency.
- c. Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.

**33. TERMINATION:** Any notice or termination made under the Contract shall be provided to the Contractor's Contract Administrator.

- a. The Parties may mutually terminate the Contract by written amendment at any time.
- b. The Department may terminate the Contract, in whole or in part, for any of the following provisions.
  - i. Termination for Cause: In the event any goods, software, or service furnished by the Contractor during performance of any Contract term fails to conform to any material requirement of the Contract, and the failure is not cured within thirty (30) days, or other time period specified by the Department, after providing written notice thereof to Contractor, the Department may cancel and

procure the articles or services from other sources; holding Contractor liable for any excess costs occasioned thereby, subject only to the limitations provided within the RFP. The rights and remedies of the Department provided above shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract. Contractor shall not be relieved of liability to the Department for damages sustained by the Department arising from Contractor's breach of the Contract; and the Department may, in its discretion, withhold any payment due as a setoff until the damages are finally determined or as agreed by the parties. Voluntary or involuntary Bankruptcy or receivership by Contractor shall be cause for termination.

- ii. Termination for Convenience Without Cause: The Department may terminate this Contract, in whole or in part, by giving thirty (30) days prior notice in writing to the Contractor. The Contractor shall be entitled to sums due as compensation for deliverables provided and services performed in conformance with the Contract. In the event the Contract is terminated for the convenience of the Department, the Department will pay for all services performed and products delivered in conformance with the Contract up to the date of termination.
- iii. Contract Expiration: The Department may elect to not exercise its option to renew this Contract. The Department shall give the Contractor written notice of its intent whether to exercise each option no later than sixty (60) days before the end of the Contract's then-current term. In addition, the Department reserves the right to extend the Contract Term for a period of up to one hundred-eighty (180) days in ninety (90) days or less increments.
- iv. Transition Assistance: If this Contract is not renewed at the end of its term, or is canceled prior to its expiration for any reason, the Contractor shall provide, at the option of the Department, up to six (6) months after such end date all such reasonable transition assistance requested by the Department to allow for the expired or canceled portion of the services to continue without interruption or adverse effect, and facilitate the orderly transfer of such services to the Department or its designees. If the Department exercises this option, the Parties agree that such transition assistance shall be deemed to be governed by the terms and conditions of this Contract (notwithstanding this expiration or cancellation), except for those Contract terms and conditions that do not reasonably apply to such transition assistance. The Department shall pay Contractor for performance of the services or resources utilized.

- 34. **TITLES AND HEADINGS**: Titles and headings in this RFP, and in any subsequent contract, are for convenience only and shall have no binding force of effect.
- 35. **UNANTICIPATED TASKS**: In the event that additional work must be performed that was wholly unanticipated, and that is not specified in the Agreement, but which in the opinion of both parties is necessary to the successful accomplishment of the contracted scope of work, the procedures outlined in this article will be followed. For each item of

unanticipated work, the Contractor shall prepare a work authorization in accordance with the Departments' practices and procedures.

- a. It is understood and agreed by both parties that all of the terms and conditions of the Agreement shall remain in force with the inclusion of any work authorization. A work authorization shall not constitute a contract separate from the Agreement, nor in any manner amend or supersede any of the other terms or provisions of the Agreement or any amendment hereto.
- b. Each work authorization shall comprise a detailed statement of the purpose, objective, or goals to be undertaken by the Contractor, the job classification or approximate skill level or sets of the personnel required, an identification of all significant material then known to be developed by the Contractor's personnel as a Deliverable, an identification of all significant materials to be delivered by the Department to the Contractor's personnel, an estimated time schedule for the provision of the Services by the Contractor, completion criteria for the work to be performed, the name or identification of Contractor's personnel to be assigned, the Contractor's estimated work hours required to accomplish the purpose, objective or goals, the Contractor's billing rates and units billed, and the Contractor's total estimated cost of the work authorization.
- c. All work authorizations must be submitted for review and approval by the procurement office that approved the original Contract and procurement. This submission and approval must be completed prior to execution of any work authorization documentation or performance thereunder. All work authorizations must be written and signed by the Contractor and the Department prior to beginning work.
- d. The Contractor shall not expend personnel resources at any cost to the Department in excess of the estimated work hours unless this procedure is followed: If, during performance of the work, the Contractor determines that a work authorization to be performed under the Agreement cannot be accomplished within the estimated work hours, the Contractor will be required to complete the work authorization in full. Upon receipt of such notification, the Department may:
  - i. Authorize the Contractor to expend the estimated additional work hours or service in excess of the original estimate necessary to accomplish the work authorization, or
  - ii. Terminate the work authorization, or
  - iii. Alter the scope of the work authorization in order to define tasks that can be accomplished within the remaining estimated work hours.
  - iv. The Department will notify the Contractor in writing of its election within seven (7) calendar days after receipt of the Contractor's notification. If notice of the election is given to proceed, the Contractor may expend the estimated additional work hours or services.

36. **WAIVER:** The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.
37. **WARRANTY:** The Contractor warrants that its services will be performed in a good and workmanlike manner. Unless otherwise agreed to by the Parties, the Contractor will reperform any services not in compliance with this warranty brought to its attention in writing within thirty (30) days after those services are performed. Additionally, the Contractor warrants that its deliverables and services which are original content will materially conform to their applicable specifications for a period of thirty (30) days from delivery to the Department. The Contractor will correct any such deliverable or service not in compliance with this warranty brought to its attention in writing within thirty (30) days after delivery of such deliverable to the State. THIS SECTION IS CONTRACTOR'S ONLY EXPRESS WARRANTY CONCERNING THE SERVICES, ANY DELIVERABLES OR MATERIALS, AND THIS CONTRACT, AND IS MADE EXPRESSLY IN LIEU OF ALL OTHER WARRANTIES, CONDITIONS, AND REPRESENTATIONS, EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE, MERCHANTABILITY, INFORMATIONAL CONTENT, SYSTEMS INTEGRATION, NON-INFRINGEMENT, INTERFERENCE WITH ENJOYMENT OR OTHERWISE.

### III. SCOPE OF WORK AND REQUIREMENTS

The Offeror must submit their Technical Response as ATTACHMENT B: TECHNICAL RESPONSE. The Department encourages Offerors to suggest innovative ways to fulfill the requirements of this RFP. The Offeror must confirm adherence to the expectations of the Department and their ability to meet the requirements of this RFP. This includes providing a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature and/or detailed information specifically tailored for the North Carolina Medicaid program to demonstrate its ability to meet requirements.

#### A. Qualifications, Experience and Federal Requirements

1. The Department seeks and requires a Contractor:
  - a. To serve as the State's Enrollment Broker and support transformation of the State's Medicaid program from fee-for-service to managed care.
  - b. That has the experience, knowledge and resources to support all the services outlined in this RFP and is willingly transparent in its dealings with the Department and the State's Medicaid beneficiaries and stakeholders.
  - c. With a history of providing choice counseling, call center capabilities, and other enrollment broker services to Medicaid programs with a population of at least 400,000 and with a proven track record of on-time implementation and delivery of services and customer satisfaction.

2. The Enrollment Broker must implement and oversee North Carolina's beneficiary support system as required under 42 C.F.R. § 438.71. The Enrollment Broker shall perform all the minimum functions of the beneficiary support system defined therein and as modified herein. In the event there are changes to any applicable law, rule or regulation, the Enrollment Broker must work with the Department to make the necessary modifications to meet all changes and requirements.
3. As defined in 42 C.F.R. § 438.71, the beneficiary support system shall include, but is not limited to:
  - a. "Choice Counseling" for all beneficiaries, including members, potential members or their authorized representatives who seek to enroll and members who seek to disenroll from a PHP. Changing PHPs is considered a form of disenrollment.
  - b. Assistance for beneficiaries in understanding managed care, including but not limited to:
    - i. The North Carolina Medicaid program, generally, and the North Carolina Medicaid managed care program, specifically, and how each operates. The Enrollment Broker shall only provide general information about Medicaid eligibility and will be expected to transfer questions related to eligibility to county DSS offices;
    - ii. How beneficiaries access covered services within the North Carolina Medicaid managed care program including physical, behavioral health and pharmacy services or access covered services not delivered through the North Carolina Medicaid managed care program;
    - iii. Beneficiary rights and responsibilities in the managed care program;
    - iv. Differences, if any, between North Carolina Medicaid managed care PHPs (e.g., in additional benefits, available provider network, service quality outcomes); and
    - v. How to find an appropriate AMH/PCP or specialist or to understand the providers available in each PHP provider network.
4. The beneficiary support system shall perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple, integrated ways including by phone, mail, Internet, and in-person, and through auxiliary aids and services as defined in 28 C.F.R. § 36.303 when requested by the beneficiary and/or authorized representative.
5. As defined in 42 C.F.R. § 438.810, the Enrollment Broker shall meet independence and freedom of conflict requirements. The Enrollment Broker shall not be expected to provide clinical guidance and/or support as part of their requirements for beneficiary support system or choice counseling.
6. All data collected, produced, or maintained must be made available for federal evaluation where required under 42 C.F.R. § 431.420(f).

## B. North Carolina Medicaid and NC Health Choice Enrollment

1. The Enrollment Broker is expected to guide and support beneficiaries, their families, and authorized representatives in the managed care program through education, PHP selection, AMH/PCP selection, and PHP disenrollment.
2. The Enrollment Broker shall be responsible for conducting enrollment and education activities for NC Medicaid and NC Health Choice managed care beneficiaries.
  - a. The Enrollment Broker will facilitate enrollment and education services for the required populations and programs as the programs expand, the population changes, and/or the managed care program geographical regions change.
  - b. The enrollment and education activities may vary according to the needs of four (4) populations: i) cross-over population; ii) new beneficiaries after cross-over open enrollment and managed care launch; iii) beneficiaries at redetermination; and iv) special populations to be phased into managed care after initial cross-over population enrollment.
  - c. Enrollment and education activities must include, but are not be limited to: i) managed care education; ii) pre-enrollment announcements, reminders, and enrollment process education; iii) PHP selection, AMH/PCP selection, and iv) disenrollment. Other requirements may be added or removed depending on changes in federal or state law or as the North Carolina managed care program needs may change.
3. Managed Care Education
  - a. The Enrollment Broker must provide resources and education to help resolve questions from members, potential members, and their authorized representatives regarding the managed care program.
  - b. The Enrollment Broker must provide, at a minimum, managed care resources, education and answer questions over the phone, internet, by mail and in-person as listed below.
    - i. Managed care resources, education, and assistance, at a minimum, must include:
      1. Services covered through the North Carolina Medicaid managed care program, including those that can be furnished without referral and how to obtain these services;
      2. Benefits that are a North Carolina Medicaid covered service, but are “carved out” of the NC Medicaid managed care program under Session Law 2015-245, as amended, and how to obtain such benefits;
      3. Advantages to beneficiaries to improve health and wellness, including smoking cessation;
      4. Education about non-emergency medical transportation and how to access the benefit;
      5. The importance of preserving relationships with current providers for continuity of care;

6. Process for selecting and changing a PHP (including plan selection period and choice periods);
  7. Process for selecting and changing a AMH/PCP during and after enrollment;
  8. The NC Medicaid rules around “with cause” and “without cause” disenrollment;
  9. Disenrollment process, including:
    - i. Opportunities for disenrollment or changing PHPs and
    - ii. The types of requests processed by the Enrollment Broker and the types of requests processed by the Department;
  10. Information about member and potential member rights to appeal and instructions on how to appeal managed care enrollment and disenrollment request decisions;
  11. The Ombudsman Program;
  12. Social determinants of health screening and health risk screening; and
  13. Any additional topic or subject the Enrollment Broker believes beneficiaries or their authorized representatives would benefit from or would improve the customer experience.
- c. All materials developed to support member education must comply with the Department defined standards and be submitted to the Department to approve prior to use.
  - d. The Enrollment Broker must provide at least thirty (30) calendar days’ notice prior to making any changes to Member education and enrollment materials, the notice must include a copy of the proposed changes and the rationale.
4. Prepaid Health Plan (PHP) Selection
    - a. Consistent with federal regulations, the Enrollment Broker must provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives, who want to select a PHP or have questions about North Carolina Medicaid managed care program.
    - b. The PHP selection process should not be unnecessarily administratively burdensome on the beneficiary and/or their authorized representative but must be consistent with the requirements herein.
    - c. The Enrollment Broker must provide, at a minimum, choice counseling and enrollment assistance over the phone, internet, by mail and in-person to assist with PHP selection as listed below.
      - i. North Carolina Medicaid managed care program education as defined within this RFP.
      - ii. Specific details about each participating PHP, including but not limited to:
        1. Provider Directory, including information on whether certain PHPs have beneficiaries’ preferred providers in-network;
        2. PHP comparison chart for key PHP quality or operational metrics;
        3. PHP brochures with service offerings for each PHP;

- 4. Key customer service or beneficiary support phone numbers or resources; and
    - 5. Links to PHP websites.
  - iii. Auto-assignment process if no PHP selected.
  - iv. Whom to call for assistance once enrolled in a PHP.
  - v. Any additional subject the Enrollment Broker suggests.
  - d. The Enrollment Broker must assist parents, guardians, and authorized representatives in the selection of a PHP for each member of the family eligible for the managed care program.
  - e. Consistent with federal regulation, the Enrollment Broker must remain impartial when assisting beneficiaries with PHP selection and ongoing support following their enrollment into PHPs.
  - f. The beneficiary is not required to select a PHP, but if a PHP selection is made, the Enrollment Broker must collect the member's PHP selection and transmit to the Department.
  - g. The Enrollment Broker must direct beneficiary complaints and questions relating to PHPs, carved out benefits, or other Medicaid-related benefits to the appropriate channels, including PHP grievances and appeals processes and non-PHP resolution channels and must be logged in the Beneficiary Management Platform.
  - h. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the PHP selection process.
  - i. All materials developed to support PHP selection must comply with Department defined standards and be submitted to the Department to approve prior to use.
  - j. In the event of a PHP termination or significant adverse change in a PHP provider network (e.g., loss of a large clinical or hospital system), the Department must provide notice to the Enrollment Broker of the expected number of beneficiaries impacted who may need assistance transitioning to a new PHP or have questions about the transition.
5. Advanced Medical Home (AMH)/Primary Care Provider (PCP) Selection
- a. The Enrollment Broker must provide enrollment assistance to beneficiaries and/or to their authorized representatives in selecting a AMH/PCP as defined by the Department.
  - b. The Enrollment Broker must provide, at a minimum, enrollment assistance with AMH/PCP selection over the phone, internet, by mail, and in-person.
    - i. The importance of and the need for selecting a AMH/PCP or medical home.
    - ii. The explanation of and benefits related to preserving an existing AMH/PCP or other provider relationships, whenever appropriate.
  - iii. PHP provider network information as provided by the PHPs, including;
    - 1. Provider Directory, including information on whether certain PHPs have beneficiaries' preferred AMH/PCP in-network;
    - 2. Provider demographics, such as address, phone number, gender, age, language, and specialty;

3. Provider hours of office operation;
    4. Whether a provider is accepting new patients; and
    5. Available provider locations within PHP provider network.
  - iv. Any additional subject the Enrollment Broker suggests.
  - c. The Enrollment Broker must assist parents, guardians, and authorized representatives in the selection of a AMH/PCP each member of the family enrolled in a PHP.
  - d. The AMH/PCP selection process should not be unnecessarily administratively burdensome on the beneficiary and/or their authorized representative but must be consistent with the requirements herein.
  - e. The Enrollment Broker must remain impartial, without conflict of interest, when assisting beneficiaries with AMH/PCP selection and must redirect beneficiary complaints relating to AMH/PCP to the appropriate channels, including the assigned PHP, and must be logged in Beneficiary Management Platform.
  - f. The beneficiary is not required to select a AMH/PCP but if a AMH/PCP selection is made, the Enrollment Broker must collect AMH/PCP selection for each member and transmit to the Department.
  - g. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the AMH/PCP selection process.
  - h. All materials developed to support AMH/PCP selection shall comply with Department defined standards and be submitted to the Department to approve prior to use.
  - i. Subsequent changes to a beneficiary's AMH/PCP selection are expected to be managed by the beneficiary's PHP/AMH, however, the Enrollment Broker shall assist the beneficiary in understanding how to change a AMH/PCP, connecting the beneficiary with the PHP to change their AMH/PCP or in addressing other questions or issues the beneficiary may have.
6. PHP Auto-assignment
- a. The Enrollment Broker shall utilize the results of the Department's PHP auto-assignment algorithm as defined in ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM when assigning a beneficiary to a PHP.
  - b. The Enrollment Broker shall accept auto-assignment from the Department at a frequency no less than once per day, with the Department desiring a real-time interaction.
  - c. The Department shall be the source of truth for PHP enrollment, and the Enrollment Broker shall maintain this information to support future choice counseling.
7. Disenrollment Requirements
- a. General requirements
    - i. A disenrollment may occur pursuant to specific criteria described below but may include complete disenrollment from the managed care program or disenrolling from one PHP to be enrolled in a different PHP.

- ii. The disenrollment process should not be unnecessarily administratively burdensome on the beneficiary and/or their authorized representative but shall be consistent with the requirements herein.
- iii. The Enrollment Broker shall accept PHP disenrollment requests from beneficiaries or their authorized representative over the phone, internet, by mail, and in-person.
- iv. The Enrollment Broker shall develop a simple, beneficiary friendly PHP disenrollment request form to be used for disenrollment requests accepted over the phone, internet, by mail and in-person.
  - 1. The Department may add other beneficiary contact channels in the future (e.g., internet access).
  - 2. The Enrollment Broker will submit the form(s) to the Department to approve prior to use.
- v. The Enrollment Broker shall log all PHP disenrollment requests in the Beneficiary Management Platform and include at a minimum the requestor, date and time of request, and any reasons provided.
- vi. At the time of the disenrollment request, the Enrollment Broker shall offer choice counseling to the member or their authorized representative and capture his or her PHP and AMH/PCP preference if the disenrollment is approved.
- vii. If the beneficiary is determined by the Department to no longer be eligible for Medicaid, he or she will be notified by the Department and the beneficiary will be disenrolled from the PHP effective the last date of his or her eligibility.
- viii. The Department may change, add, or remove a disenrollment requirement to be consistent with NC State laws or regulations, Federal laws or regulations, or as a matter of Department policy. The Department will provide written notice to Enrollment Broker describing the change, addition, or removal of disenrollment criteria.
- ix. The Enrollment Broker shall develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the PHP disenrollment process.
  - 1. The Enrollment Broker shall post the policies on its North Carolina website and make them accessible to the public.
- b. Without Cause Disenrollment
  - i. Consistent with federal regulations, the Enrollment Broker shall allow members to switch PHPs without cause for the following reasons:
    - 1. During the initial ninety (90) day period following the effective date of new PHP enrollment (referred to as the “90-day choice period”);
    - 2. At least once every twelve (12) months as associated with the beneficiary redetermination period as described within this RFP;
    - 3. If the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity; or

4. If the Department imposes any intermediate sanctions on the PHP<sup>4</sup>.
- ii. The Enrollment Broker shall allow foster care children, children in adoptive placement and former foster children up to age twenty-six (26), members of federally recognized tribes and individuals receiving LTSS in institutional and community-based settings to switch plans without cause at any point.
- iii. The Enrollment Broker shall process all “without cause” requests for disenrollment from members or their authorized representatives.
- iv. Upon receipt, the Enrollment Broker shall:
  1. Review all requests and log in the Beneficiary Management Platform;
  2. Confirm the “without cause” request form, as described in this section, is complete;
  3. Approve all complete “without cause” requests for disenrollment if the member is still within his or her 90-day choice period;
  4. Approve all complete “without cause” requests for individuals per the requirements defined within this RFP;
  5. Follow up by mail and phone with member or authorized representative on any incomplete “without cause” request form within one (1) calendar day of receipt of the request;
  6. Deny all “without cause” requests if the request is incomplete or the member is outside his or her 90-day choice period; and
  7. Notify the Department of denial or approval of the request by the next calendar day.
- v. The Department will notify the member or authorized representative of the denial or approval of the without cause disenrollment request.
- vi. A detailed data flow for “without cause” disenrollment is included in ATTACHMENT J: PROPOSED MANAGED CARE ELIGIBILITY AND ENROLLMENT PROCESS FLOWS.
- vii. The Enrollment Broker shall develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the “without cause” disenrollment process.
- c. With Cause Disenrollment
  - i. Consistent with federal regulations, the Enrollment Broker shall allow members to request disenrollment from PHP with cause at any time. A “with cause” request for disenrollment does not automatically disenroll a member from their PHP.
  - ii. To initiate a “with cause” request, the member must contact the Enrollment Broker. The Enrollment Broker shall allow members to submit with cause disenrollment requests for the following “with cause” reasons during the lock-in period and after the without cause 90-day choice period. The member should submit the request within sixty (60) days of one or more of the “with cause: reasons listed below.

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<sup>4</sup> As defined in C.F.R. § 438.702(a)(4).

1. A PHP does not cover a service the member seeks because of the plan's moral or religious objection.
  2. Member needs concurrent, related services that are not all available within the PHP's network, and member's provider determines receiving services separately would subject the member to unnecessary risk.
  3. An LTSS member would be required to change his or her residential, institutional or employment supports provider based on a change in status from in- to out-of-network.
  4. Member's complex medical conditions would be better served under different PHP. "Complex medical conditions" will be defined by the conditions that qualify for an expedited appeal.
  5. Family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the member.
  6. Poor performance of PHP, as determined by the Department after evaluation of PHP performance.
  7. "Other reasons," including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need as defined by the Department.
- iii. The Enrollment Broker shall process all "with cause" requests for disenrollment from members in accordance with guidelines to be established by the Department.
  - iv. The Department shall maintain "with cause" disenrollment decision authority for clinical-related request including concurrent related services, complex medical conditions, "other reasons", and urgent medical need as defined within this RFP.
  - v. Upon receipt of the "with cause" request, the Enrollment Broker shall:
    1. Review all requests and log in the Beneficiary Management Platform;
    2. Confirm the "with cause" request form is complete; and
    3. Follow up by mail and phone with members or authorized representatives on any incomplete "without cause" request form within one (1) calendar day of receipt of the request;
    4. Classify complete requests as clinical or non-clinical as defined in this section and process according to timelines defined below.
  - vi. If the "with cause" request is non-clinical, as described in the section, the Enrollment Broker shall approve or deny all complete "with cause" requests based on if the requests meet the required "with cause" policy reasons, and notify the Department of denial or approval of request within three (3) calendar days of receipt of the request. The Department will notify the member or authorized representative of the denial or approval of non-clinical related "with cause" requests for disenrollment.
  - vii. If the "with cause" request is clinical, as described in the section, the Enrollment Broker shall transmit complete clinical-related "with cause" request to the Department for processing within twelve (12) hours of receipt. The Department shall receive, review, and approve or deny all complete clinical related "with

- cause” requests for disenrollment on the same timeline required of the Enrollment Broker. The Department shall communicate the decision of approval or denial of clinical related “with cause” requests to the Enrollment Broker, and the member or the member’s authorized representative.
- viii. The Enrollment Broker must allow for expedited review of “with cause” disenrollment based on urgent medical need standard to include the situation where continued enrollment in the PHP that could jeopardize the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited disenrollment for urgent medical needs must occur on or within twenty-four (24) hours day after receipt.
  - ix. A detailed data flow for “with cause” disenrollment is included in ATTACHMENT K: PROPOSED MANAGED CARE ELIGIBILITY AND ENROLLMENT PROCESS FLOWS.
  - x. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the “with cause” disenrollment process.
- d. PHP Requested Disenrollment
- i. The Enrollment Broker must allow PHPs to submit requests for member disenrollment.
  - ii. The Enrollment Broker must accept disenrollment request from the PHPs and transfer the request to the Department for review within three (3) calendar days after receipt.
  - iii. PHP requested disenrollment shall only be approved if the beneficiary’s behavior seriously hinders the PHP’s ability to care for the member, or other members, and the PHP has documented efforts to resolve the member’s issues.
  - iv. The Department shall prohibit PHPs from requesting member disenrollment because of an adverse change in the member’s health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member’s special needs
  - v. The Department shall communicate the decision of approval or denial PHP requested disenrollment to the Enrollment Broker, the member and the member’s authorized representative by the seventh (7) calendar day.
  - vi. A detailed data flow for PHP requested disenrollment is included in ATTACHMENT K: PROPOSED MANAGED CARE ELIGIBILITY AND ENROLLMENT PROCESS FLOWS.
  - vii. The Enrollment Broker shall develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the PHP requested disenrollment process.
8. Key Service Metrics: *Table 6 – Key Service Metrics* defines the metrics to be monitored and measured for enrollment and disenrollment processing. This includes the “without cause” disenrollment processing time and the non-clinical “with cause” processing time. Reports for these metrics must be provided in accordance with the reporting requirements of this RFP.

### C. Member Appeals of Disenrollment

1. To ensure beneficiaries are enrolled in PHPs that best meet their needs, the Department will allow beneficiaries to appeal disenrollment decisions made by the Department or the Enrollment Broker which cannot be resolved through existing administrative processes.
2. For member and PHP requested disenrollment's that are denied by the Enrollment Broker or the Department, the Department shall send to the member, or the authorized representative, a notice of the decision as developed by the Department, including information regarding member's right to appeal the decision and instructions on how to appeal the decision.
3. The member or authorized representative shall submit the appeal request form for a State Fair Hearing to the Office of Administrative Hearings (OAH) and the Department within thirty (30) calendar days of the date on the Notice of Denial of Enrollee's Disenrollment Request.
4. OAH shall conduct disenrollment-related State Fair Hearings and issue final decisions.
5. The Enrollment Broker shall participate in any mediation, pre-hearing preparation and the State Fair Hearing, and provide any necessary documentation and evidence, upon the Department's request.
6. The Enrollment Broker shall develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the Enrollment Broker's participation in the beneficiary's appeal process.

### D. Beneficiary Support Under Managed Care

1. To support the Department's transition to and ongoing operation of the managed care program, the Enrollment Broker shall provide beneficiary support to meet the needs of the North Carolina Medicaid and NC Health Choice population. The Enrollment Broker shall support five (5) populations: 1) the cross-over population with open enrollments; 2) new beneficiaries after cross-over open enrollments close; 3) beneficiaries at redetermination; 4) special populations to be phased into managed care after cross-over population enrollment; and 5) populations exempt from managed care.
2. Cross-over population: The Department will transition approximately 1.5 million beneficiaries through a two-phase roll-out with an anticipated Phase 1 roll-out from the fee-for-service program to the managed care program beginning July 1, 2019 (or a date determined by the Department)<sup>5</sup>. During Phase 1 roll-out beneficiaries referred to as the "cross-over population residing in 2 regions will be transitioned to managed care.

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<sup>5</sup> Pending the approval of North Carolina's amended 1115 waiver application.

Phase 2 roll-out for the remaining four regions, will follow the same approach but with different dates to be determined upon PHP contract award.

- a. To support beneficiary choice, the Department will offer the cross-over population a sixty (60) days open enrollment period. The open enrollment period will begin no later than one hundred and five (105) days prior to its PHP effective date of July 1, 2019, or a date determined by the Department.
  - i. The Enrollment Broker shall conduct open enrollment periods for each Phase 1 and Phase 2 cross-over population transitioning into the managed care program.
- b. The Department will provide the Enrollment Broker with the beneficiary names, relevant contact, demographic and AMH/PCP information necessary to assist beneficiaries through open enrollment.
- c. The Enrollment Broker shall provide managed care education to managed care eligible beneficiaries and support PHP selection during the open enrollment period.
  - a. During the open enrollment period, the Enrollment Broker shall do proactive outreach to beneficiaries to describe the Enrollment Broker's services, including managed care education and PHP and AMH/PCP selection support. Outreach shall be by phone, internet, by mail and in-person.
  - i. The Enrollment Broker shall, at a minimum, provide a managed care welcome packet to include materials defined by the Department and stated within this RFP.
  - ii. The complete managed care welcome packet must be submitted to the Department for approval prior to use and distribution.
- b. If a beneficiary selects a PHP, the Enrollment Broker shall enter that PHP selection in their Beneficiary Management Platform and transmit real-time via NC Fast.
- c. If a beneficiary does not select a PHP during the open enrollment period as defined by the Department, the Department will auto-assign the beneficiary to a PHP based on the algorithm defined in ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM.
- d. After PHP coverage becomes effective, members will have a ninety (90) day choice period to change their PHP before being locked into that PHP until their annual redetermination date or if involuntarily disenrolled due to no longer meeting eligibility requirements or PHP termination. The Enrollment Broker shall provide choice counseling and support PHP selection to members during the ninety (90) day choice period.
- e. The Enrollment Broker shall follow the proposed timeline for the cross-over population as defined by the Department in *Table 3 – Phase 1 Cross-over Population Timeline*.

***Table 3 – Phase 1 Sample Cross-over Population Timeline***

Key activity	Proposed date
Soft launch of Enrollment Broker call center/website to support choice counseling and PHP selection	January 1, 2019

Open enrollment period begins	March 15, 2019
Open enrollment period ends	May 15, 2019
PHP effective date	July 1, 2019
Ninety (90)-day choice period begins	July 1, 2019
Member may change PHPs without cause	July 1, 2019 - September 29, 2019
Ninety (90)-day choice period ends	September 29, 2019
Member may change PHPs “with cause”	Ongoing

3. New beneficiaries after cross-over open enrollment: New beneficiaries applying and being determined eligible for Medicaid or NC Health Choice after the cross-over open enrollment period closes will be given an opportunity to select a PHP and AMH/PCP as part of the Medicaid or NC Health Choice application.
  - a. If a beneficiary does not select a PHP as part of the Medicaid or NC Health Choice application, the beneficiary will be auto-assigned to a PHP based on the algorithm defined in ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM.
  - b. After PHP coverage becomes effective, members will have a ninety (90)-day choice period to change their plan before being locked into that plan until their annual redetermination date. The Enrollment Broker shall provide choice counseling and support PHP selection to beneficiaries during the ninety (90) day choice period.
  - c. The Enrollment Broker shall follow the proposed timeline for the new members after cross-over open enrollment as defined by the Department. A sample timeline for these beneficiaries is provided as *Table 4 – Phase 1 Sample New Beneficiary Timeline*.

**Table 4 – Phase 1 Sample New Beneficiary Timeline**

Key activity	Proposed date
New beneficiary applies for and is determined eligible for Medicaid without making PHP selection	November 1, 2019
Beneficiary auto-assigned to PHP	November 1, 2019
Ninety (90)-day choice period begins	November 1, 2019
Member may change PHPs without cause	November 1, 2019 – January 30, 2020
Ninety (90)-day choice period ends	January 30, 2020

4. Beneficiaries at redetermination: “Redetermination” is the annual review of beneficiaries’ income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and NC Health Choice. If a beneficiary is redetermined to be eligible, he or she will be offered the opportunity to select a new PHP through a notice from the Department.
  - a. If a beneficiary is redetermined to be eligible, the Department will auto-assign the beneficiary to a PHP based on the algorithm, defined in ATTACHMENT K: MANAGED

CARE AUTO-ASSIGNMENT ALGORITHM, to the same PHP from the prior year, provided that the PHP continues to participate in the program.

- b. The member will be offered a ninety (90)-day choice period to select a new PHP if the member desires to change his or her PHP. The Enrollment Broker shall provide choice counseling and support PHP selection to members during the ninety (90)-day choice period.
  - c. If the beneficiary is determined to no longer be eligible, he or she will be notified by the Department, and the beneficiary will be disenrolled from the PHP effective the last date of his or her eligibility.
5. Special populations to be phased into managed care after cross-over population enrollment: The Department anticipates phasing-in special populations into the managed care program over a period of four (4) years after Phase 1 launch. The Enrollment Broker shall propose an open enrollment period for each new population transitioned into the managed care program over the potential duration of the Contract (including extensions), similar to what is described above for the cross-over population.
- a. To support beneficiary choice, the Department anticipates offering any special populations phased into managed care after the cross-over population a sixty (60) day open enrollment period. The open enrollment period will begin no later than one hundred-five (105) days prior to its PHP effective coverage date as defined by the Department.
  - b. The Enrollment Broker shall provide managed care education to managed care eligible beneficiaries and support PHP selection during the open enrollment period.
  - c. During the open enrollment period, the Enrollment Broker shall do proactive outreach to beneficiaries to describe the Enrollment Broker's services, including managed care education and PHP and AMH/PCP selection support. Outreach shall be by phone, internet, by mail and in-person.
    - i. The Enrollment Broker shall, at a minimum, provide a managed care welcome packet to include materials defined by the Department and stated within this RFP. The complete managed care welcome packet must be submitted to the Department for approval prior to use and distribution.
  - d. If a beneficiary does select a PHP, that selection will be entered the Enrollment Broker's Beneficiary Management Platform and transmitted real-time via NC Fast
  - e. If a beneficiary does not select a PHP during the open enrollment period as defined by the Department, the Enrollment Broker shall notify the Department after open enrollment closes and the Department will auto-assign the beneficiary to a PHP based on the algorithm defined in ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM.
  - f. After PHP coverage becomes effective, members will have a ninety (90)-day choice period to change their plan before being locked into that plan until their annual redetermination date or if involuntarily disenrolled generally due to no longer meeting eligibility requirements or plan termination. The Enrollment Broker shall provide Choice Counseling and provide PHP selection to members during the ninety (90)-day choice period.

- g. The Department may add, remove or change requirements for special populations to be phased into managed care after cross-over enrollment. The Department will provide written notice to the Enrollment Broker of any such changes.
- h. The Enrollment Broker shall follow the proposed timeline for special populations to be phased into managed care after the year 2019 population as defined by the Department in *Table 5 – Sample special population beneficiary enrollment in managed care in Year 2*.

***Table 5 – Sample special population beneficiary enrollment in managed care in Year 2***

<b>Key activity</b>	<b>Proposed date</b>
Open enrollment period begins for special population	March 15, 2020
Open enrollment period ends for special population	May 15, 2020
PHP effective date for special population	July 1, 2020
90-day choice period begins	July 1, 2020
Member may change PHPs without cause	July 1, 2020 - September 29, 2020
90-day choice period ends	September 29, 2020
Member may change PHPs with cause	Ongoing

- 6. Exempt populations: The Members of federally recognized tribes are exempt from mandatory enrollment in managed care. Assignment of members of federally recognized tribes varies based on whether a Tribal option exists. The Enrollment Broker will allow members of federally recognized tribes to opt in or out of managed care and back into fee-for-service at any time, upon request.
  - a. The Enrollment Broker shall provide choice counseling to these members and support PHP/ AMH/PCP selection in a manner similar to the other populations defined in this section, based on when the exempt member becomes eligible for Medicaid or NC Health Choice and the existence of a tribal option.
  - b. The Enrollment Broker shall provide the following to managed care exempt members of federally recognized tribes, at a minimum:
    - i. The Enrollment Broker shall accept tribal member information from the Department and use to support choice counseling and PHP selection;
    - ii. The Enrollment Broker shall train their staff in providing cultural sensitive and consumer-specific supports to the tribal population to support plan choice in accordance with all requirements of this RFP; and
    - iii. If the tribal option is available, the Enrollment Broker shall provide choice counseling to enrollees identified as members of federally recognized tribes:
      - a. On the differences in covered services between managed care and fee-for-service, and
      - b. That members of federally recognized tribes will default into the tribal option if they live in the geographic area covered by the tribe but may

choose to change plans or delivery system (e.g. FFS vs. managed care) at any time.

- c. If the tribal option is not available to a member of a federally recognized tribe that member will default into fee for services and may choose to remain in fee for service or choose a PHP.
7. The Department is working with the General Assembly such that beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder, or an intellectual / developmental disability will have a delayed mandatory enrollment into managed care during the transition period between the initial launch of managed care Standard Plans and the subsequent launch of BH I/DD Tailored Plans. During the transition period, these beneficiaries will have the option to voluntarily enroll in a Standard Plan. During the transition period, the Enrollment Broker will allow beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder, or an intellectual / developmental disability to opt in or out of managed care and back into fee-for-service at any time, upon request).
8. The Enrollment Broker shall provide choice counseling to enrollees who meet the BH I/DD TP eligibility criteria and explain the differences in covered BH and I/DD services between standard plans and LME-MCOs and that the standard plan enrollees will not be able to access services covered only by the LME-MCOs.
9. The Enrollment Broker shall provide, at a minimum, the following to beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder, or an intellectual / developmental disability, until implementation of BH/IDD Tailored Plans:
  - a. The Enrollment Broker shall accept BH I/DD TP eligibility information from the Department and use to support choice counseling and PHP selection;
    - i. The Enrollment Broker shall accept from the Department updates on beneficiaries who the Department determines to be eligible to enroll in BH I/DD TP either through historical claims analysis or other means;
  - b. The Enrollment Broker shall train their staff in providing consumer-specific supports to BH I/DD TP population to support plan choice;
  - c. The Enrollment Broker shall accept and act on requests for transfers from standard plans to BH I/DD TPs as allowable by the Department;
  - d. The Enrollment Broker shall participate in the BH I/DD TP eligibility verification process by:
    - i. Sending a blank BH I/DD TP Assessment Form to enrollees who self-identify;
    - ii. Informing beneficiaries who can complete the assessment; and
    - iii. Transmitting the completed BH I/DD TP Assessment Form to the Department for review.
10. Proposed process flows outlining the Department's intended enrollment processes and Enrollment Broker expectations are included in ATTACHMENT J: PROPOSED MANAGED CARE ELIGIBILITY AND ENROLLMENT PROCESS FLOWS.

11. The Enrollment Broker shall develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the beneficiary support under managed care process for each of the five (5) populations defined in this section.
12. The Enrollment Broker shall be responsible for providing full beneficiary support and Choice Counseling functions as required in this RFP during any:
  - a. New program or initiative implementation defined by the Department;
  - b. Any phased regional rollout;
  - c. New PHP participation in a Medicaid region;
  - d. Expansion of other “cross-over” Medicaid populations into the Medicaid managed care program such as dually eligible beneficiaries or tailored plans; and
  - e. Contract termination of or change in a PHP which may result in the redistribution of enrolled members.
  - f. Contract standards and quality of services shall be maintained during these occurrences for the duration of the Contract.

#### E. Beneficiary Grievances

1. In support of beneficiary engagement in the managed care program, beneficiaries will have the ability to file a grievance with the Enrollment Broker regarding actions taken by the Enrollment Broker relating to the enrollment process at any time in writing or orally based on the process to be defined by the Department.
  - a. A grievance shall be defined as an expression of dissatisfaction about any matter. Grievances may include, but are not limited to:
    - i. Quality of services provided;
    - ii. Aspects of interpersonal relationships such as rudeness of an Enrollment Broker’s employee, or failure to respect the beneficiary’s rights regardless of whether remedial action is requested; and/or
    - iii. Responsiveness to beneficiaries regarding a problem or question.
  - b. The Enrollment Broker Grievance process should not be unnecessarily administratively burdensome on the beneficiary and/or their authorized representative and shall be consistent with the requirements herein.
  - c. The Enrollment Broker will provide beneficiaries assistance in completing forms and other procedural steps related to a grievance, including but not limited, to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability and assistive listening devices, or referring beneficiary to Ombudsman program for assistance if desired. The Enrollment Broker shall provide examples and/or descriptive information of how it will accommodate special needs of beneficiaries.
  - d. The Enrollment Broker shall acknowledge, in writing, receipt of each grievance within five (5) calendar days of receipt of the grievance
  - e. The Enrollment Broker will send written notices related to grievances via mail or, with beneficiary and/or authorized representative consent, via email.

- f. The Enrollment Broker shall provide written notice of resolution of the grievance to the beneficiary and/or authorized representative no later than thirty (30) calendar days of receipt of grievance.
- g. The Enrollment Broker shall record all Grievances in the Beneficiary Management Platform tied to the beneficiary for whom the Grievance is made and report to the Department upon request.
- h. The Enrollment Broker shall develop, subject to Department review and approval prior to implementation, policies and processes related to beneficiary grievances and shall post them on a publicly available website. The references to the beneficiary grievance policies and processes must be included in education materials.

## F. Member Outreach, Education and Enrollment Materials

### 1. Member Outreach and Education

- a. The Enrollment Broker must develop, execute, and maintain an outreach and education campaign strategy targeted to meet the identified managed care enrollment needs of North Carolina's Medicaid beneficiaries and those who support them before, during and after managed care implementation.
- b. The Enrollment Broker's outreach and education campaign strategy approach must reflect the needs of the following audiences: beneficiaries, members of federally recognized tribes, authorized representatives, family members, providers, PHPs, county DSS offices, PHHS offices and community-based organizations which may routinely interact with North Carolina's Medicaid beneficiaries.
- c. The Enrollment Broker's outreach and education campaign strategy, materials and formats (e.g., print, electronic) must take into account:
  - i. Medicaid population size and geographic/regional needs or differences;
  - ii. Primary language and first language;
  - iii. People with disabilities;
  - iv. People who may be deaf, hard of hearing or deaf-blind;
  - v. People who may be blind or visually impaired;
  - vi. Web content accessibility guidelines in accordance with the Americans with Disabilities Act (ADA);
  - vii. Literacy reading capability;
  - viii. Age;
  - ix. Cultural needs of North Carolina's federally recognized tribe;
  - x. Age-specific or other targeted learning skills or capabilities;
  - xi. Ability to access and use technology; and
  - xii. Federal and state statutes and requirements, including auxiliary aids and services.
- d. The Enrollment Broker must collaborate with county DSS offices, PHHS offices, community based and advocacy organizations to:
  - i. Understand the needs of Medicaid beneficiaries in selected local communities and regions and incorporate into the outreach and education campaign strategy; and

- ii. Host outreach events during the open enrollment period for the cross-over population in each of the six (6) PHP regions to educate potential members and members about the managed care program, how to select a PHP, how to select a AMH/PCP, and the enrollment and disenrollment processes.
      - 1. During the open enrollment period for the cross-over population, there will be at least two (2) outreach events per region per month, with exact number of events to be determined by the Department and the Enrollment Broker (up to eight (8) additional outreach events during open enrollment).
      - 2. The number and location of outreach events must consider the number of beneficiaries per region, geographic dispersal and capability of beneficiaries or their supports to access the event, demand or attendance at the events, and independent PHP outreach activities.
    - iii. After each outreach event, the Enrollment Broker must report back to the Department all feedback received on the Medicaid and NC Health Choice program, and outreach events information, presentations, facilities, and associated topics.
    - iv. The Enrollment Broker must always consider modifying, updating, removing, changing, or adding materials, call center scripts, enrollment or disenrollment procedures, website content, education materials, outreach activities, presentations or other administrative or operational processes to improve the beneficiary experience based on feedback.
  - e. The Enrollment Broker must submit the outreach and education campaign strategy to the Department for approval within thirty (30) calendar days after the Contract Effective Date.
  - f. The Department is interested in technologies to support member outreach, such as mobility and social media. The Enrollment Broker should provide information to support additional technologies and their experience where possible.
2. Member Education Materials
- a. Consistent with the requirements herein, the Enrollment Broker must develop member education materials to support choice counseling and PHP and AMH/PCP selection, subject to review and approval by the Department prior to use with beneficiaries and/or authorized representatives.
  - b. The materials must contain sufficient information to assist beneficiaries or their authorized representatives in the selection of a PHP and/or AMH/PCP, transfer from one PHP to another, disenrollment from a PHP, appeal rights and process for PHP enrollment or disenrollment decision made by the Enrollment Broker or Department, deciding between managed care and fee for service program for exempt and information about the PHPs.
  - c. The Enrollment Broker must ensure that educational materials are developed according to language and information accessibility standards defined within this RFP.
  - d. The Enrollment Broker must ensure that all educational materials:
    - i. Are consistent with federal regulations;

- ii. Comply with privacy and security requirements related to protected health information defined by Federal or North Carolina law;
    - iii. Are accurate and approved by the Department;
    - iv. Do not use the Department's or State's logo without prior approval from the Department;
    - v. Do not specifically list or reference providers who are not part of any North Carolina PHP network or is under contract with a licensed North Carolina PHP; and
    - vi. Are distributed throughout North Carolina as determined necessary by the Department; such as regional or statewide distribution.
  - e. The Enrollment Broker must ensure that member education materials are available and accessible to all members and potential members, including individuals who may have a disability, have limited reading comprehension and/or who are non-English speaking.
  - f. The Enrollment Broker must make education materials available in hard copy and electronic form, and are available to county DSS offices, PHHS office, and other Department offices so that members and potential members who may visit county DSS or PHHS offices can take the educational materials to review at their convenience.
  - g. The Enrollment Broker must submit all member education materials to the Department for review and approval prior to distributing to beneficiaries and/or their authorized representative no later than ninety (90) days prior to the cross-over open enrollment period.
3. Partnerships with PHPs and Ombudsman Program
- a. The Enrollment Broker must engage in joint community-based outreach events or activities with the staff of the Ombudsman Program and PHPs as requested by the Department, including but not limited to, health fairs and community events that occur in the following possible locations:
    - i. Community Centers;
    - ii. Markets/Malls/Retail Establishments;
    - iii. Hospitals, Pharmacies, and Other Provider Sites;
    - iv. Schools; and
    - v. Public libraries.
  - b. The Enrollment Broker must engage in at least two (2) outreach events in each region (*Table 1 - List of Counties by PHP Region*) in each month of that region's open enrollment period, with exact number of events to be determined by the Department and the Enrollment Broker according to number of beneficiaries per region, geographic dispersal, and capability to access the event. The Enrollment Broker must engage in at least one (1) outreach event quarterly thereafter.
    - i. The Enrollment Broker must submit for review and approval by the Department the location, time, and materials to be provided at all outreach events. The Department must also review and approve call center scripts providing information about the outreach events.

- ii. Prior to hosting an outreach event, the Enrollment Broker must post meeting locations and times in a manner to maximize attendance such as:
      - 1. In the local paper;
      - 2. At county DSS offices or PHHS office;
      - 3. On its website; and
      - 4. Call Center hold or IVR message.
    - iii. After each outreach event, the Enrollment Broker must report back to the Department all feedback received on the Medicaid and NC Health Choice program, outreach events information, presentations, facilities, and associated topics.
    - iv. The Enrollment Broker must always consider modifying, updating, removing, changing, or adding materials, call center scripts, enrollment or disenrollment procedures, website content, education materials, outreach activities, presentations or other administrative or operational processes to improve the member experience based on feedback.
  - 4. Partnership with county DSS offices
    - a. The Enrollment Broker must establish an ongoing partnership with the 100 counties' DSS offices that support North Carolina Medicaid and NC Health Choice eligibility. The Enrollment Broker must provide a dedicated DSS/County Liaison – as defined in ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL.
    - b. The Enrollment Broker must develop and implement a DSS engagement strategy that ensures seamless integration with county DSS staff and the Enrollment Broker. The strategy must include methods for supporting county DSS offices with managed care education and “warm hands-offs” between county DSS staff and the Enrollment Broker when beneficiaries present or call in the county DSS office.
  - 5. Partnership with EBCI PHHS
    - a. The Enrollment Broker must establish an ongoing partnership with the EBCI PHHS that supports North Carolina Medicaid and NC Health Choice recipients who are tribal members. The Enrollment Broker must provide a dedicated Tribal Liaison – as defined in ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL.
    - b. The Enrollment Broker must develop and implement a Tribal engagement strategy that ensures seamless integration with local PHHS staff and the Enrollment Broker. The strategy must include methods for supporting the local PHHS office with managed care education and developing resources that address how EBCI and other resources and programs may be different and outside of the state system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities.
    - c. The Enrollment Broker must provide information on the different service types and benefit plans available through the Tribal Option, if finalized.
  - 6. Enhanced Outreach and Potential Onsite Support – OPTIONAL SERVICES

- a. The Department seeks proposals from the Enrollment Broker to provide enhanced outreach and community level engagement with county DSS/EBCI PHHS offices to assist beneficiaries in the transition from fee-for-service to manage care.
- b. The Enrollment Broker must develop and submit the following for consideration by the Department.
  - i. A proposal for providing onsite support to each county DSS/EBCI PHHS offices by assigning outreach staff to be physically located in the offices during open enrollment of the cross-over population for a minimum of eight (8) hours per week.
  - ii. A proposal for providing enhanced support to local DSS/EBCI PHHS offices during other potential peak periods that includes locating outreach staff onsite at the local offices.
  - iii. Each of the above proposals should include, but not be limited to, the following:
    - a. Method for providing outreach, i.e. face to face, telephonic, etc.
    - b. Target groups, i.e. cross-over, populations, new beneficiaries;
    - c. Timeframes and hours of operation during which support will be available;
    - d. A detailed description of the approach and workplan for implementation;
    - e. Consideration of the phased rollout of the cross-over population
    - f. Options for offering or expanding enhanced support on a targeted or as needed basis;
    - g. Other aspects or considerations impacting the Enrollment Broker's ability to successfully provide enhanced outreach; and
    - h. Fees associated with onsite and enhanced support as outlined in ATTACHMENT C: COST PROPOSAL.
  - iv. Enhanced outreach and/or potential onsite services are optional under this RFP, and the Department reserves the right to engage some, all or none of the services submitted by Offeror.

#### G. Language, Accessibility, and Cultural Competency

1. The Enrollment Broker must ensure that all contact with beneficiaries/authorized representatives, whether oral or written, be culturally competent, appropriate to the beneficiary's literacy level and in a manner, that accommodates the beneficiaries/authorized representatives with developmental and/or physical disabilities (e.g., modifying scripts or materials to address the needs of these populations or communicating with legally responsible persons) as defined within this RFP.
2. Furthermore, 42 C.F.R. 438.10(a) requires that Enrollment Broker must provide all required information to members and potential members in a manner and format that

may be easily understood and is readily accessible by such members and potential members.

3. No later than ninety (90) calendar days prior to cross-over open enrollment period the Enrollment Broker must submit to the State for review examples, samples and/or detailed information specifically tailored for the North Carolina Medicaid and NC Health Choice program to demonstrate its ability to meet these requirements.
4. The Enrollment Broker must ensure that oral, written language translation and oral sign language services are provided as legally required and can accommodate dialects and other beneficiary needs.
5. The Enrollment Broker must consult with and comply with practices of the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.
6. The Enrollment Broker must ensure that all written materials must be culturally competent and offered at no cost to the beneficiary or their authorized representative. Written materials must:
  - a. Be written according to the Associated Press Stylebook and Department-specific style guide;
  - b. Be designed to accommodate screen readers; e.g., reading order, tags, Alt Text labels, captions; and elimination of multiple spaces, blank lines, and other interference;
  - c. Use a san serif font in a type size appropriate to the audience, and that takes the font into account (generally 14-16 points);
  - d. Be made available in alternative formats upon request of the potential member or member at no cost; and
  - e. Include tagline in the top 15 languages spoken by individuals with limited English proficiency in North Carolina on all documents that explains the availability of written translation or oral interpretation to understand the information according to 42 C.F.R. § 438.10 and 42 C.F.R. § Part 92. Alt Text means accessible for screen readers and is a feature to provide text descriptions of images on electronic documents such as websites and in most Microsoft Office Programs. Large print means printed in a font size no smaller than eighteen (18) points.
7. The Enrollment Broker must ensure that its staff have knowledge and understanding specifically for the North Carolina based federally recognized Tribe of the Eastern Band of Cherokee Indians, its history, culture, and the impact of that on engagement and communication styles most appropriate when interacting with EBCI members specifically:
  - a. Awareness and understanding of the impact that history has on Native American culture and how that negative influence has created barriers to healthcare and services;

- b. Knowledge of managed care Tribal option if available in North Carolina;
  - c. Ability to adapt individual engagement strategies to fit the cultural needs of tribal members; and
  - d. Knowledge of differences between Federally recognized tribes and state recognized tribes including benefit plan, North Carolina Medicaid and NC Health Choice eligibility and other allowances/exceptions as applied for federal and state Tribes (e.g. Federally recognized tribes eligible for the Tribal Option, Medicaid is payer of first resort for Federally recognized tribes).
8. The Enrollment Broker must ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Sec. 508 of the Rehabilitation Act of 1973 as amended January 2017. All materials made available electronically must be accessible on user agents, such as mobile phones. All internet content must meet the same literacy standards identified for written materials defined in this RFP.
9. The Enrollment Broker must ensure that all audio-reliant materials, such as videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to beneficiaries and authorized representatives in their original format.
10. The Enrollment Broker must provide sign language interpreters if closed captioning is not the appropriate auxiliary aid for the beneficiary.
11. The Enrollment Broker must provide assistive listening devices and professional sign language interpreters during presentations and other events with beneficiary audiences.
12. The Enrollment Broker must comply with technical requirements regarding language accessibility as required by Title VI of the Civil Rights Act of 1964 including:
- a. Specific approaches that support multiple languages and cultural needs and are accessible to persons with limited English proficiency, and persons with disabilities, including persons who are blind or visually impaired;
  - b. Adherence to accessibility standards for oral and written communication, including the provision of TTY and relay services;
  - c. Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
  - d. Translation of materials into Spanish and up to three additional languages, as required by the Department.
13. The Enrollment Broker must have interpreter services available for oral contacts with beneficiaries and authorized representatives whose primary language is not English.
- a. The Enrollment Broker must provide callers who prefer to converse in Spanish with call center services required of the contract as defined in this RFP.

- b. All other languages shall be handled through a language line service at no cost to the beneficiary or the Department. Oral interpretations must be available in all languages required by regulation or determined by the Department. The Enrollment Broker must report back to the Department, at a minimum:
    - i. The number of times the language line is requested by language;
    - ii. Beneficiary ID of member requesting the language line; and
    - iii. Language requested for or by each beneficiary.
  - c. When completing PHP and AMH/PCP enrollment or disenrollment, the Enrollment Broker must determine if the member or potential member has specific language preferences. The Enrollment Broker must ensure that member assignments to PHPs include their language/cultural preference, if stated.
  - d. The Enrollment Broker must record the beneficiary's language preference in the Beneficiary Management Platform and transmit the information to the Department at a frequency and format to be defined by the Department after the Contract becomes effective.
- 14. The Enrollment Broker must provide enrollment materials to be translated into Spanish, closed captioned, accessible by screen readers or other beneficiary needs at the time they are made available in their original form. Within forty-five (45) calendar days of notice from the Department, the Enrollment Broker must translate and make available materials in languages identified by the Department as a prevalent non-English language spoken by members or potential members throughout the State, at no additional cost to the Department or the beneficiary.
- 15. The Enrollment Broker must provide taglines indicating the availability of language services for individuals with limited English proficiency on website content and written documents that are crucial for understanding the enrollment process and/or selecting a PHP.
- 16. The Enrollment Broker must ensure compliance with 42 C.F.R. § Part 92 which prohibits discrimination based on race, color, national origin (including immigration status and English language proficiency).
- 17. The Offer must comply with the Americans with Disabilities Act.
- 18. The Enrollment Broker must comply with Section 1557 of the Patient Protection and Affordable Care Act.

#### H. Call Center Support

A Department goal is to reduce the administrative burden on beneficiaries and authorized representatives by providing easy access to manage their Medicaid program benefits, at a low cost to the Department. Therefore, in addition to an Internet option to engage with the beneficiary, the Department requires a call center to provide beneficiaries and authorized

representatives an option and support an integrated beneficiary experience to manage their enrollment needs in a seamless manner.

1. The Enrollment Broker must install, operate, monitor, and support an Automated Voice Response System (AVRS) with automated call distribution to call center representatives to provide enrollment assistance and processing of plan selection for potential and existing managed care program members, and authorized representatives.
2. The Enrollment Broker's telecommunication system and call center must be located within the contiguous United States, preferably within North Carolina, and have the capability to accept local and toll-free calls, make outbound calls, and meet all the requirements defined in this RFP.
3. These requirements must be clearly stated in the Enrollment Broker's proposed Call Center Service Level Agreement (CC SLA).
  - a. Capacity to handle all telephone calls during the hours of operation as defined in this Section;
  - b. Provides capability for Customer Service Call Center/Help Desk to include, without limitation, hardware, software, and toll-free telephone access to operate the Customer Service Call Center/Help Desk System
  - c. Capability to receive calls after-hours with the option for callers to leave a request for a call back. If a request for a call back is made, the return phone call must be made the following business day during normal hours of operations. The Department must approve the after-hours message;
  - d. Ability to handle increased call volume during peak hours, currently identified by the Department as Monday – Friday, 11:00 AM EST – 2:00 PM EST, and 5:00 PM EST – 7:00PM EST, and subject to change based on call volume reports once implemented;
  - e. Staffing levels and the technology capacity during Department initiatives that will require more interaction with beneficiaries and authorized representatives, such as open enrollment, new program implementations, expansions to meet contract standards;
  - f. Capacity to handle at a minimum one hundred (100) calls simultaneously and have the upgrade capability to simultaneously handle at least one hundred-fifty (150) calls during open enrollment periods or in the event of a PHP termination or significant adverse change in a PHP provider network (e.g., loss of a large clinical or hospital system). The Department must provide notice to the Contractor of the expected number of beneficiaries impacted who may need assistance transitioning to a new PHP or have questions about the transition as soon as the need is identified or no later than 30 days.
  - g. Capability to utilize an overflow call center with no change in call handling quality or service levels described herein, in the rare event that call handling capacity is exceeded at the primary call center The Enrollment Broker may use an overflow call center in cases when the primary call center is not able to answer calls promptly

and to prevent callers from waiting beyond 3 minutes. The Enrollment Broker will ensure overflow call center staff know how to handle a NC call, answer the call within the time frame needed and record the call in the beneficiary platform to capture customer experience and for reporting purposes.

- h. Effectively manage all calls received by the automated call distributor (ACD) and assign incoming calls to appropriate available staff, i.e. bilingual, in an efficient manner
  - i. Effectively manage outbound call volume;
  - j. Provide educational messages or other messages which improve the customer experience (i.e. announcement of new program changes or reminders) approved by the Department while callers are on hold;
  - k. Ensure call center has sufficient technology and training to handle Deaf, hard of hearing and Deaf-Blind callers to include TTY, Captions phones and amplified phones;
  - l. Transfer calls to the Department's (FFS) Provider and Medicaid call centers, county DSS or EBCI PHHS offices, and all participating PHPs or LME-MCOs when appropriate and without impacting the capacity to handle in-bound calls simultaneously;
  - m. Direct calls to Enrollment Broker's member enrollment satisfaction survey in accordance with the requirements of this RFP;
  - n. Digitally record and store 100% of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months;
  - o. Allow the Department real-time remote access via secure internet connection to all call recordings, with the Department having ownership and control of these recordings;
  - p. Ensure that telephone translation services are accessible via the toll-free number and that beneficiaries and authorized representatives will be involved in three-way conversation with the language line without having to make an additional call; and
  - q. Comply with language and information accessibility standards defined within this RFP; and
  - r. Provide people who are hard of hearing an option to correspond through email.
4. The Enrollment Broker must operate the Call Center at a minimum during following times:
- a. During open enrollment for the cross-over population, implementation of new or expanded managed care populations, and emergency situations (including natural disasters such as hurricanes) as designated by the Department, the Enrollment Broker must operate the call center a minimum of thirteen (13) hours a day, 7:00 AM EST to 8:00 PM EST, seven (7) days a week.
  - b. At other times, the Enrollment Broker must operate the Call Center 7:00 AM EST to 5:00 PM EST, Monday through Saturday, including state and federal holidays.
  - c. Under special circumstance at the request of the Department, the Enrollment Broker must work extended weekend hours with at least thirty (30) days' notice from the Department.

5. The Enrollment Broker must develop an AVRS for the Call Center that will prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the member prior to the call being distributed to a call center representative.
  - a. The voice prompt must be a recorded voice of a real person and not a computer-generated voice in English and in Spanish or other languages deemed appropriate by the Enrollment Broker. The Call Center Representative's call documentation software must be auto-populated with relevant information from prior contacts or calls as well with beneficiary demographic, member enrollment and eligibility information from NCTracks/NC FAST, as determined by the Department.
  - b. The Department will work with the Enrollment Broker to determine the appropriate technical integration approach (real-time web services, batch, messaging, etc.), however real-time web services calls are the Department's preferred approach.
  - c. By January 1, 2020, unless a later date is specified by the Department, the AVRS must also have the capability to allow callers to determine what plan they are currently enrolled with and/or what plan they will be enrolled (except during the crossover period) within the next thirty (30) to sixty (60) calendar days by keying in their Medicaid ID# or an alternative identifier, as defined by the Department for identifying the member, if applicable.
  - d. The AVRS script must be approved by the Department prior to initial implementation or if changes to the script are necessary or recommended.
6. The Enrollment Broker must install, operate, monitor, and support an Automated Call Distribution (ACD) system. Features of the ACD system must facilitate the most efficient use of Enrollment Broker resources while meeting, or exceeding, beneficiary service expectations, and must include but not be limited to:
  - a. Effective management of all calls offered and assignment of incoming calls to available staff in an efficient manner;
  - b. Monitoring capabilities that allow Enrollment Broker supervisors to audit the way a call is processed, as well as the efficiency of the operator performance by monitoring call center metrics such as calls offered, response time, abandonment rates, length of calls, first call resolution, etc. against performance at the operator level;
  - c. Average wait time must not exceed three (3) minutes. During the hold period, the Enrollment Broker must have informational messages which update the caller regarding expected hold time on the line;
  - d. AVRS options that are user-friendly and easy to be understood by Medicaid beneficiaries and authorized representatives, and include a decision tree illustrating AVRS system;
  - e. Ability to transfer calls to other telephone lines without diminishing in-bound or out-bound call capacity;
  - f. Capability of routing calls from specific sources (e.g., beneficiaries, PHPs, LME/MCOs) to a designated group of operators without diminishing in-bound or out-bound call capacity;

- g. Monitoring capability that allows real-time updates of an operator's availability (i.e., available, on a call, completing after-work, etc.);
  - h. Providing personalized and relevant messages or notifications appropriate for the caller;
  - i. Automatic routing of call to the next available operator; and
  - j. The capability for all calls to be answered promptly during normal business hours.
7. The Enrollment Broker must ensure that the installation and maintenance of the call center system functions in a way which allows calls to be remotely monitored by the Department or its designee for the purposes of evaluating Enrollment Broker performance.
- a. Callers must receive notification, with language to be provided by the Department, which informs the beneficiary or authorized representative that "call monitoring may occur."
  - b. Call monitoring by the Department or its designee must be available at the location of the Enrollment Broker and remotely from the Department or its designee's location.
  - c. Remote access must be obtained through a secure communication connection as defined within this RFP.
8. The Enrollment Broker must develop call center scripts for use by Call Center staff when talking with beneficiaries and authorized representatives. All scripts must be clear and easily understandable and approved by the Department prior to use. The Enrollment Broker must submit to the Department for approval a listing of topic for which scripts will address and will modify the scripts as required by the Department. Topics for scripts must include, but not be limited to:
- a. Managed care resources, education and assistance for Medicaid and NC Health Choice Enrollment;
  - b. The member or potential member's options for PHP selection;
  - c. Factors to consider when selecting a PHP;
  - d. How the regional phased in rollout may affect the beneficiary;
  - e. Collection or confirmation of the potential or existing member's demographic, mailing or contact information necessary for enrolling, maintaining enrollment or disenrolling a member;
  - f. Instructions to assist potential or existing members in determining which PHP includes the AMH/PCP, specialists, or other providers which the potential or existing member may need to serve their health care needs;
  - g. Instructions to inform and make PHP selection or change;
  - h. Instructions on how to request disenrollment;
  - i. Callers who believe there is a problem or inaccuracy in the PHP enrollment; and
  - j. Other topics as identified by the Department.
9. The Enrollment Broker must ensure that the telephone systems will have the capability to transfer beneficiaries and authorized representatives from the call center to

appropriate state staff when applicable without disconnecting the call, including but not limited to the Department's (FFS) Provider and Medicaid call centers, the Ombudsman program, county DSS/EBCI PHHS offices and all participating PHPs/LME-MCOs when appropriate. The Department will provide contact information to the Enrollment Broker after award of the Contract.

10. The Enrollment Broker must ensure the Call Center is staffed with professionals who have sufficient training and knowledge on North Carolina Medicaid and NC Health Choice benefits including the managed care program and services, and the customer service skills defined within this RFP.
11. The Enrollment Broker must acquire the necessary phone number(s) to support the requirements of this Section within sixty (60) calendar days after the Contract Effective Date. The Enrollment Broker must relinquish ownership of the toll-free number(s) upon contract termination or expiration, at which time the Department must take title of these telephone numbers. All costs accrued, due, and owing on these numbers, including but not limited to, any taxes, penalties or fines must be the sole obligation of the Enrollment Broker.
12. The Enrollment Broker must provide detailed analysis of Call Center performance as outlined in ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS.
13. As part of the Enrollment Broker's Beneficiary Management Platform, the Enrollment Broker must track all call center interactions with beneficiaries, members, potential members, and authorized representative.
  - a. Enrollment Brokers that propose to include chat functionality as an alternative or supplement to voice interactions must indicate this offering in their response. This functionality must improve the customer experience and cannot be used to replace any other requirement.
  - b. The Enrollment Broker may include "robotic" technologies that provide resolution to simpler tasks, without negatively impacting the member or customer experience. The State must approve any technologies that replace or supplement the Call Center Representative and how the technologies are utilized.
  - c. All chat interactions, whether through a call center agent (live person) or through robotic technologies must be included in ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS.
14. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe call center requirements as defined in this Section.
15. Key Service Metrics: *Table 6 – Key Service Metrics* defines the metrics to be monitored and measured for the Call Center. This includes the calls abandoned, Call Center outage,

wait/hold times for callers, call-answer time, and first call resolution. Reports for these metrics must be provided in accordance with the reporting requirements of this RFP.

#### I. Enrollment Services Website

A Department goal is to reduce the administrative burden on beneficiaries and their authorized representatives by providing easy access to manage their Medicaid program benefits, at a low cost to the Department. Therefore, the Department requires an interactive website to provide beneficiaries an option and support an integrated beneficiary experience to manage their enrollment needs in a seamless manner. The Department also desires functionality that provides access via mobile devices, and the Enrollment Broker should include information on existing or potential functionality for mobile device access.

1. The Enrollment Broker must develop and maintain a secure enrollment services website that allow potential or existing members and authorized representatives to access educational materials, access choice counseling services, provider directory, and select a PHP and/or AMH/PCP.
2. The Website must support authentication without the need for the beneficiary to provide a user ID / password pair by taking the session state from NC FAST or ePASS. This can be accomplished in several ways including leveraging SSO/SAML tokens through the NCID system. This is expected functionality as part of the eligibility determination on the State's systems and the plan selection on the Enrollment Broker's systems. The Department will work with the Enrollment Broker to facilitate authentication.
3. The website must comply with Department standards related to the look and feel of the managed care program enrollment site. The Department will work with the Enrollment Broker to develop design elements that align to the Department's standards. The Enrollment Broker must provide screen shots of other websites implemented for similar clients in its response.
4. The Enrollment Broker must develop and maintain the website to comply with the Web Content Accessibility Guidelines (WCAG) 2.0, and the current release of web content accessibility guidelines published by the Web Accessibility Initiative, and as outlined in Sec. 508 of the Rehabilitation Act of 1973, as amended January 2017.
5. Educational materials:
  - a. The Website must include, at a minimum, the defined educational materials in a web-readable format.
  - b. Any materials that references a member or contains any personally identifiable information (PII), personal health information (PHI), or other data as defined by the Department must be secured by a login and meet applicable privacy and security standards.

6. PHP Selection Tool:
  - a. In support of the Department's vision for streamlined eligibility and enrollment process, the Enrollment Broker must provide a PHP selection tool to be used by potential and existing members, and authorized representatives to select a PHP when applying for Medicaid, during open enrollment period (for cross-over population), during eligibility redetermination process, and during PHP "with" and "without cause" disenrollment requests.
  - b. The PHP selection tool must provide at a minimum:
    - i. Integration with the ePASS portal to ensure seamless beneficiary experience when transitioning from the State system to the Enrollment Broker's technology platform;
    - ii. Weighted view of the PHPs available to the potential or existing member, and authorized representative based on data sourced from NC FAST including, eligibility determination and category, prior PHP enrollment, prior AMH/PCP, region in which the beneficiary lives and the PHPs operate, and household. For the purposes of this section "Weighted" is defined as the ability to visually highlight a specific plan or plans based on the objective best fit for the member. The State will work with the Enrollment Broker to define the criteria for the weighting;
    - iii. Available in-network providers based on PHP selected as defined within this RFP. This information may be made available via links to an external tool and need not appear in the plan selection interface; and
    - iv. Integration with Department's secure inbox functionality within the ePASS platform. The Enrollment Broker must leverage this platform for any communications that include member related information. The Enrollment Broker must only send to members via email a message indicating the member has a message in their ePASS Secure Inbox. The Department will work with the Enrollment Broker to develop the integration needed for this requirement.
  - c. Once the beneficiary makes a PHP and/or AMH/PCP selection, the Enrollment Broker must pass the information to NC FAST on a no less than daily frequency. The Department prefers real-time web service calls and integration.
  - d. The PHP Selection tool must have the ability to maintain an inventory of available benefit plans provided by the Department. PHPs may offer additional benefits subject to Department approval. Generally, the Department provides a common benefit across all PHPs, however this may change in the future.
  - e. The Plan Selection tool must utilize the Provider Directory as sole source to determine Provider-PHP relationships. This information will be used to guide plan selection by weighting PHPs that have contracted with the beneficiary's AMH/PCP.
7. Hours of operation/maintenance: The website and the PHP selection tools are to be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's Systems that impact the ability for the website

and PHP selection tools to operate correctly. The Service Level Agreement must address the hours of operation and maintenance, and include metrics to support a required 99% uptime, with the exceptions stated in this provision.

8. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the Department's enrollment services website requirements.
9. Key Service Metrics: *Table 6 – Key Service Metrics* defines the metrics to be monitored and measured for the Enrollment Services Website. This includes the web portal response and timely response to electronic correspondence. Reports for these metrics must be provided in accordance with the reporting requirements of this RFP.

#### J. Beneficiary Management Platform

1. The Enrollment Broker must develop and maintain a Beneficiary Management Platform (BMP) responsible for maintaining an electronic record of all interactions, including capturing updated or changed demographic information between the Enrollment Broker and members/potential members, including phone, internet, mail and in-person interactions. The Department will work with the Enrollment Broker to define what data elements will be updated without impacting a beneficiary's eligibility. Data that may impact eligibility must be updated by the county case worker or the Department.
2. The Beneficiary Management Platform must include the following fields, which may be populated by real-time data calls to other data sources:
  - a. Member/potential member's name;
  - b. Medicaid identification number (if assigned/known);
  - c. Channel of interaction;
  - d. Member/potential member information and demographics, including, but not limited to:
    - i. Date of birth,
    - ii. Address,
    - iii. Phone number,
    - iv. Assigned PHP,
    - v. AMH/PCP and other preferred providers,
    - vi. Third-party liability, and
    - vii. Redetermination date;
  - e. Notes summary of member/potential member interaction (e.g. summary of issue, if issue was resolved or addressed, what information was provided by the Enrollment Broker's representative);
  - f. Record of the time and date of interaction;
  - g. Contact agent;
  - h. Resolution and/or if additional follow-up is or was required;
  - i. PHP assignment (including historical PHP assignment for 12 months prior);

- j. Interpreter requests and the language requested;
  - k. Enrollment, disenrollment requests and determinations; and
  - l. Any other information the Department specifies, or the Enrollment Broker recommends.
3. The BMP must have the capability to make real-time calls to the State's systems to populate BMP screens and data with the current information at the time of an interaction with a beneficiary.
  4. The BMP must have the capability to pass data via interfaces to State systems when escalations or handoffs are required. The Department desires real-time interactions.
  5. The Enrollment Broker must report individual activity and update data to the Department upon request. Information contained in the Beneficiary Management Platform database must be the property of the State.
  6. The Enrollment Broker must report separately on beneficiary complaints as defined in ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS but the Enrollment Broker may propose using the Beneficiary Management Platform. Complaints requiring the immediate attention of the Department must be reported daily, following the occurrence, via phone or secure email notification.
  7. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe the beneficiary management platform.

#### K. Consolidated, Beneficiary Facing, Provider Directory

1. The Enrollment Broker must develop and maintain a consolidated provider directory for the State on the Enrollment Broker's platform.
  - a. The consolidated provider directory must be an easily searchable repository of provider-to-PHP relationships to provide the most up to date information to inform and support choice counseling and PHP selection.
  - b. To satisfy the requirements of this Section, the Department will not accept links, connections, redirects to tools maintained by the PHP.
  - c. The Department expects a searchable repository of the most up to date information on provider to PHP relationships, as provided by PHPs in a standardized format.
  - d. The directory must also be used to support AMH/PCP selection during the Medicaid application process in NC FAST/ePASS, and to provide support through the call center.
  - e. In addition to PHP provider network information, the directory must also contain and display providers who participate in North Carolina fee for service program. For this section, the North Carolina fee for service program must be treated as a PHP.

- f. The Provider Directory must incorporate information provided by PHPs, and PHPs and not the Enrollment Broker must be responsible for the accuracy of the information provided to the Enrollment Broker.
- 2. The Enrollment Broker must integrate with each of the PHPs for the purposes of pulling provider directory information. The Enrollment Broker will pull, transform as needed, and update the data required for the Consolidated Provider Directory at least daily on business days. The Department strongly encourages the Enrollment Broker leverage the open source tools developed by Healthcare.gov in developing the directory<sup>6</sup>, at no extra cost to the Department.
  - a. The Department will include in PHP contracts language, terms, and requirements that will allow the Enrollment Broker to meet its requirements.
  - b. The Enrollment Broker's mechanism for PHP integration (real-time, batch, etc.) must be approved by the Department.
  - c. Data to be included in the Provider Directory should include, but is not limited to the following:
    - i. Provider to PHP affiliations. This includes clearly differentiating providers who are contracted to multiple plans;
    - ii. Provider office locations where services are provided;
    - iii. Provider specialties by location, accessibility;
    - iv. Provider office hours; and
    - v. A Managed Care Indicator identifying which providers participate in managed care and are enrolled with a PHP.
- 3. The Enrollment Broker's directory must be used as the sole source for AMH/PCP selection in NC FAST and the Department's internet portals during the application process.
  - a. The directory must interface with NC FAST to provide the application process with a list of AMH/PCPs. Other data elements may be included in the final interfaces based on the needs of the Department.
  - b. The Department will work with the Enrollment Broker to determine the appropriate implementation of this interface, and whether it is a real-time web service or a batch interface. The Department desires real-time web service calls. See Section M – Enrollment Information System Integration *Figure 2: Current Architecture* for the current architecture that the Department anticipates being required for implementation.
  - c. PHPs, not the Enrollment Broker and Department, must have the final responsibility for assigning a beneficiary to a AMH/PCP. The PHPs must be required to make all appropriate efforts to assign the beneficiary to a AMH/PCP that they selected through the Enrollment Broker or other Department-maintained tool.

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<sup>6</sup> The tools are available at <https://www.healthcare.gov/developers/>. The Department can help facilitate communications with the federal teams if needed, but previous experience with the tools is preferred.

4. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe consolidated provider directory as defined in this Section.

#### L. Mailing Requirements

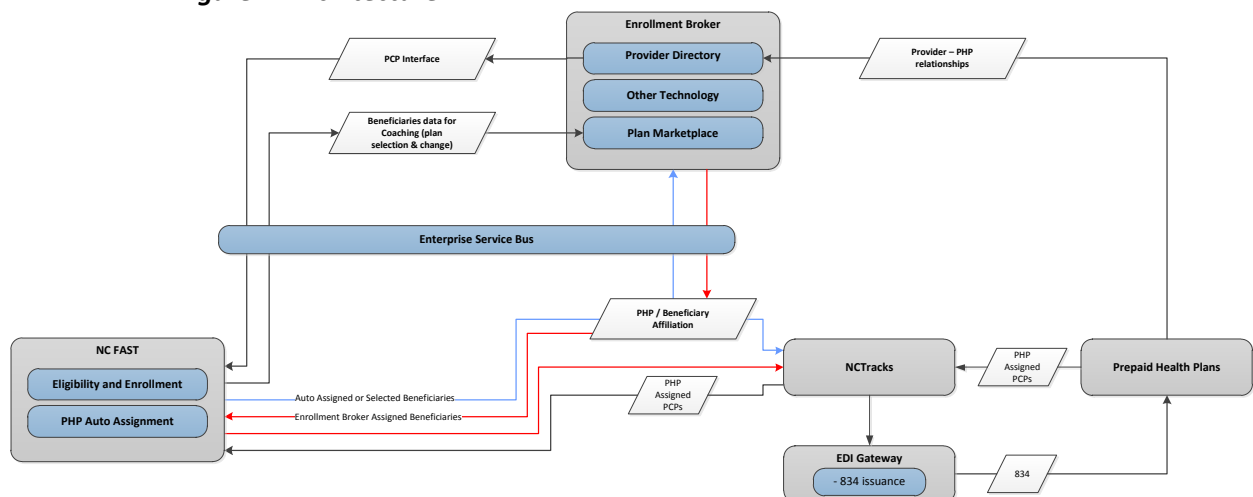
1. The Enrollment Broker must make available by mail all member education and enrollment materials required by the Department to support managed care education, PHP and AMH/PCP enrollment and disenrollment.
2. The Department will provide beneficiary mailing addresses to the Enrollment Broker in an electronic format and frequency to be defined by the Parties after the Contract Effective Date.
3. The Enrollment Broker must perform address verification check against a United States Postal Service (USPS) approved product or service on all beneficiaries prior to mailing materials, at no additional cost to the Department.
  - a. The Enrollment Broker must make all reasonable attempts to identify the correct mailing address and mail the information to the beneficiary.
  - b. The Enrollment Broker must notify the Department of all non-verifiable addresses in an electronic format and frequency to be defined by the Parties after the Contract Effective Date.
  - c. The Enrollment Broker must notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency to be defined by the Parties after the Contract Effective Date .
4. The Enrollment Broker must notify the Department of all returned mail due to incorrect mailing address in an electronic format and frequency to be defined by the Parties after the Contract Effective Date.
  - a. If the Enrollment Broker identifies a new, updated address, the Enrollment Broker must make all reasonable attempts to identify the correct mailing address and resend only beneficiary specific information not to include general information such Enrollment Broker brochures at no additional cost to the Department.
5. All mailed materials to potential and existing members, and authorized representatives must be sent via first class mail.
6. The Enrollment Broker must take into consideration cost-effective methods for controlling postage costs when producing member materials that will be mailed.
7. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe mailing requirements as defined in this Section.

## M. Enrollment Information System Integration

The vision of a streamlined beneficiary experience includes integration of state systems with contractor systems without interruption or change in level of services. The Department and Enrollment Broker will partner to build seamless system integration to ensure beneficiaries experience a streamlined experience through the transition into managed care. The Enrollment Broker will be required to work closely with the Department's System Integrator for all integration, testing and implementation activities.

1. The Enrollment Broker must demonstrate the ability to interface with the State of North Carolina and Department Systems including NC FAST, NCTracks, and other systems as prescribed by the Department. *Figure 2: Architecture* below presents sample components of the architecture that will need to be implemented. (Note: Figure 2 is based on the time this RFP was issued, and is subject to change prior to implementation.) The Enrollment Broker must have the ability to interface in both real-time and through standard x12 EDI transactions.

**Figure 2: Architecture**



2. The State will continue to intake applications, determine the eligibility of a beneficiary, and auto assign PHPs in the NC FAST platform. Once eligibility is determined, NC FAST will pass the member to the Enrollment Broker's PHP Selection tool for PHP choice. If no PHP is chosen, the beneficiary will be assigned to a plan utilizing the auto-assignment algorithm – as defined in APPENDIX K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM. If the member chooses to change plans with or without cause, the Enrollment Broker will manage the choice counseling and the new PHP selection and pass the updated information to NC FAST. NC FAST will interface with NCTracks to coordinate enrollment effectuation with the PHPs. The transmission of PHP selection data between NC FAST to the Enrollment Broker will be at a minimum daily, however the State prefers real-time transactions where possible.

3. The Department uses the National Information Exchange Model (NIEM - niem.gov) as the standard canonical model for the real-time interchange of data. Real-time interfaces can be implemented using SOAP or REST APIs, and the Department's ESB team will work with the Enrollment Broker to implement the exchanges as needed. In the event the Enrollment Broker hosts software at a location other than a North Carolina Department of Information Technology data center, the Enrollment Broker must comply with all the State's security requirements.
4. The Enrollment Broker must integrate to other Department partners such as PHPs, Provider Member portals and repositories, CVO, and other partners as prescribed by the State and as required to fulfill the obligations of the contract. All integrations between the Department's partners will comply with all the State's security requirements and will be real-time unless otherwise agreed to by the Department and the Enrollment Broker.
5. As noted in the sections above there may be instances where the Enrollment Broker will collect updated information from the beneficiary. The department will work with the Enrollment Broker to define what data elements can be updated without potentially impacting the beneficiary's eligibility. These data elements will be transmitted to the State on a real-time basis unless otherwise agreed.
6. All architecture implementations must comply with the Statewide architecture, and the Statewide and Department's privacy and security manuals. The State IT Architecture can be located at <https://it.nc.gov/services/service-directory/it-architecture>. The Statewide Information Security Manual can be located at <https://it.nc.gov/document/statewide-information-security-manual>. The Department's Privacy and Security Manual can be located at <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>.
7. The Department will notify Enrollment Broker of any changes to the technical requirements. The Enrollment Broker shall have sixty (60) calendar days from the date of notice to develop, test and implement the requirements before the Service Level Agreement expectations apply unless an alternate timeline is proposed and agreed to by the Department.
8. The Enrollment Broker must develop policies and internal process flows, subject to Department review and approval prior to implementation, which describe consolidated provider directory as defined in this Section.

#### N. Staffing and Key Personnel

1. The Enrollment Broker must identify Key Personnel to be assigned for the duration of this Contract. Key Personnel must be identified and mapped to the Staffing Roles

provided in ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL. The Enrollment Broker must indicate the name of the proposed individual to perform each role.

2. The Enrollment Broker must demonstrate that Enrollment Broker staff proposed as Key Personnel have the proper credentials and experience to perform all duties and responsibilities of that role. For each Key Personnel proposal, the Enrollment Broker must include:
  - a. Name;
  - b. Role;
  - c. Experience relevant to the services to be provided under this Contract;
  - d. Resume; and
  - e. Any certifications or credentials for the Role where requested by the Department.
3. The Enrollment Broker must not substitute Key Personnel to the performance of this Contract without prior written approval by the Department.
  - a. The Enrollment Broker must notify the Department of any desired substitution of Key Personnel, including the name, role, resume, and other information where requested by the Department for the recommended substitute.
  - b. Within ten (10) calendar days of the request, the Department will notify the Enrollment Broker if the recommended substitute is acceptable. If the Department does not accept the recommended substitute, the Enrollment Broker will have ten (10) calendar days to make another recommendation.
  - c. At no time, however, may a Key Personnel Role be vacant. It is the Enrollment Broker's responsibility to keep the role filled until the Department approves a substitution.
  - d. The Department may, at its sole discretion, terminate the services of any person providing services under this contract. Upon such termination, the Department may request an acceptable personnel substitution or terminate the contract services provided by such personnel.
4. The Enrollment Broker must provide a detailed staffing contingency plan for handling sudden and unexpected increases in enrollment, PHP transfers and call volumes with a description on how the plan will be implemented and coordinated with the Department. This must be included as part of the Technical Response in ATTACHMENT B: TECHNICAL RESPONSE.

#### O. Account Management

1. The Enrollment Broker must work with the Department and the PHPs to be good stewards of State funds and State personnel time and to ensure effective administration of the managed care program. The Enrollment Broker must:
  - a. Participate in meetings with the Department, the PHPs, county DSS offices, members of the EBCI, and any other agencies or groups deemed necessary by the Department. Enrollment Broker staff participating must include the Project Director

and any other staff recommended by the Project Director or deemed necessary by the Department. Such meetings may include, but are not limited to:

- i. Status calls with the Department and PHPs during implementation to discuss operational and technical issues;
  - ii. Updates with the Department and PHPs after go-live; and
  - iii. Annual enrollment planning meetings with the Department and PHPs to plan for routine business or program changes, as needed.
- b. Submit a status report to the Department, on the frequency determined by the Department, outlining the activities and progress for that period. The format and requirements of the Status Report must be developed by the Enrollment Broker and approved by the Department; and
  - c. Submit an Annual Report to the Department, by 12:00 PM EST within twenty (20) Business Days following the end of the calendar year. The format and requirements of the Annual Report must be developed by the Enrollment Broker and approved by the Department.

## P. Training

1. No later than ninety (90) days after the Contract Effective Date, the Enrollment Broker must submit a training and evaluation module for customer service staff to ensure adequate knowledge of North Carolina Medicaid programs, including the various Medicaid managed care systems and any other covered program. The training module must utilize Department resources where available and must be approved by the Department before use with any Enrollment Broker's staff.
2. Once approved, the Enrollment Broker must ensure all Enrollment Broker staff, including new hires, receive training on the special needs of the North Carolina Medicaid population, at least annually, including:
  - a. Awareness of and sensitivity to the needs of persons who may be disadvantaged by income, disability and/or illiteracy, or who may be non-English speaking;
  - b. Unique needs, experiences of tribal members including
    - i. The significance of extended families including an understanding that the definition of extended families is different than non-native families
    - ii. The different service eligibility for non-enrolled family members of EBCL enrolled members
    - iii. Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish)
    - iv. Respect for traditions where gender and age may play an important role:
      1. Elders have a highly respected status due to their life experiences; Elders tend to be non-verbal
      2. Pregnant individuals
      3. Veterans
    - v. The different service types and benefit plans available through the Tribal Option.

- c. Sensitivity to different cultures and beliefs;
  - d. Sensitivity to the needs, experiences, history and cultural of tribal members;
  - e. Use of bilingual interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled;
  - f. HIPAA;
  - g. Overcoming barriers to accessing medical care; and
  - h. Understanding the role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to beneficiaries' health and health care needs.
3. The Enrollment Broker must collaborate with the Department on providing training to Department, county DSS staff, the EBCI, the Ombudsman program and PHPs.
- a. Training must:
    - i. Be complete at least sixty (60) calendar days prior to the cross-over open enrollment period;
    - ii. Be hosted at regional locations for county social services and PHHS staff;
    - iii. Contain information on the role of the Enrollment Broker in plan selection;
    - iv. Relationship and integration of Enrollment Broker with Department, county DSS staff as outlined in the DSS engagement strategy, the EBCI PHHS, the Ombudsman program, and PHPs;
    - v. Include sample beneficiary materials;
    - vi. Outline the process for beneficiary assignment to plans;
    - vii. Describe how to navigate the public facing websites;
    - viii. Describe how to properly use and update the beneficiary data within the Beneficiary Management platform;
    - ix. Describe plan for outreach events; and
  - b. Materials for the training must be provided to the Department no later than thirty (30) days prior to scheduled events for review, if necessary.
  - c. The Enrollment Broker must develop separate training in collaboration with EBCI for PHHS staff and other tribal entities as identified by EBCI and the Department.
  - d. The Enrollment Broker must update the training materials and the training of personnel as changes are made to the managed care program or in response to improving the customer experience.

#### Q. Fraud, Waste, and Abuse

- 1. To promote integrity in Enrollment Broker activities, the Enrollment Broker must:
  - a. Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (recipients, providers, PHPs or others) fraud, abuse, or waste of benefits, program funds and misuse of the systems that support the Enrollment Broker programs;
  - b. Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, abuse, or waste prior to enrollment or the Department's issuance of benefits;

- c. Describe proposed solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, abuse, and waste;
  - d. Develop a fraud, abuse, and waste prevention compliance plan that establishes criteria for preventing, detecting, and referring cases of suspected fraud, abuse, or waste;
  - e. Create processes to investigate suspected fraud, abuse, and waste that do not infringe on the rights of individuals and are consistent with due process of law;
  - f. Designate a compliance officer who is responsible for making the decisions on cases to refer to the State;
  - g. Develop policies and processes to identify, report and investigate suspected fraud, abuse, or waste;
  - h. Refer all cases of suspected fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department; and
  - i. Maintain appropriate records for a period of seven (7) years or until the end of the Contract term, whichever is later. Deliver the records to the State at the end of the Contract term and/or make these records available to the Department upon request.
2. Failure to notify the Department of possible or potential fraud, waste, and abuse within five (5) calendar days may result in the Department exercising its right to enforce performance related liquidated damages or sanctions defined within this RFP

#### R. Performance Reporting and Delivery Requirements

1. The Enrollment Broker must comply with the required timelines for delivery of all reporting requirements as described in ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS. Although the Department has indicated the reports that are required, the Enrollment Broker may suggest additional reports. The Department requires receiving data in XML format, unless otherwise approved by the Department. The Department's standard is NIEM. Microsoft Word is acceptable for textual descriptions or narratives associated with reports.
2. The Department reserves the right to require additional reports (e.g., monthly, "ad hoc") beyond what is included in this document. The Enrollment Broker must submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

#### S. Reconciliation

The Medicaid eligibility and enrollment will be determined by NC FAST and communicated to the Enrollment Broker via a real-time web service thru the State's ESB. Beneficiaries can apply or makes changes in circumstances through the county DSS offices, ePASS, or Healthcare.gov. These changes are facilitated in NC FAST, and any changes in eligibility due to a change in circumstances

determined by NC FAST. All changes that are relevant to the Enrollment Broker role will be provided to the Enrollment Broker via interfaces.

1. The Enrollment Broker must develop, document, and maintain computer systems necessary to carry out all functions described in this contract. The Enrollment Broker must ensure that systems and files meet all state and federal requirements including HIPAA and that all enrollment files exchanged between the enrollment broker and health plans, and the enrollment broker and the state systems, must be HIPAA compliant. The Enrollment Broker will conduct a bi-weekly status report to review all the reconciliation data with Department staff.
2. The following Daily, Weekly, and Monthly reconciliation processes define how the Enrollment Broker will provide an auditable reconciliation that all beneficiary information and requests were processed per the agreement and per DHHS, State, and Federal regulation and laws. If technologies such as real-time web services are implemented, the Department reserves the right to change these processes based on the nature of the technology, however the intent of the reconciliation processes will not change. The Enrollment Broker must identify its ability to meet all reconciliation requirements as outlined below.
3. Daily Reconciliation:
  - a. The Enrollment Broker must perform a Daily Enrollment Transaction Reconciliation of all Enrollment, Disenrollment, and related transactions that it receives from and sends to the Department. The daily reconciliation will be used to determine if the Enrollment Broker received and fully processed, all appropriate transactions forwarded by the Department. Validation of the daily reconciliation process will be based on the Department's Number of Records Transmitted by Transaction Type Report.
  - b. The Enrollment Broker must complete the Daily Enrollment Transaction Reconciliation by the close of the next business day, unless the Department approves an extension to that date.
  - c. The Enrollment Broker must report to the Departmental Contract Administrator and correct any Enrollment data transmission discrepancies to the Departmental Contract Administrator within two (2) business days from the time the discrepancies are known to the Enrollment Broker.
  - d. The Enrollment Broker must submit a Corrective Action Plan (CAP) to the Department within five (5) business days after the discrepancies are known to the Enrollment Broker outlining the steps the Enrollment Broker will implement to ensure that the discrepancies will not continue to occur or advise the Department and/or the respective PHP of another appropriate corrective action.
  - e. The Enrollment Broker must provide the Department with a weekly summary report of the Daily Paper Enrollment Transaction Reconciliation, noting all discrepancies, the corrective action taken by the Enrollment Broker to resolve any problems, and a chart by PHP reflecting:
    - i. All transactions sent from the Department to the Enrollment Broker; and

ii. All transactions processed on the Enrollment Broker's Enrollment system.

4. Weekly Reconciliation

- a. As a component of its enrollment systems, the Enrollment Broker must design, develop, and implement a comprehensive weekly electronic reconciliation of all Enrollment, Disenrollment, and related transactions that it receives from the Department. The weekly electronic reconciliation will be used to determine if the Enrollment Broker received and fully processed on their files all appropriate transactions forwarded by the Department.
- b. Any discrepancies identified by the Enrollment Broker in the weekly electronic reconciliation must be reported to the Department and the respective PHP(s) upon discovery of the discrepancy. Discrepancies caused by the Enrollment Broker must be corrected within three (3) business days, unless otherwise agreed upon by the Department. The Enrollment Broker must submit a CAP to the Department to ensure that all appropriate Enrollment transactions are consistent on the Department's and the Enrollment Broker's files.
- c. The weekly electronic reconciliation must be submitted to PHPs by 12:00 PM EST each Monday for the prior week. The Enrollment Broker must provide the Department and each PHP with a summary and detailed report of the weekly electronic reconciliation, as well as information concerning the correction of discrepancies and/or any other details relating to the reconciliation.
- d. The Enrollment Broker must coordinate the requirements of the weekly reconciliation with all PHPs. The weekly electronic reconciliation will be a standing item in the Department's bi-weekly status meetings with the Enrollment Broker as stated within this RFP.

5. Monthly Reconciliation

- a. As a component of its enrollment systems, the Enrollment Broker must design, develop, and implement a comprehensive monthly electronic reconciliation of all Enrollment, Disenrollment, and related transactions that it receives and processes from the Department, and that it forwards to the respective PHPs. The monthly electronic reconciliation will be used to determine if the Enrollment Broker received and fully processed on its files all appropriate transactions forwarded by the Department.

## T. Security and Audit Requirements

1. Physical Security:

- a. Each person who is an employee or agent of the Enrollment Broker or subcontractor must display his or her company ID badge always while on State premises. Upon request of State personnel, each such employee or agent must provide additional photo identification.
- b. At all times at any State facility, the Enrollment Broker's personnel must cooperate with State site requirements, that include but are not limited to, being prepared to

be escorted always, providing information for badging, and wearing the badge in a visible location always.

2. Information Technology:

- a. The Enrollment Broker must comply with and adhere to the Federal rules such as HIPAA, CMS and State IT Security Policy and Standards, and Department Privacy and Security Policies. These policies may be revised from time to time. The Department will notify the Enrollment Broker of revisions and the Enrollment Broker must comply with all revisions.
- b. The Enrollment Broker must not connect any of its own equipment to a State LAN/WAN without prior written approval by the State. The Enrollment Broker must fill-out any necessary paperwork as directed and coordinated with the Department's Contract Administrator to obtain approval by the State to connect Enrollment Broker-owned equipment to a State LAN/WAN.
- c. The Enrollment Broker must ensure all beneficiary interactions to comply with Web Content Accessibility Guidelines (WCAG) 2.0 and the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Sec. 508 of the Rehabilitation Act of 1973 as amended January 2017.

3. Duty to Report:

- a. The Enrollment Broker must report all incidents, suspected or confirmed security breach to the Department's Privacy and Security Office Incident Website at <https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security> within twenty-four (24) hours after the incident is first discovered, provided that the contractor must report a breach involving Social Security Administration data or Internal Revenue Service data within twenty-four (24) hour after the breach is first discovered.
- b. During the performance of this contract, the contractor is to notify the Department's Contract Administrator and Department Privacy and Security Office of any contact by the federal Office for Civil Rights (OCR) received by the contractor.

4. Cost Borne by Enrollment Broker: If any applicable federal, state, or local law, regulation, or rule requires the division or the contractor to give affected persons written notice of a security breach arising out of the contractor's performance under this contract, the contractor must bear the cost of the notice.

5. Continuous Monitoring:

- a. Enrollment Broker must always adhere the State CIO's mandate for a Continuous Monitoring Process. Enrollment Broker must work with the owning division/office to implement a risk management program that continuously monitors risk through assessments, risk analysis and data inventory. The requirements are based on NIST 800-37, Continuous Monitoring Process and originates from G.s. § 143B-1376, located at: <http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter>

[143B.html](#), which requires the North Carolina State CIO to annually assess each agency and each agency's contractors' compliance with enterprise security standards.

- b. Enrollment Brokers must assist the owning division/office with risk assessment and security assessment of their critical systems and infrastructure.
    - i. Assessments are to be performed either through third-party or self-assessment on a three-year cycle (with a third-party assessment mandated every third year).
    - ii. All findings identified in the assessment must be provided to the North Carolina Department of Information Technology within thirty (30) calendar days of assessment completion and a plan to remediate each finding.
  - c. Assessment of agency cloud-hosted providers or off-site hosting services.
    - i. Contractors providing Infrastructure as a Service, Platform as a Service and/or Software as a Service may be required to obtain approval from the State CIO and/or the Department and ensure Contractor compliance with Statewide security policies.
    - ii. The contractor will provide attestation to their compliance and an industry recognized, third party assessment report performed annually. Types of these reports include: Federal Risk and Authorization Management Program (FedRAMP) certification, SOC 2 Type 2, SSAE 16 and ISO 27001.
    - iii. Departments and their divisions/offices are required to review these reports, assess the risk of each Enrollment Broker, and provide annual certification to their compliance to the State CIO.
    - iv. A data inventory of all cloud hosted services is required and performed through completion of a Privacy Threshold Analysis (PTA) documenting the data classification and data fields hosted within the cloud, offsite or contractor hosted environment. The PTA must be reviewed annually and when changes have been made to the data being collected.
6. Record Retention:
- Records must not be destroyed, purged, or disposed of without the express written consent of the Department. State basic records retention policy requires all grant records to be retained for a minimum of five (5) years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years. Records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five (5) year period described above, whichever is later.
- a. Any records created or modified by the Enrollment Broker and not duplicated in Department system via interfaces must be retained per State policy. The

State policy is mandated by the State Archives of North Carolina and is located here: <https://archives.ncdcr.gov/government/retention-schedules>. The Department will work with the Enrollment Broker to validate that all Department and federal retentions schedules follow State policy. Additionally, at the point the Contract terminates/expires, all data must be transitioned to the State in a format prescribed by the Department unless that data has exceeded its archive requirements. The Department may request verification from the Enrollment Broker that archive requirements are being met.

- b. The record retention period for Temporary Assistance for Needy Families (TANF) and MEDICAID and Medical Assistance grants and programs is a minimum of ten (10) years, the period for HIPAA is a minimum of six (6) years, and the period for both the IRS and SSA is a minimum of seven (7) years.
7. The Enrollment Broker must obtain from each prospective employee a signed statement permitting a criminal background check. The Enrollment Broker must obtain (at their own expense) and provide the Departmental Contract Administrator with a North Carolina State Bureau of Investigation(SBI) and/or FBI background check on all new employees prior to assignment. The Enrollment Broker may not hire an employee who has a criminal record that consists of a felony or misdemeanor unless prior written approval is obtained from the Departmental Contract Administrator.
8. The Department, State, CMS, the Office of the Inspector General, and their designees may, at any time, inspect, perform compliance reviews, and audit any records or documents of the Enrollment Broker, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under 42 C.F.R. § 483.3 exists for ten (10) years from the final date of the Contract Termination/Expiration Date, or from the date of completion of any audit, whichever is later.
9. Integration Services:
  - a. The Enrollment Broker must work with the State to implement data exchanges that comply with the State's security policies, as defined by the North Carolina Department of Information Technology. The State's preferred method of exchanging data with other applications in the Medicaid Enterprise System (MES) is through synchronous real-time web services and/or asynchronous queue-based messaging. The data exchanges are provided in *Figure 2: Current Architecture*.
  - b. The Enrollment Broker must have the ability to securely exchange files through secure file transfer protocol (SFTP) with other systems.
10. Within thirty (30) days after the Contract Effective Date, the Enrollment Broker must provide the Department with all Enrollment related systems documentation, including, but not limited to, flow charts, file formats, processing logic, data element dictionary, valid values for all Enrollment related information transaction processing, provider directory and hard-copy print file directories, and telecommunications systems. The

Enrollment Broker must also provide the Department with Department approved updates/changes to this documentation within five (5) business days after the Department's approval.

11. The Enrollment Broker must understand and follow North Carolina Statewide Information Security Manual (located at <http://it.nc.gov/document/statewide-information-security-manual>), the North Carolina Statewide Information Architecture Framework (located at <https://it.nc.gov/services/it-architecture/statewide-architecture-framework>), and any Department derivatives of these documents. The Enrollment Broker will provide documentation as needed for the Department to assess the security of the Enrollment Broker facilities and systems, including Contractor Security Plans. The security review is part of the overall readiness and noncompliance may be subject to Contract Termination for Cause.
12. Service Organization Control (SOC) reports. All SOC 1, 2 and 3 must be submitted to the Department's Privacy and Security Office.
13. Data Security: The Enrollment Broker will review and comply with the data security classification and handling policies set forth in the Statewide Data Classification and Handling Policy located at <https://it.nc.gov/document/statewide-data-classification-and-handling-policy>.
14. NCID: The proposed solution must externalize identity management and may be required to utilize the North Carolina Identity Service (NCID) for the identity management and authentication related functions performed by the Enrollment Broker's applications. NCID is the State's enterprise identity management (IDM) service. The North Carolina Department of Information Technology operate it. Additional information regarding this service can be found in the DIT Service Catalog at: <http://it.nc.gov/it-services> (see Identity Management - NC Identity Management under the main menu item Application Services) and the NCID Website at: <https://www.ncid.its.state.nc.us/>. The use of any other IDM service will require Department and State approval. The protocol (web services, LDAP, SAML, etc.) be determined by the Department and the Enrollment Broker based on the implementation.

#### U. Business Continuity Plan

1. The Enrollment Broker must develop and maintain a business continuity plan that is acceptable to the Department, demonstrate and test the plan at the Department's request. The Enrollment Broker must adhere to all applicable published state, the Department's privacy and security policies, (located at <http://it.nc.gov/document/statewide-information-security-manual> and <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>) and all other requirements set forth in this RFP. An example of the template to be used for the

Business Continuity Plan is included as ATTACHMENT N: BUSINESS CONTINUITY MANAGEMENT PROGRAM.

- a. Within thirty (30) days after the Contract Effective Date, the Enrollment Broker must submit a Business Continuity Plan, to include disaster recovery processes, which provides a detailed description of its disaster contingency and recovery plan for all requirements specified in this RFP. The Enrollment Broker will demonstrate how it will restore call center operations within twenty-four (24) hours and resume all remaining operations within three (3) working days following a natural or manmade disaster. The plan must meet recognized industry standards for security and disaster recovery requirements. The plan must identify disaster situations (e.g., fire, flood, terrorist event, hurricanes/tornadoes), which could result in a major failure. For each identified situation, the Enrollment Broker must explain in detail the:
  - i. Preventive measures that would be instituted to minimize the likelihood of its occurrence;
  - ii. Back-up, off-site storage, and other pre-disaster safeguards that would be implemented to minimize any disruption or data loss; the data back-up policy and procedures must include, but is not be limited to:
    1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;
    2. Documented back-up procedures;
    3. The location of data that has been backed up (off-site and on-site, as applicable);
    4. Identification and description of what is being backed up as part of the back-up plan;
    5. Any change in back-up procedures in relation to the Enrollment Broker's technology changes; and
    6. A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.
  - iii. Tasks that would be involved, and identify by job description or title the Enrollment Broker's staff and the Department staff involvement;
  - iv. Recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans;
  - v. Time-frame required to accomplish full recovery from the point of interruption;
  - vi. Processes and triggers for implementing the plan, including coordination with the Department;
  - vii. Procedures for coordinating with the Department in the event of a disaster; and
  - viii. Procedures for notifying the Department, PHP recipients, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.
2. As part of the Business Continuity Plan, the Enrollment Broker must include a section specific to the call center that will be submitted for the Department for approval within

thirty (30) days after the Contract Effective Date and be updated at least every six (6) months.

- a. The Enrollment Broker must notify the Department each time the business continuity plan is activated within two (2) hours of the event.
- b. The plan must at a minimum include an overflow or redundant telephone system to operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.
  - i. The overflow system must interface with the call tracking and recording standards and technology required in this RFP.
  - ii. Additionally, all contract quality and performance standards required in this contract must apply to the overflow call center.

#### V. Member Enrollment Satisfaction Survey

A Department priority is understanding and improving the customer experience. Capturing customer feedback and acting to review and potentially modify policy or process from that feedback is critical to improving the customer experience.

1. The Enrollment Broker must develop and implement Member Satisfaction Surveys to ensure enrollment process is meeting Department and beneficiary needs. The Enrollment Broker must use results to create a baseline, identify and resolve potential concerns early, address targeted issues, and develop strategy for ongoing improvements. The surveys must include, but not be limited to:
  - a. Call Center Survey to measure responsiveness, knowledge, timeliness, politeness, and overall quality of service. This survey must be offered as optional for all enrollees.
    - i. The Enrollment Broker must minimally sample a statistically relevant number of calls received monthly to obtain a minimal response rate of 10% of callers.
  - b. Enrollment Process Internet Survey to measure web-based enrollment for ease of use, convenience, average length of time to enroll, help function effectiveness; clarity and comprehensiveness; and beneficiary's overall ability to make enrollment decisions. This survey must be automatically offered at the end of the web-based enrollment as optional for all enrollees.
  - c. Education event survey to measure if presentation/handouts were understandable, presenter was effective, opportunities or topics for future events and content was useful. This survey must be offered to attendees as optional at the end of each event.
2. The Enrollment Broker must submit survey questions and methodology to the Department for review and approval prior to use with beneficiaries.
3. Reports, including Enrollment Broker's evaluation of survey results and recommendations for enrollment/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.

4. Based on survey results, the Enrollment Broker may be required to provide further targeted research to better define and resolve issues or improve processes.
5. Key Service Metrics: *Table 6 – Key Service Metrics* defines the metrics to be monitored and measured for the Satisfaction Survey. This includes the Call Center enrollment survey responses and the web-based enrollment survey responses. Reports for these metrics must be provided in accordance with the reporting requirements of this RFP.

#### W. Readiness Review

1. The Department will conduct an on-site review and/or desk audits to assess the readiness of the Enrollment Broker to effectively administer and provide the services defined in this RFP and subsequent contract.
2. Prior to the EB Services for Managed Care Go-Live Date, the Enrollment Broker must demonstrate, to the Department's satisfaction, that Enrollment Broker is fully capable of performing all duties under this contract, including demonstration of the following:
  - a. Enrollment Broker's Call Center is fully operational;
  - b. Enrollment Broker's Enrollment Services Website is fully operational;
  - c. Enrollment Broker's Beneficiary Management Platform is fully operational;
  - d. Enrollment Broker's Consolidated Provider Directory is fully operational;
  - e. Enrollment Broker's mailing capability is fully operational;
  - f. Enrollment Broker's integrated information technology systems and services are adequate to ensure that any disruptions to service will be minimal and not impact the delivery of services to beneficiaries;
  - g. Enrollment Broker has hired and trained its staff in accordance with the requirements outlined in this RFP;
  - h. Enrollment Broker has successfully tested using mutually agreed upon testing standard all real-time, batch, and EDI interfaces with the Department and other entities (PHPs) as specified by the Department prior to Contract Start Date. The Department will provide a complete list of required interfaces to the Enrollment Broker after the award for the contract; and
  - i. Enrollment Broker has provided all required privacy and security documentation and Continuity of Operations and Disaster Recovery documentation, including any test results.
  - j. Enrollment Broker has developed, implemented and earned Department approval of all policies and process required for successful implementation and maintenance of the Enrollment Broker program required herein.
3. Any changes required to the Enrollment Broker's processes as identified through readiness review activities must be made by the Enrollment Broker prior to implementation. Costs associated with these changes must be borne by the Enrollment Broker.

4. The Enrollment Broker's inability to demonstrate to the Department's satisfaction that Enrollment Broker is fully capable of performing all duties under this contract no later than thirty (30) days may be grounds for the immediate termination in accordance with the termination provisions and application of any contract performance penalties stated within this RFP.
5. The Department reserves the right to conduct additional pre- or post-implementation reviews and performance compliance audits as needed to determine compliance to contract terms. This is exclusive of SLA and KPI report reviews.
6. Upon approval of the Enrollment Broker's operational readiness and a determined start date, the Enrollment Broker may invoice the Department in accordance with the invoicing provisions of this RFP.

#### X. Implementation Plan

The Department requires an experienced Enrollment Broker who can implement comprehensive Enrollment Broker Services quickly and efficiently. The Department has defined the Enrollment Brokers implementation period as the time between the Contract Effective Date and the Start Date of enrollment broker operations on January 2, 2019, or a date determined by the Department.

1. The Enrollment Broker must submit, no later than thirty (30) days after the Contract Effective Date, a detailed Implementation Plan to implement Enrollment Broker Services no later than January 2, 2019, or a date determined by the Department.
2. A comprehensive report on the status of each task, subtask, and deliverable in the work plans must be provided to the Department by the Enrollment Broker every week from the time of Contract execution through three (3) months after successful implementation, in MS Project 2016 or format agreed upon by the Department and Enrollment Broker.
3. The Enrollment Broker and Department will work together during implementation period to establish a schedule for key activities and define expectations for the content and format of contract deliverables through the implementation period and first contract year.
4. Key Service Metrics: *Table 6 – Key Service Metrics* defines the metrics to be monitored and measured for Implementation. This includes the initial upload of the eligibility file, accurate upload of the eligibility file, and EB integration of the Consolidated Provider Directory. Reports for these metrics must be provided in accordance with the reporting requirements of this RFP.

## Y. System Interface Plan

1. The Department and the Enrollment Broker will mutually agree to the file formats and transfer protocols for all data exchanges.
2. The Enrollment Broker will provide to the Department of a detailed inventory of interfaces and formats to be implemented as determined mutually by the Department and the Enrollment Broker. As outlined in this agreement the Department will work with the Enrollment Broker to define the interfaces required. The Department strongly prefers real-time web services as a standard for exchanging data. These documents will be provided to the State no less than 60 days prior to go live. The plan will include the following:
  - a. Detailed inventory of all interfaces and exchanges with the Department or its partners, including but not limited to data, frequency, protocols, file names, sources and target system. This inventory will be in Microsoft Excel
  - b. A detail diagram(s) showing data flows between systems including but not limited to source and destination, data, frequencies, direction.

## Z. Responsibilities

1. The Department has the following responsibilities during the performance of the Enrollment Broker Contract.
  - a. Meet with the Enrollment Broker's representative as defined within this RFP and communicate as needed to discuss the Enrollment Broker's activities and manage the day-to-day activities.
  - b. Determine a schedule for and conduct readiness reviews as determined necessary.
  - c. Provide access to necessary systems and information for the Enrollment Broker to conduct required services. The Department will work with the Enrollment Broker to provide eligibility and auto-assignment information for both beneficiaries requiring coaching and keeping the Enrollment Broker's systems up to date.
  - d. Provide data to the Enrollment Broker related to member eligibility via interfaces. Include and enforce contractual requirements on other entities when those entities need to provide data to the Enrollment Broker for the Enrollment Broker to fulfill its contractual obligations (e.g. the PHP must provide data to the EB for the Consolidated Provider Directory).
  - e. Auto assign members to PHPs based on the State's criteria and share this data with the Enrollment Broker.
  - f. Effectuate coverage with the PHPs using 834 transactions and eligibility files as determined by the State.
  - g. Conduct oversight and monitoring, reviewing the Enrollment Broker performance and regular reporting and provide feedback to the Enrollment Broker.
  - h. Maintain websites with current managed care program information.
  - i. Perform disenrollment determinations for clinically-related requests.
  - j. Provide written notices to beneficiaries of Medicaid eligibility determinations and redeterminations, PHP assignment and disenrollment decision.
  - k. Notify the Enrollment Broker when corrective actions are required.

- l. Create templates and content requirements for reference, notices, and educational materials.
  - m. Establish guidelines to be followed where necessary and as mentioned within this RFP. Guidelines will be drafted by the Department. The Department will provide the guidelines to the Enrollment Broker and indicate the date that guidelines are effective.
2. The Offeror must provide any additional responsibilities of the Department that the Offeror believes are necessary during performance of the Enrollment Broker Contract.

## IV. CONTRACT PERFORMANCE

### A. Contract Performance and Sanctions

The Contractor must comply with all terms, conditions, requirements and service level metrics set forth in this Contract. The Department reserves the right to impose, at the Department's sole discretion, any and all remedies available under the terms of this Contract, at law or equity including but not limited to, intermediate sanctions, liquidated damages, and/or termination of the Contract, if the Contractor violates any provision of the Contract or amendments thereto, or if the Contractor does not comply with any other applicable federal or state law, regulation compliance with which is mandated expressly or implicitly by the Contract.

1. The decision to impose intermediate sanctions and/or liquidated damages may include consideration of some or all the following factors:
  - a. The nature, severity, and duration of the violation;
  - b. Whether the violation jeopardizes the health, safety, and welfare of enrollee(s);
  - c. Whether the violation jeopardizes the integrity and financial sustainability of the program;
  - d. Whether the violation impairs the efficient operation of the program and impacts the Department's ability to effectively administer and oversee the program;
  - e. Whether the violation (or one that is substantially similar) has previously occurred;
  - f. The Contractor's history of compliance and the good faith exercised by the Contractor in attempting to stay in compliance, including self-reporting of the violation by the Contractor.
2. The Department may, in its sole discretion, waive the imposition of any intermediate sanction or assessed liquidated damage for self-reported noncompliance by the Contractor or for any other good cause as determined by the Department.
3. Intermediate Sanctions
  - a. Intermediate sanctions exclude the assessment of liquidated damages and termination of the Contract and include, but are not limited to:
    - i. Immediate remediation of the non-compliant behavior or practice as determined by the Department in a manner consistent with the nature of the non-compliance;
    - ii. Participation in additional education and/or training;
    - iii. Referral to the appropriate State or federal agency for investigation in accordance with the nature of the noncompliance;

- iv. Submission of a corrective action plan;
- v. Suspension of all or part of marketing activities; and/or
- vi. Suspension of part of the contract.
- b. Notice
  - i. Prior to the imposition of intermediate sanctions, the Department must provide the Contractor with written notice detailing the nature of the noncompliance, any applicable intermediate sanction(s) and the method and timeframes by which the Contractor may dispute the claim of noncompliance and the imposed sanctions and/or liquidated damages no later than 90 days after the Department discovers the Contractor is in violation of the terms of this Contract.

#### 4. Liquidated Damages

- a. If the Contractor is determined to be in violation with the terms, conditions, requirements, and/or service level metrics of this Contract, the Department must be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Department due to the Contractor's failure to meet any aspect of the requirements of the Contract and/or to meet specific service level metrics set forth in the Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of the Contractor's noncompliance with the terms, conditions, requirements and/or service level metrics of this Contract, the Department may assess liquidated damages against the Contractor, provided the Department has not materially caused or contributed to the violation.
- b. The liquidated damages prescribed in this section are not intended to be a penalty but are intended to be reasonable estimates of the Department's projected financial loss and damage resulting from the Contractor's nonperformance. Accordingly, in the event the Contractor fails to perform in accordance with the Contract, the Department may assess liquidated damages as provided in this Section. If the Contractor fails to perform any of the services or requirements described in the Contract, the Department may assess liquidated damages for each occurrence as provided in *Table 6 – Key Service Level Metrics*.
- c. Notice
  - i. Prior to the assessment of liquidated damages, the Department must provide the Contractor with written notice detailing the nature of the noncompliance, any applicable assessed liquidated damages, and the method and timeframes by which the Contractor may dispute the claim of noncompliance and the imposed sanctions and/or liquidated damages no later than 90 days after the Department discovers the Contractor is in violation of the terms of this Contract.
- d. Payment
  - i. If the Contractor elects not to dispute the assessment of liquidated damages, the liquidated damages must be due and payable within thirty (30) calendar days of the date on the written notice assessing the liquidated damages.
  - ii. If the Contractor elects to dispute the assessment of liquidated damages, but does not prevail in the dispute resolution, the liquidated damages must be due and payable within thirty (30) calendar days of the date on the written notice

- of final decision issued by the Department following the dispute resolution upholding its original decision.
- iii. If the Contractor fails to pay liquidated damages by the applicable due date, the Contractor must be subject to interest and a late payment penalty in accordance with G.S. 147-86.23 until the past due amount is paid. The Department reserves the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount from future payments owed to the Contractor.
  - iv. Notwithstanding the Contractor's request for a dispute resolution, the Department must have the right to retroactively impose liquidated damages on the Contractor for violations of the terms of this contract during the pendency of a dispute in accordance with this Section and *Table 6 – Key Service Level Metrics*, if the Contractor does not prevail in the dispute and the violations continued during the dispute resolution process.
6. Key service level metrics:
- a. The Contractor must be required to meet key service level metrics and is subject to the assessment of liquidated damages as outlined in *Table 6 – Key Service Level Metrics*. If the Contractor fails to meet the metrics, liquidated damages may be assessed in the amounts indicated below for the period in which the deficiency occurs. Liquidated damages may be retroactive to the date of required written notice assessing liquidated damages against the Contractor, and such damage assessments may continue until the Department determines the deficiency has been cured.
  - b. A general liquidated damage of five hundred dollars (\$500) per day/occurrence, as applicable, may be assessed at the sole discretion of the Department for any violation of a contract provision that is not specifically listed in *Table 6 – Key Service Level Metrics*.
  - c. Accurate Data is where all data elements are in the file as defined by the Department with no errors.

**Table 6 – Key Service Level Metrics**

Description	Standard	Liquidated Damage
<b>Implementation</b>		
1) <u>Initial upload of eligibility file</u> : Defined as initial Medicaid and NC Health Choice eligibility file uploaded to EB platform in advance of open enrollment period	Initial file upload date as defined in Department approved implementation plan	\$5,000 per day for each day beyond the first two (2) business days  Escalates to \$10,000 per day for each day delayed beyond the first five (5) business days delay
2) <u>Accurate upload of eligibility file</u> : Defined as final date in which accurate Medicaid and	Final date for accurate eligibility data as defined in Department approved implementation plan	\$10,000 per day for each day beyond the first two (2) business days

NC Health Choice eligibility data must be uploaded to EB platform in advance of open enrollment period		Escalates to \$15,000 per day for each day delayed beyond the first five (5) business days delay
3) <u>EB integration of Consolidated Provider directory:</u> Defined as final date, by region, in which accurate PHP provider data must be integrated into and publicly available through the provider directory in advance of open enrollment period	Final date for accurate provider directory data as defined in Department approved implementation plan	<p>\$10,000 per day for each day beyond the first two (2) business days</p> <p>Escalates to \$15,000 per day for each day delayed beyond the first five (5) business days delay</p>
<b>Call Center</b>		
<p>4) <u>Calls Abandoned:</u> Defined as the number of inbound calls offered but are disconnected by the caller after three (3) seconds and are neither a Call Handled nor a Self Service.</p> <p>Calls Abandoned rate will be calculated as: (Total Calls Offered - Total Calls Short Abandoned - (Total Calls Handled plus Total Self-Service Calls)) / Total Calls Offered.</p>	Rate must not exceed five percent (5%) per month.	1% of monthly invoice
5) <u>Call Center outage:</u> Defined as the number of minutes the call center is unable to accept new inbound calls.	Rate must not exceed five (5) minutes of unscheduled time in which the call center is unable to accept new inbound calls.	1% of monthly invoice
6) <u>The wait/hold time for callers:</u> Defined as the time between a call being initially answered including answered by an operating system and a response by a live	No longer than three (3) minutes for 95% of all incoming calls.	1% of monthly invoice

operator to a caller's inquiry.		
7) <u>Call Answer Time:</u> Defined as the number of seconds it takes for an inbound call to reach a live agent or reach a self-service option. Measured in seconds.	Rate must not exceed one three (3) minutes for 95% of Calls Offered.	1% of monthly invoice
8) <u>First Call Resolution:</u> Define as the percent of contacts that are resolved by the call center on the first interaction with the customer	98%	0.5% of monthly invoice
<b>Enrollment services website</b>		
9) <u>Web portal response:</u> Defined as elapsed time from the command to view a response until the response appears or loads to completion.	Rate must not exceed five (5) seconds 99% of the time.	
10) <u>Timely response to electronic correspondence:</u> Defined as response time to all electronic correspondence including email, fax, web enrollments or other electronic responses.	Response rate to all members and PHP of 100% within 3 business days	Up to 3% of monthly invoice  100% - 95%: 1% deduction Less than 95% - 85%: 2% deduction Less than 85%: 3% deduction
<b>Satisfaction survey</b>		
11) <u>Call center enrollment survey response:</u> Defined as member satisfaction as measured by Department approved call center member enrollment satisfaction survey	Average rate must not fall below percent agreed upon in Department approved member enrollment satisfaction survey	0.5% of monthly invoice
12) <u>Web-based enrollment survey response</u> Define as Defined as member satisfaction as	Average rate must not fall below percent agreed upon in Department approved	0.5% of monthly invoice

measured by Department approved call center member enrollment satisfaction survey	member enrollment satisfaction survey	
<b>Enrollment and disenrollment processing</b>		
13) <u>Without cause disenrollment processing time:</u> Defined as average time from receipt of complete member without cause disenrollment requests to notification to Department of decision	Average processing time must not exceed five (5) calendar days	2% of monthly invoice
14) <u>Non-clinical with cause processing time:</u> Defined as average time from receipt of complete member non- clinical with cause disenrollment requests to notification to Department of decision	Average processing time must not exceed five (5) calendar days	1% of monthly invoice

## ATTACHMENT A: MINIMUM REQUIREMENTS TABLE

The Offeror must demonstrate they meet Minimum Requirements to have their response evaluated by the Department. The Offeror **MUST** complete this table, and provide the appropriate details to support each requirement and the Reference for the related experience. The Offeror must attest to acceptance of the Terms and Conditions of this RFP by checking the box and signing this ATTACHMENT A.

The MS Word template for ATTACHMENT A: MINIMUM REQUIREMENTS TABLE may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

**MINIMUM REQUIREMENTS TABLE**

<b>Requirement</b>	<b>Minimum Years of experience Required</b>	<b>Offeror's Statement of Demonstration and Capabilities. Include the section citation, exhibit name/number and page numbers where details can be found in Offeror's response if not included in this table.</b>
A. Experience in Medicaid Managed Care providing Enrollment Broker Services for a program population with a total of at least 400,000 beneficiaries	Three (3) Years	
B. Experience providing Call Center capabilities to support Choice Counseling and Enrollment Broker services for an open enrollment population of at least 400,000 beneficiaries	Three (3) Years	

C. Experience integrating with existing Medicaid program eligibility and customer service systems	Three (3) Years	
D. Offeror must be financially stable and disclose any legal actions that could adversely affect its financial condition or ability to meet the requirements of this RFP	Not Applicable	Offeror's response to Attachment G: Certification of Financial Condition and Legal Action Summary will be reviewed.

- ☐ The Offeror accepts all terms and conditions of this RFP as required in Section II.A.3 Request for Proposal. The Offeror may request modifications per the instructions in Section II.A.3, and acknowledges these are not part any subsequent Contract unless explicitly accepted by the Department in accordance with Section II.A.3.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

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## ATTACHMENT B: TECHNICAL RESPONSE

The Offeror must submit ATTACHMENT B: TECHNICAL RESPONSE. The Department encourages Offerors to suggest innovative ways to fulfill the requirements of this RFP. The Offeror must confirm adherence to the expectations of the Department and their ability to meet the requirements of this RFP. This includes providing a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature and/or detailed information specifically tailored for the North Carolina Medicaid program to demonstrate its ability to meet requirements.

The Technical Response must be submitted using the following MS Word template and the directives therein. The MS Word template may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

RFP Section	Response																						
Qualifications, Experience and Federal Requirements Section III. A, 1-6	<p>The Department requests the response to this section be limited to twelve (12) pages.</p> <ol style="list-style-type: none"><li>The Offeror must describe:<ol style="list-style-type: none"><li>The company, its operations and ownership.</li><li>Their experience in providing services similar to those included in the scope of this RFP, with an emphasis on clients of similar size to North Carolina’s Medicaid program and details on the number of years of providing services.</li><li>Factors viewed as being critical to the success of the enrollment broker program in North Carolina.</li></ol></li><li>The Offeror must provide:<ol style="list-style-type: none"><li>A list of other State Medicaid programs served, including the size of the population and contract term using the following table:</li></ol></li></ol> <table><tr><th rowspan="2">State</th><th rowspan="2">Number of Beneficiaries</th><th colspan="2">Contract Term</th></tr><tr><th>Month/Year Effective</th><th>Month/Year Terminated/Expired</th></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table> <ol style="list-style-type: none"><li>A list of terminated contracts for enrollment broker services, including expired or non-renewed contracts, in the last seven (7) years and the reason/circumstances pertaining to the termination.</li><li>A list of any litigations or sanctions that have been applied under any current or former enrollment broker services contract in the last seven (7) years.</li></ol> <ol style="list-style-type: none"><li>The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. A. Qualifications, Experience and Federal Requirements.</li></ol>	State	Number of Beneficiaries	Contract Term		Month/Year Effective	Month/Year Terminated/Expired																
State	Number of Beneficiaries			Contract Term																			
		Month/Year Effective	Month/Year Terminated/Expired																				
North Carolina Medicaid and NC Health	The Department requests the response to this section be limited to ten (10) pages, not including the samples/examples of process flows.																						

<p><i>Choice Enrollment</i> Section III. B, 1-8</p>	<ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. B. North Carolina Medicaid and NC Health Choice Enrollment.</li> <li>2. Offeror must provide sample process flows describing the PHP selection process.</li> <li>3. Offeror must describe procedures for PHP and AMH/PCP selection and disenrollment processes which are efficient and not unnecessarily administratively burdensome for beneficiaries.</li> <li>4. Offeror must provide sample managed care resources and educational materials which describe the process for selecting and changing a PHP.</li> <li>5. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Member Appeals of Disenrollment</i> Section III. C, 1-6</p>	<p>The Department requests the response to this section be limited to four (4) pages, including the sample/example Beneficiary Disenrollment Form.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. C. Member Appeals of Disenrollment.</li> <li>2. Offeror must describe and provide internal process flows for participation in the beneficiary appeal process.</li> <li>3. Offeror must provide a sample of a Beneficiary Disenrollment Form.</li> <li>4. Offeror must describe previous participation in mediation, pre-hearing preparation or State Fair Hearings.</li> <li>5. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Beneficiary Support Under Managed Care</i> Section III. D, 1-12</p>	<p>The Department requests the response to this section be limited to ten (10) pages, not including the sample Welcome Packet.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. D. Beneficiary Support Under Managed Care.</li> <li>2. Offeror must describe managed care education provided in other states or for other clients during open enrollment period.</li> <li>3. Offeror must include a sample welcome packet. Considerations for mailing weight and print costs should be made.</li> <li>4. Offeror must describe proactive outreach provided during open enrollment periods in other states or for other clients.</li> <li>5. Offer must describe the Plan Selection Tool, its functionality, and include screen shots and visual displays of information viewable by beneficiaries.</li> <li>6. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Beneficiary Grievances</i> Section III. E, 1</p>	<p>The Department requests the response to this section be limited to three (3) pages, not including the grievance policy and education materials samples/examples.</p> <p>The Offeror must include at least two (2) samples/examples of each, but may not submit more than three (3) for each.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. E. Beneficiary Grievances.</li> </ol>

	<ol style="list-style-type: none"> <li>2. Offeror must describe how grievance processes will be efficient and not unnecessarily administratively burdensome for beneficiaries.</li> <li>3. Offeror must provide sample educational materials available to beneficiaries explaining current grievance policy and procedures.</li> <li>4. Offeror must provide link to existing beneficiary grievance policy on a publicly available website.</li> <li>5. Offeror must describe assistance provided to beneficiaries in completing forms and other procedural steps related to grievances.</li> <li>6. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Member Outreach, Education and Enrollment Materials</i> Section III. F, 1-6</p>	<p>The Department requests the response to this section be limited to ten (10) pages, not including the items stated below.</p> <p>The sample/example Tribal Engagement Strategy should be limited to five (5) pages.</p> <p>The sample/example DSS Engagement Strategy should be limited to five (5) pages.</p> <p>The proposed approach for enhanced outreach and community level engagement should be limited to five (5) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. F. Member Outreach, Education and Enrollment Materials.</li> <li>2. Offeror must describe the outreach and education campaign strategy for beneficiaries, members of federally recognized tribes, authorized representatives, family members, providers, PHPs, local DSS offices, PHHS offices and community-based organizations which may routinely interact with North Carolina's Medicaid beneficiaries.</li> <li>3. Offeror must provide evidence of previous outreach events hosted making sure to include information on location, agenda and survey results.</li> <li>4. Offeror must describe technologies which will be employed to support member outreach. <ol style="list-style-type: none"> <li>a. Include information to support additional technologies.</li> <li>b. Describe experience using technology in support of outreach in other states.</li> </ol> </li> <li>5. Offeror must provide a sample Tribal Engagement Strategy.</li> <li>6. Offeror must provide a sample DSS Engagement Strategy.</li> <li>7. Offeror must list current contracts or states where joint outreach is performed with ombudsman programs, PHPs, local social service or other community agencies.</li> <li>8. Offeror must describe an approach for enhanced outreach and community level engagement with local DSS/EBCI PHHS offices to assist beneficiaries in the transition from fee for service to manage care making sure to propose in its response to ATTACHMENT C: COST PROPOSAL:: <ol style="list-style-type: none"> <li>a. Plan and cost for onsite support; and</li> <li>b. Plan and cost for providing enhanced support to local DSS/EBCI PHHS offices during open enrollment and other potential peak periods.</li> </ol> </li> </ol>

	<p>9. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</p>
<p><i>Language, Accessibility, and Cultural Competency</i> Section III. G, 1-18</p>	<p>The Department requests the response to this section be limited to three (3) pages, not including the cultural competency samples/examples.</p> <p>The Offeror should include at least two (2) cultural competency samples/examples, but should not submit more than three (3).</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. G. Language, Accessibility, and Cultural Competency.</li> <li>2. Offeror must describe how materials for and contacts with beneficiaries are culturally competent.</li> <li>3. Offeror must provide examples, samples and/or detailed cultural competency information specifically tailored for the North Carolina Medicaid and NC Health Choice program.</li> <li>4. Offeror must describe how oral, written and sign language translation services are certified.</li> <li>5. Offeror describe how screen readers are accommodated.</li> <li>6. Offeror must provide examples of existing materials with language taglines.</li> <li>7. Offeror must describe how assistive listening devices and professional sign language interpreters will be made available during presentations and other events with beneficiary audiences.</li> <li>8. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Call Center Support</i> Section III. H, 1-15</p>	<p>The Department requests the response to this section be limited to eight (8) pages, not including the sample/example call script stated below.</p> <p>The sample/example call script to assist beneficiaries in understanding the factors for consideration when selecting a PHP must be limited to three (3) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. H. Call Center Support.</li> <li>2. Offeror must describe AVRS in use for other clients or in other states.</li> <li>3. Offeror must describe the capacity of AVRS to allow callers to enter their MID or alternative ID to identify the member prior to the call being distributed to a call center representative.</li> <li>4. Offeror must describe how software will auto-populate with relevant information from prior contacts or calls as well with beneficiary demographic, member enrollment and eligibility information from NCTracks/NC FAST.</li> <li>5. Offeror must Identify location of telecommunication system and call center which will support this contract.</li> <li>6. Offeror must describe the capacity to handle all telephone calls during normal business hours, after hours and peak hours.</li> <li>7. Offeror must list the location of and parameters for the planned usage of the overflow call center.</li> <li>8. Offeror must describe the plan for the Department to have real-time remote access via secure internet connection to all calls and call recordings.</li> </ol>

	<ol style="list-style-type: none"> <li>9. Offeror must describe successful implementation of call center for other clients or in other states, maximum number of lives managed, maximum calls handled.</li> <li>10. Offeror must provide sample of call script to be used by beneficiary that is clear and easily understandable describing factors to consider when selecting a PHP.</li> <li>11. Offeror must specify If web chat functionality will be provided as an alternative or supplement to voice interactions making sure to describe how this functionality will work.</li> <li>12. Offeror must provide data on successful use of webchat functionality if used in other states or for other contractors.</li> <li>13. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Enrollment Services Website</i> Section III. I, 1-9	<p>The Department requests the response to this section be limited to five (5) pages, not screen shot samples/examples.</p> <p>The screen shot examples of websites implemented for similar clients, preferably state agencies, must be limited to three (3) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. I. Enrollment Services Website.</li> <li>2. Offeror must describe how the Enrollment Services website is interactive and allows the beneficiary to manage enrollment in a seamless manner.</li> <li>3. Offeror must describe existing or potential access to enrollment services website via mobile devices. If the access is designated for future implementation identify timeline for implementation.</li> <li>4. Offeror must provide screen shots of websites implemented for similar clients.</li> <li>5. Offeror must describe how the website will support authentication without the need for the beneficiary to provide a user ID / password pair by taking the session state from NC FAST or ePASS.</li> <li>6. Offeror must describe how the Plan Selection Tool will utilize the PHP Provider Directory to display available network providers to the beneficiary based on PHP selection.</li> <li>7. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Beneficiary Management Platform</i> Section III. J, 1-7	<p>The Department requests the response to this section be limited to twelve (12) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. J. Beneficiary Management Platform.</li> <li>2. Offeror must describe the features of Beneficiary Management Platform in existence detailing the information contain or which need to be developed including but not limited to: <ol style="list-style-type: none"> <li>a. Demographic information;</li> <li>b. Records of enrollments, disenrollments, grievances, language preferences;</li> <li>c. Tracking call center interactions; and</li> <li>d. Exchanging information with state systems and data interfaces.</li> </ol> </li> <li>3. Offeror must describe how the Beneficiary Management Platform has capacity to manage North Carolina data.</li> <li>4. Offeror must provide sample process flow for use of the Beneficiary Management Platform.</li> <li>5. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>

<p><i>Consolidated Beneficiary-Facing Provider Directory</i> Section III. K, 1-4</p>	<p>The Department requests the response to this section be limited to five (5) pages, not including Beneficiary-facing Provider Directory Information samples/examples.</p> <p>The Offeror must include at least two (2) Beneficiary-facing Provider Directory Information samples/examples, but must not submit more than three (3).</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. K. Consolidated, Beneficiary Facing Provider Directory.</li> <li>2. Offeror must describe the Beneficiary Facing Provider Directory identifying <ol style="list-style-type: none"> <li>a. information available in the directory,</li> <li>b. how the directory will be easily searchable,</li> <li>c. how the directory will be kept up to date.</li> </ol> </li> <li>3. Offeror must provide up to 3 examples of Beneficiary Facing Provider Directory information.</li> <li>4. Offeror must Describe initial policies and internal process flows which describe consolidated provider directory.</li> <li>5. Offeror must identify how the data therein shall be gathered and displayed.</li> <li>6. Offeror must describe how providers's information that participate in the North Carolina fee-for-service program will be displayed.</li> <li>7. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Mailing Requirements</i> Section III. L, 1-7</p>	<p>The Department requests the response to this section be limited to three (3) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. L. Mailing Requirements.</li> <li>2. Offeror must provide a description of address verification procedures.</li> <li>3. Offeror must provide the proposed format and frequency for notification of the Department of incorrect or non-verifiable addresses and returned mailed.</li> <li>4. Offeror must describe cost-effective methods for controlling postage costs when producing member materials that will be mailed.</li> <li>5. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Enrollment Information System Integration</i> Section III. M, 1-8</p>	<p>The Department requests the response to this section be limited to fifteen (15) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. M. Enrollment Information System Integration.</li> <li>2. Offeror must describe the Enrollment Information System ability to interface with the State of North Carolina and Department Systems including NC FAST, NCTracks at a minimum on a daily basis, or in real time as preferred by the Department and through standard x12 EDI transactions.</li> <li>3. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>

<p><i>Staffing and Key Personnel</i> Section III. N, 1-4</p>	<p>The Department requests the response to this section be limited to ten (10) pages, not including ATTACHMENT D: OFFEROR'S KEY PERSONNEL with resumes for the staff proposed therein.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. N. Staffing and Key Personnel.</li> <li>2. Offeror must describe proposed staffing for the call center to ensure performance metrics as defined in <i>Table 68 - Key Service Level Metrics</i> are met.</li> <li>3. Offeror must provide a detailed staffing contingency plan for handling sudden and unexpected increases in enrollment, PHP transfers and call volumes with a description on how the plan will be implemented and coordinated with the Department.</li> <li>4. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Account Management</i> Section III. O, 1</p>	<p>The Department requests the response to this section be limited to three (3) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. O. Account Management.</li> <li>2. Offeror must describe proposed format, requirements and frequency for a status report to include key activities/milestones completed.</li> <li>3. Offeror must describe proposed format and requirements of the Annual Report.</li> <li>4. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Training</i> Section III. P, 1-3</p>	<p>The Department requests the response to this section be limited to ten (10) pages, not including beneficiary materials for training state Medicaid and county DSS staff samples/examples.</p> <p>The Offeror must include two (2) beneficiary materials for training state Medicaid and county DSS staff samples/examples, with each sample/example limited to three (3) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. P. Training.</li> <li>2. Offeror must provide an example of a training and evaluation module for customer service staff to ensure adequate knowledge of North Carolina Medicaid programs, including the various Medicaid managed care systems and any other covered program.</li> <li>3. Offeror must provide sample beneficiary materials used for training state Medicaid or local social services staff.</li> <li>4. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Fraud, Waste and Abuse</i> Section III. Q, 1-2</p>	<p>The Department requests the response to this section be limited to eight (8) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. Q. Fraud, Waste, and Abuse.</li> <li>2. Offeror must provide a sample fraud, abuse, and waste prevention compliance plan that establishes criteria for preventing, detecting, controlling and referring cases of suspected fraud, abuse, or waste and include a description of processes to be used to prevent, investigate and control suspected fraud, abuse, and waste.</li> <li>3. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>

<p><i>Performance Reporting and Delivery Requirements</i> Section III. R, 1-2</p>	<p>The Department requests the response to this section be limited to ten (10) pages, not including samples/examples of the specified reports herein.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. R. Performance Reporting and Delivery Requirements.</li> <li>2. The Offeror must include samples/examples of reports as outlined in ATTACHMENT L: OFFEROR REPORTING REQUIREMENTS for the following categories: <ol style="list-style-type: none"> <li>a. Enrollment;</li> <li>b. Disenrollment;</li> <li>c. Call Center stats;</li> <li>d. Website stats; and</li> <li>e. Mailing stats.</li> </ol> </li> <li>3. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Reconciliation</i> Section III. S, 1-5</p>	<p>The Department requests the response to this section be limited to six (6) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. S. Reconciliation.</li> <li>2. Offeror must describe how it will ensure systems and files meet all state and federal requirements and are HIPAA compliant and focus on how electronic reconciliations of all Enrollment, Disenrollment, and related transactions will be transmitted to the Department on a daily, weekly and monthly basis.</li> <li>3. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Security and Audit Requirements</i> Section III. T, 1-14</p>	<p>The Department requests the response to this section be limited to eight (8) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. T. Security and Audit Requirements.</li> <li>2. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Business Continuity Plan</i> Section III. U, 1-2</p>	<p>The Department requests the response to this section be limited to six (6) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. U. Business Continuity Plan.</li> <li>2. Offeror must include a sample Business Continuity Plan addressing the requirements including disaster recovery processes, and how call center functions would be restored in the event of a natural or manmade disaster.</li> <li>3. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<p><i>Member Enrollment Satisfaction Survey</i></p>	<p>The Department requests the response to this section be limited to five (5) pages.</p> <ol style="list-style-type: none"> <li>1. The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. V. Member Enrollment Satisfaction Survey.</li> </ol>

Section III. V, 1-5	<ol style="list-style-type: none"> <li>Offeror must provide the results of the most recent customer service satisfaction surveys by call center, web-based and/or in person outreach responses.</li> <li>The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Readiness Review</i> Section III. W, 1-6	<p>The Department requests the response to this section be limited to four (4) pages.</p> <ol style="list-style-type: none"> <li>The Offeror must confirm adherence to the expectations of the Department and their ability and approach to meet the requirements of Section III. W. Readiness Review.</li> <li>The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Implementation Plan</i> Section III. X, 1-4	<p>The Department requests the response to this section be limited to fifteen (15) pages.</p> <ol style="list-style-type: none"> <li>The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. X. Implementation Plan.</li> <li>The Offeror must submit a detailed proposed Implementation Plan for Enrollment Broker Services.</li> <li>The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>System Interface Plan</i> Section III. Y, 1-2	<p>The Department requests the response to this section be limited to fifteen (15) pages.</p> <ol style="list-style-type: none"> <li>The Offeror must confirm adherence to the expectations of the Department and describe their ability and approach to meet the requirements of Section III. Y. System Interface Plan.</li> <li>Offeror must provide a detailed inventory of interfaces and formats. The Department will work with the Offeror to define the interfaces required.</li> <li>Offeror must describe its ability to provide real-time web services as a standard for exchanging data.</li> <li>Offeror must provide a detailed inventory in Microsoft Excel of all interfaces and exchanges opportunities with the Department or its partners, including but not limited to data, frequency, protocols, file names, sources and target system.</li> <li>Offeror must provide detailed diagram(s) showing data flows between systems including but not limited to source and destination, data, frequencies, direction.</li> <li>The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Department Responsibilities</i> Section III. Z, 1-2	<ol style="list-style-type: none"> <li>The Offeror must list and provide details for any expected/anticipated Department Responsibilities and/or resources that have not been identified in Section Z. Department Responsibilities, but will be necessary to implement and support the services required by this RFP.</li> <li>The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> </ol>
<i>Contract Performance and Sanctions,</i> Section IV.A 1-8	<ol style="list-style-type: none"> <li>The Offeror must confirm adherence to the expectations of the Department regarding contract performance, sanctions and damages as specified in Section IV.A. Contract Performance and Sanctions.</li> <li>The Offer must demonstrate its understanding of the Key Service Level Metrics included in Table <a href="#">86</a> and provide a description of its capability to accurately capture, track, report and audit each metric.</li> </ol>

	<ol style="list-style-type: none"> <li>3. The Offer must provide its methodology or mathematical formula for calculating each metric</li> <li>4. The Offeror must describe any limitations and/or issues with meeting the requirements of this Section.</li> <li>5. The Offeror must request any modifications to Section IV.A. per the instructions in Section II.A.3, and acknowledge these are not part any subsequent Contract unless explicitly accepted by the Department in accordance with Section II.A.3</li> </ol>
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### Use Case Scenarios

Responses must focus how beneficiaries will be assisted in navigating North Carolina's complex primary and behavioral health systems, including collaboration with key stakeholders. The response for *each* Use Case Scenario must not exceed four (4) pages.

Scenario Number	Scenario
<b>Scenario #1</b>	<p>The mother of a minor child contacts the Enrollment Broker regarding a PHP denial of her daughter having an MRI for headaches. The mother reports that she previously contacted the PHP to file an appeal but has not heard back about the resolution. The mother, who is anxious and concerned about her daughter's health and the lack of response to the denial, reports the complaint was filed one week ago. The mother has not spoken with anyone since the original call with the PHP.</p> <p>Provide a detailed narrative of the resolution of the contact detailing the specific information provided to the beneficiary and the supports offered to the beneficiary.</p> <p>If a referral is made to or contact with an external entity, identify which entities and the steps initiated for the referral.</p> <p>Detail what, how and in which system information is recorded.</p>
<b>Scenario #2</b>	<p>An individual who received a Medicaid Eligibility Determination Notice and new Medicaid card shows up at a local DSS agency on April 2, 2019, to communicate his selection of a PHP.</p> <p>Provide a detailed narrative for the end to end supports available to a) the beneficiary and b) the case worker. Describe how the enrollment process is initiated and completed.</p> <p>Describe the materials, information and other resources that will be available to DSS to address future incidents.</p>
<b>Scenario #3</b>	<p>In July 2020, an individual diagnosed at a local emergency room with a serious mental illness contacts the Enrollment Broker call center seeking a follow up appointment with a psychiatrist.</p> <p>Provide a detailed narrative on the process the call center staff follows to ensure the efficient and timely enrollment of the beneficiary. Include how the special needs of the beneficiary are addressed and the plan options available to the beneficiary.</p> <p>Provide a description of the proposed enrollment process from the call initiation to call resolution, including the entities engaged, methods and outcome of the contact.</p>

## ATTACHMENT C: COST PROPOSAL

### Instructions for completing Attachment C: Cost Proposal

The Cost Proposal must include the total all inclusive, turn key costs associated with the services to be provided as part of this RFP and any subsequent contract.

The Cost Proposal must be submitted using the following MS Excel Spreadsheet and instructions. The MS Excel Spreadsheet may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

### Implementation Costs:

1. The Offeror may propose reasonable implementation fees as part of the cost proposal to support any one-time or start-up costs associated with the contract.
2. The Department reserves the right to limit reimbursement of implementation costs to three million dollars (\$3,000,000).
3. Payment of any implementation costs is contingent upon the Contractor's ability to meet all readiness review requirements and as provided in Section II.E.22.f.
4. Complete the appropriate information on the worksheets titled "*WS.1. Core Services Fees*" and "*WS.2. Fees Alternative SLAs*."

### On-going Fees for Core Services:

1. Complete the appropriate information on the worksheets titled "*WS.1. Core Services Fees*" and "*WS.2. Fees Alternative SLAs*" to provide fees associated with the core services specified in the RFP as well as fees associated with Offeror's recommended Call Center service level metrics. See worksheets titled "*WS.2. Fees Alternative SLAs*" and "*WS.2.1 Offeror SLAs*" for more information and instructions.
2. Complete the blue highlighted or designated cells only; do not change other cells.

### Optional In-Person and Enhanced Support Services:

1. Complete the appropriate information on the worksheet titled "*WS.3. Optional Services*" to provide hourly rates associated with providing optional in-person and enhanced beneficiary support services as outlined in Section III.F.
3. Complete the blue highlighted or designated cells only; do not change other cells.

### Other Enrollment Broker Related Services:

1. Offerors are encouraged to provide fees for related, potentially value-added, services not otherwise specifically requested as part of the RFP.
2. Complete the worksheet titled "*WS.4. Other EB Related Services*."
3. Provide a narrative description of any such fees, including any assumptions, restrictions or other considerations. Additional exhibits or information may be attached to fully explain the Other EB Related Services.

## Attachment C: Cost Proposal, Worksheet 1, Enrollment Broker Core Services Fees

Offeror Name:

Offeror must propose fees, including implementation costs, if any, to provide the enrollment broker core services (i.e. choice counseling, call center capabilities, other beneficiary supports) and to meet the requirements specified in the RFP, including the service level metrics specified in Section IV.A.

### Instructions:

- 1) Complete blue highlighted cells only; do not change other cells.
- 2) Provide narrative description of fee development and any assumptions. Include below Table 1.3 or add and label new worksheet.
- 3) Proposed fees must be inclusive of all costs, including travel expenses, and any other direct and indirect costs.

**Table 1.1: One-Time Implementation Fees**

<b>IT</b>							
Systems							
Call center							
Website							
Mail capabilities							
Beneficiary management platform							
Consolidated provider directory							
Equipment							
Other (define and describe)							
<b>Total IT</b>	\$	-					
<b>Non-IT</b>							
Personnel/salaries							
Other (define and describe)							
<b>Total Non-IT</b>	\$	-					
<b>Total Start-up/Implementation Fee</b>	\$	-					
<b>Start-up/Implementation Fees for Activities Prior to Open Enrollment</b>							\$ -

**Table 1.2: Proposed Per Member Per Month (PMPM) Fees for Core Services**

Item		Year 1 <sup>2</sup>	Year 2	Year 3	Year 4	Year 5	Total
Core Services	Assumed Member Months <sup>1</sup>	13,572,500	18,300,000	19,920,000	19,920,000	22,524,000	
	Proposed PMPM Call Center Services						\$0.00
	Proposed PMPM Other Core Services						\$0.00
	Total Assumed Fees for Evaluation	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

**Table 1.3: Total Implementation and Core Services Fees**

	Yr 1 and Prior <sup>2</sup>	Yr 2	Yr 3	Yr 4	Yr 5	Total
<b>Total Fees</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

<sup>1</sup> Assumed member months are for comparing cost proposals across Offerors only. Payment will be made based on the number of Mandatory PHP enrolled beneficiaries for a given month.

Assumed member months are based on SFY 2016 historical data and the Department's proposed roll-out schedule as described in Attachment I.

<sup>2</sup> The beginning of Year 1 aligns with the start of the soft launch enrollment period.

## Attachment C: Cost Proposal, Worksheet 2, Enrollment Broker Core Services Fees - Alternative SLAs

Offeror Name:

The Department seeks information on costs associated with the Offeror's standard, preferred or recommended **Call Center** service level metrics. Offerors should provide alternative pricing, including implementation costs, if any, to provide the enrollment broker core services (i.e. choice counseling, call center capabilities, other beneficiary supports) associated with alternative Call Center service level metrics as specified by the Offeror in WS.2.1 Offeror SLAs.

### Instructions:

- 1) Complete blue highlighted cells only; do not change other cells.
- 2) Provide narrative description of fee development and any assumptions. Include below Table 2.3 or add and label new worksheet.
- 3) Proposed fees must be inclusive of all costs, including travel expenses, and any other direct and indirect costs.

**Table 2.1: One-Time Implementation Fees - Alternative SLAs**

<b>IT</b>							
Systems							
Call center							
Website							
Mail capabilities							
Beneficiary management platform							
Consolidated provider directory							
Equipment							
Other (define and describe)							
<b>Total IT</b>	\$	-					
<b>Non-IT</b>							
Personnel/salaries							
Other (define and describe)							
<b>Total Non-IT</b>	\$	-					
<b>Total Start-up/Implementation Fee</b>	\$	-					

Start-up/Implementation Fees for Activities Prior to Open Enrollment \$ -

**Table 2.2: Proposed Per Member Per Month (PMPM) Fees for Core Services - Alternative SLAs**

Item		Year 1 <sup>2</sup>	Year 2	Year 3	Year 4	Year 5	Total
Core Services	Assumed Member Months <sup>1</sup>	13,572,500	18,300,000	19,920,000	19,920,000	22,524,000	
	Proposed PMPM Call Center Services						\$0.00
	Proposed PMPM Other Core Services						\$0.00
	Total Assumed Fees for Evaluation	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

**Table 2.3: Total Implementation and Core Services Fees - Alternative SLAs**

	Yr 1 and Prior <sup>2</sup>	Yr 2	Yr 3	Yr 4	Yr 5	Total
<b>Total Fees</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

<sup>1</sup> Assumed member months are for comparing cost proposals across Offerors only. Payment will be made based on the number of Mandatory PHP enrolled beneficiaries for a given month.

Assumed member months are based on SFY 2016 historical data and the Department's proposed roll-out schedule as described in Attachment I.

<sup>2</sup> The beginning of Year 1 aligns with the start of the soft launch enrollment period.

## Attachment C: Cost Proposal, Worksheet 2.1, Enrollment Broker Core Services Fees - Offeror's Alternative SLAs

**Offeror Name:**

The Offeror should list Offeror's standard, preferred or recommended **Call Center** service level metrics in Table 2.12 below for comparison with the Department's requirement specified in Section IV.4 and Table 2.11 below.

**The Department is under no obligation to accept or negotiate Offeror's proposed Call Center Service Level Metrics.**

**Instructions:**

- 1) Complete Table 2.12 Offeror's Proposed Call Center SLAs; do not change other cells.
- 2) Offeror may propose additional, fewer and/or revised Service Level Metrics.
- 3) Include definitions, explanations and calculation methodologies for all metrics and standards, and indicate whether any proposed metric/standard would require modification of any other requirement specified in the RFP and include the Section number.
- 4) Offeror may propose revised liquidated damages and allocation across the metrics, provided the total monthly fees at risk (4.5%) remains unchanged.

**Table 2.11 Department's Requires SLAs From Section IV.4**

Description	Standard	Liquidated Damage
<b>Call Center</b>		
4) <u>Calls Abandoned:</u> Defined as the number of inbound calls offered but are disconnected by the caller after three (3) seconds and are neither a Call Handled nor a Self Service.	Rate must not exceed five percent (5%) per month.	1% of monthly invoice
Calls Abandoned rate will be calculated as:		
(Total Calls Offered - Total Calls Short Abandoned - (Total Calls Handled plus Total Self Service Calls)) / Total Calls Offered.		
5) <u>Call Center outage:</u> Defined as the number of minutes the call center is unable to accept new inbound calls.	Rate must not exceed five (5) minutes of unscheduled time in which the call center is unable to accept new inbound calls.	1% of monthly invoice
6) <u>The wait/hold time for callers:</u> Defined as the time between a call being initially answered including answered by an operating system and a response by a live operator to a caller's inquiry.	No longer than three (3) minutes for 95% of all incoming calls.	1% of monthly invoice
7) <u>Call Answer Time:</u> Defined as the number of seconds it takes for an inbound call to reach a live agent or reach a self-service option. Measured in seconds.	Rate must not exceed one three (3) minutes for 95% of Calls Offered.	1% of monthly invoice
8) <u>First Call Resolution:</u> Define as the percent of contacts that are resolved by the call center on the first interaction with the customer	98%	0.5% of monthly invoice

**Table 2.12 Offeror's Proposed Call Center SLAs**

Description	Standard	Liquidated Damage
<b>Call Center</b>		
4) <u>Calls Abandoned:</u>		
Calls Abandoned rate will be calculated as:		
5) <u>Call Center outage:</u>		
6) <u>The wait/hold time for callers:</u>		
7) <u>Call Answer Time:</u>		
8) <u>First Call Resolution:</u>		

## Attachment C: Cost Proposal, Worksheet 3, Optional In-Person and Enhanced Support Services

Offeror Name:							
Offeror must propose fees to provide on-site, in-person beneficiary support and off-site enhanced support for local offices as specified in Section III.F. These services are optional under the RFP, and the Department reserves the right to engage some, all or none of the services submitted by Offeror.							
<b>Instructions:</b>							
1) Complete blue highlighted cells only; do not change other cells.							
2) Provide narrative description of fee development and any assumptions. Include below Table 3.1 or add and label new worksheet.							
3) Proposed fees must be inclusive of all costs, including travel expenses, and any other direct and indirect costs.							
<b>Table 3.1 Optional In-Person Beneficiary Support and Enhanced Support for DSS and EBCI PHSS Offices</b>							
<b>Item</b>		<b>Year 1</b>	<b>Yr 2</b>	<b>Yr 3</b>	<b>Yr 4</b>	<b>Yr 5</b>	<b>Total</b>
On-site, in-person beneficiary support or DSS/PHHS enhanced support at local DSS and EBCI PHHS offices or other locations as directed by DHHS (as described in Section III.F)	Assumed hours for evaluation*	8,000	4,000	4,000	2,000	2,000	
	Hourly rate						
	Total Assumed Fees for evaluation	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Off-site enhanced support for local DSS and EBCI PHHS office staff as directed by DHHS (as described in Section III.F)	Assumed hours for evaluation*	1,000	500	500	250	250	
	Hourly rate						
	Total Assumed Fees for evaluation	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total Fees Assumed for Evaluation</b>		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*Hours assumed are for evaluation purposes only. Actual hours will vary and may be capped by the Department.							

## Attachment C: Cost Proposal, Worksheet 4, Other Enrollment Broker Related Services

Offeror Name:						
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The Department seeks information on costs associated with any related, potentially value-added services not otherwise specifically requested in the RFP. Offerors are encouraged to provide pricing for these optional services.

**Instructions:**

- 1) Provide a fee schedule for any related, potentially value-added services not otherwise specifically requested in the RFP; indicate the basis of the fee.
- 2) Provide a narrative description of any such fees, including any assumptions, restrictions or other considerations.
- 3) Proposed fees must be inclusive of all costs, including travel expenses, and any other direct and indirect costs
- 4) Additional exhibits or information may be attached to fully explain the Other EB Related Services.

**Table 4.1 Proposed Fees for Other Enrollment Broker Services**

Description/Service	Fee Basis					
	(e.g., per member, hourly rate, per occurrence, etc.)	Year 1	Year 2	Year 3	Year 4	Year 5

## ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL

The following must be completed by the Offeror as required by Section III. N. Staffing and Key Personnel.

The MS Word template for ATTACHMENT D: ENROLLMENT BROKER'S KEY PERSONNEL may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

<b>Role</b>	<b>Duties and Responsibilities of the Role</b>	<b>Minimum Certifications and/or Credentials Requested by the Department</b>	<b>Enrollment broker's Proposed Staff Name. Must attach resume to support. Include the section citation, exhibit name/number and page numbers where details can be found in Offeror's response if not included in this table.</b>
Program Director	This person will serve as the key accountable lead and the primary point of contact for all program activities. The Program Director must have the authority to make decisions, be responsible for directing operations throughout the life of the Contract, and attend all meetings as requested by the Department.	Six (6) years of experience in managing a similar program of equal or greater scope.	
Deputy Program Director	This person will serve as the primary backup to the Program Director for all program activities. The Deputy Program Director must have the authority to make decisions, be responsible for directing operations throughout the life of the Contract, and attend all meetings as requested by the Department.	Four (4) years of experience in managing a similar program of equal or greater scope.	
Project Manager	This person will serve as the project manager, responsible for on-time delivery of the business functionality and system integration described herein.	Three (3) years of experience managing a similar project of equal or greater scope.	
Technical Program lead	This person will serve as the technical point of contact for the State and other partners, including PHPs, for system integration, the provider directory and the Beneficiary Management Platform. The lead must have the authority to make decisions necessary	Four (4) years of experience acting as technical lead in systems management and integration supporting a similar program of equal or greater scope.	

	to resolve problems related to PHP integration and the provider directory.		
Outreach Manager	This person will serve as the lead communications professional in the development and distribution of member education and enrollment materials.	Three (3) years of experience in developing and implementing comprehensive communications plans and outreach materials with Medicaid populations, including the use of websites as well as electronic and social media.	
Call Center Manager	This person will be responsible for managing the Contractor's call center, and must have demonstrated experience in managing a large volume Call Center preferably for a health care related or Medicaid program.	Three (3) years of experience in member relations to supervise the toll-free telephone line operators.	
DSS/County Liaison	The person will serve as the primary liaison with the local DSS offices to support integration of Contractor with local offices and coordinate outreach and education events.	Three (3) years of experience in managing a similar project of equal or greater scope.	
Tribal Liaison	The person will serve as the primary liaison with the EBCI PHHS to support integration of Contractor with the tribe.	Three (3) years of experience in working with federally recognized tribes and managing a similar project of equal or greater scope.	
Training Manager	This person will be responsible for developing training plans and overseeing training of new hires to assure they are well-versed on the Medicaid program and in customer satisfaction. This person will collaborate with Medicaid to develop targeted training that will better serve the program.	Three (3) years of experience in managing trainings of internal staff supporting Medicaid enrollment activities.	

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## ATTACHMENT E: LOCATION OF WORKERS UTILIZED BY CONTRACTOR

The MS Word template for the ATTACHMENT E: LOCATION OF WORKERS UTILIZED BY CONTRACTOR may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

Upon Contract Award, the successful Offeror becomes a Contractor providing goods and or services to the State. In addition to any other evaluation criteria identified in this RFP, the Department may, for purposes of evaluating proposed or actual contract performance outside of the United States, also consider how that performance may affect the following factors to ensure that any award will be in the best interest of the Department:

1. Total cost to the Department;
2. Level of quality provided by the Contractor;
3. Process and performance capability across multiple jurisdictions;
4. Protection of the State's information and intellectual property;
5. Availability of pertinent skills;
6. Ability to understand the Department's business requirements and internal operational culture;
7. Identified risk factors such as the security of the State's information technology;
8. Relations with citizens and employees; and
9. Contract enforcement jurisdictional issues.

In accordance with G.S. § 143-59.4, the Contractor shall detail the location(s) at which performance will occur, as well as the way it intends to utilize resources or workers outside of the United States in the performance of this Contract. The Department will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Items a, b, and c below MUST BE COMPLETED.

**a) Will any work under this Contract be performed outside the United States?**

☐ YES ☐ NO

If the Contractor answered "YES" above, the Contractor shall complete items 1 and 2 below:

1. List the location(s) outside the United States where work under this Contract will be performed by the Contractor,  
any subcontractors, employees, or other persons performing work under the Contract:
  
2. Describe the corporate structure and location of corporate employees and activities of the Contractor, its affiliates, or any other subcontractors that will perform work outside the U.S.:

**b) The Contractor agrees to provide notice, in writing to the Department, of the relocation of the Contractor, employees of the Contractor, subcontractors of the Contractor, or other persons performing services under the Contract outside of the United States**

☐ YES ☐ NO

NOTE: All Contractor or subcontractor personnel providing call or contact center services to the State of North Carolina under the Contract **shall** disclose to inbound callers the location from which the call or contact center services are being provided.

**c) Identify all U.S. locations at which performance will occur:**

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Signature of Authorized Representative

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Name of Entity

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Name and Title

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DATE

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## ATTACHMENT F: BUSINESS ASSOCIATE AGREEMENT

The MS Word template for the ATTACHMENT F: BUSINESS ASSOCIATE AGREEMENT may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

**NORTH CAROLINA**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**BUSINESS ASSOCIATE AGREEMENT**

This Agreement is made effective the \_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_, by and between the North Carolina Department of Health and Human Services ("Covered Entity") and \_\_\_\_\_ ("Business Associate") (collectively the "Parties").

### 1. BACKGROUND

- a. Covered Entity and Business Associate are parties to a contract entitled \_\_\_\_\_, whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
- b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
- c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.
- d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

### 2. DEFINITIONS

*Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:*

- a. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.
- b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
- c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
- d. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. § Part 160 and Part 164.
- e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

- f. "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.
- g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.
- h. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

### **3. OBLIGATIONS OF BUSINESS ASSOCIATE**

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.
- b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
- e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
- h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

### **4. PERMITTED USES AND DISCLOSURES**

- a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
  - 1) would not violate the Privacy Rule if done by Covered Entity; or
  - 2) would not violate the minimum necessary policies and procedures of the Covered Entity.
- b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
  - 1) The disclosures are Required by Law; or

- 2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
- d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

## **5. TERM AND TERMINATION**

- a. Term. This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
- b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
  - 1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
  - 2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
  - 3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.
- c. Effect of Termination.
  - 1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
  - 2) If Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

## **6. GENERAL TERMS AND CONDITIONS**

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. If a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.

- d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Name of Entity

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
DATE

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## ATTACHMENT G: CERTIFICATION OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY

The MS Word template for ATTACHMENT G: CERTIFICATION OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

The Offer must complete and sign this Attachment, and include the required documents as indicated herein.

**The undersigned hereby certifies that:**

- ☐ The Offeror has included the following documents with this completed ATTACHMENT G: CERTIFICATION OF FINANCIAL CONDITION AND LEGAL ACTION SUMMARY.
  - a. ☐ Audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant (CPA for the two most recent fiscal years, including at a minimum balance sheet, income statement, and cash flow statement for each year. Must provide the contact information for the CPA/audit firm.
  - b. ☐ The current Month End Balance Sheet and Year-to-Date Income Statement at the time of proposal submission.
  - c. ☐ The most recent corporate tax filing OR independent audit report. If submitting the independent audit report, must include contact information for the audit firm.
- ☐ The Offeror is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.
- ☐ The Offeror has included a brief statement outlining and describing its financial stability.
- ☐ The Offeror has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.
- ☐ The Offeror is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.
- ☐ The Offeror is not the subject of any current litigation or findings of noncompliance under federal or state law.
- ☐ The Offeror has not been the subject of any past or current litigation, findings in any past litigation, or findings of noncompliance under federal or state law that may impact in any way its ability to fulfill the requirements of this Contract.
- ☐ The Offeror acknowledges that this is a continuing certification, and the Offeror shall notify the Department within fifteen (15) calendar days of any material change to any of the representations made herein.

If any one or more of the foregoing boxes is NOT checked, the Offeror shall explain the reason in the space below:

Offerors are encouraged to explain any negative financial information in its financial statement below and are encouraged to provide documentation supporting those explanations:

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By completing this Certification of Financial Condition and Legal Action Summary, the Offeror affirms the ability to financially support implementation and on-going costs associated with this Contract, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the Offeror.

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Signature

Date

---

Printed Name

Title

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## ATTACHMENT H: OFFEROR'S CLIENT REFERENCES

The MS Word template for ATTACHMENT H: OFFEROR'S CLIENT REFERENCES may be requested by contacting Ken Dahlin at [Ken.Dahlin@dhhs.nc.gov](mailto:Ken.Dahlin@dhhs.nc.gov).

Offerors must provide four (4) client references for which it has provided services of similar size and scope to that requested herein. The Department prefers at least three (3) references for state Medicaid programs. If three (3) state Medicaid programs are not provided, Offeror must include a statement explaining why. The Offeror must complete the reference table below for each Reference Requirement, and sign the bottom of this attachment to include in your proposal. The Department may contact these clients to determine the services provided are substantially similar in scope to those proposed herein, and that the Offeror's performance has been satisfactory. The Offeror must also state the state Medicaid agencies where the Offeror has provided Enrollment Broker services, including the number of beneficiaries for the services of each agency. The information obtained in this attachment will be considered in the evaluation of the proposal.

Company Name and Address	Company Contact with email address and phone number	Summary of services provided which are relevant to the scope and requirements of this RFP
1.		
2.		
3.		
4.		

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## ATTACHMENT I: NC MEDICAID AND HEALTH CHOICE HISTORICAL ENROLLMENT

Below is a summary of North Carolina Medicaid and NC Health Choice anticipated enrollment by region for the populations that the Department intends to enroll in the managed care program over the next five years. Detailed enrollment estimates are available at:

<https://files.nc.gov/ncdhhs/documents/files/PopulationProfiles.pdf?oI2oB1itRV6ozGxXBzNkaPZPK1zG3jgx>

### ***Year 1 – Cross-over population***

<b>Region</b>	<b>FY2016 average member months</b>
Region 1	143,000
Region 2	257,000
Region 3	365,000
Region 4	293,000
Region 5	260,000
Region 6	207,000
<b>TOTAL</b>	<b>1,525,000</b>

### ***Populations considered for enrollment for future years:***

Foster care and adoptive placement:

<b>Region</b>	<b>FY2016 average member months</b>
Region 1	3,600
Region 2	3,700
Region 3	4,900
Region 4	4,100
Region 5	3,900
Region 6	2,300
<b>TOTAL</b>	<b>22,500</b>

BH/IDD TP (including duals):

<b>Region</b>	<b>FY2016 average member months</b>
Region 1	14,000
Region 2	17,000
Region 3	25,000
Region 4	23,000
Region 5	18,000
Region 6	15,000
<b>TOTAL</b>	<b>112,000</b>

Medicaid-only beneficiaries receiving long-stay nursing home services and Medicaid-only Community Alternatives for Children (CAP/C) and Community Alternatives for Disabled Adults (CAP/DA) waiver beneficiaries:

<b>Region</b>	<b>FY2016 average member months</b>
Region 1	700
Region 2	900
Region 3	1,300
Region 4	1,000
Region 5	800
Region 6	700
<b>TOTAL</b>	<b>5,400</b>

Individuals who are dually-eligible for Medicare and Medicaid (excluding those enrolled in BH I/DD TPs)

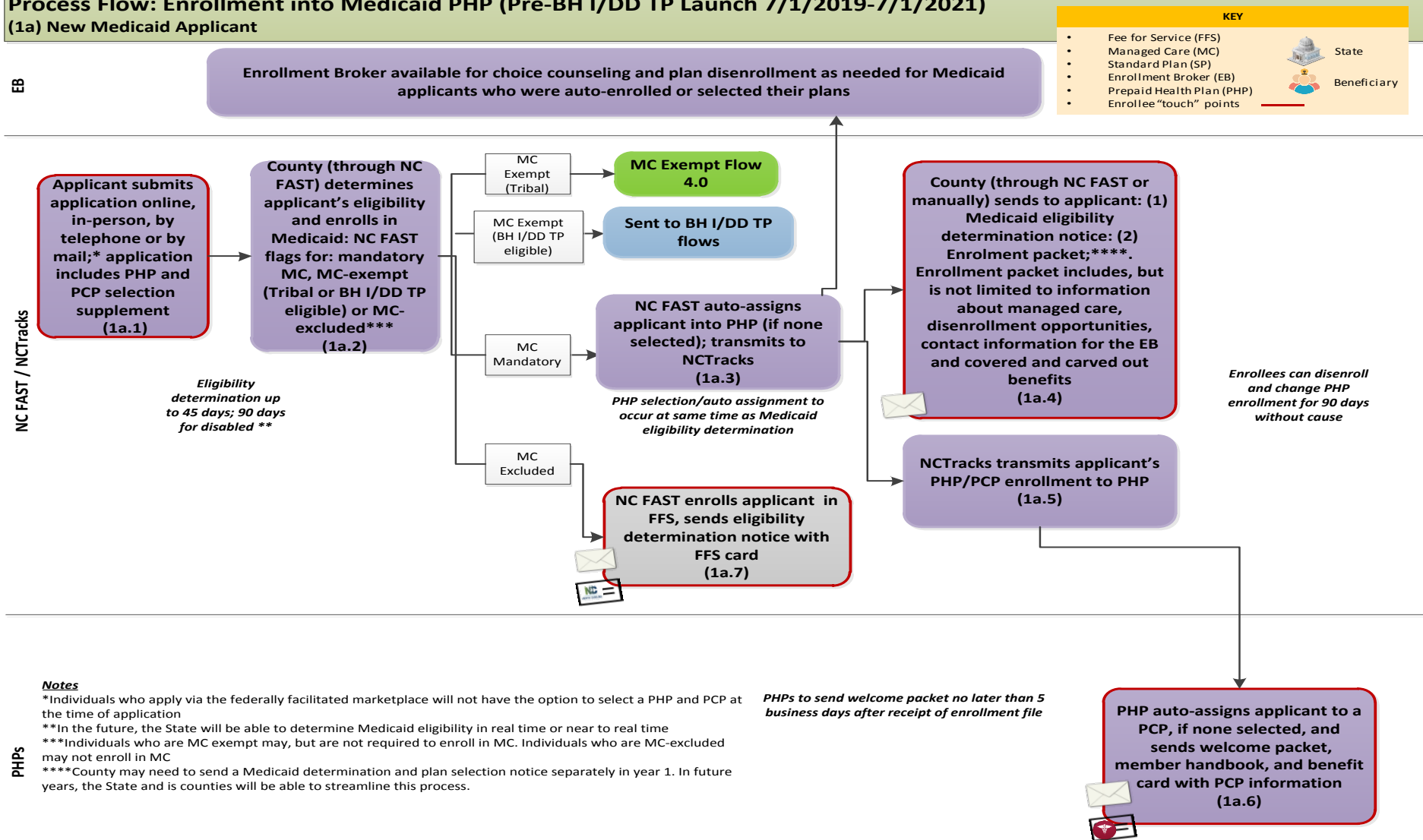
<b>Region</b>	<b>FY2016 average member months</b>
Region 1	25,000
Region 2	36,000
Region 3	41,000
Region 4	37,000
Region 5	38,000
Region 6	35,000
<b>TOTAL</b>	<b>212,000</b>

Carolina Cares: The size of the Carolina Cares population will depend on final legislation with the premium and eligibility requirements to be determined by the N.C.G.A. and as approved by CMS. Initial estimates indicate between 300,000 and 600,000 Carolina Cares enrollees.

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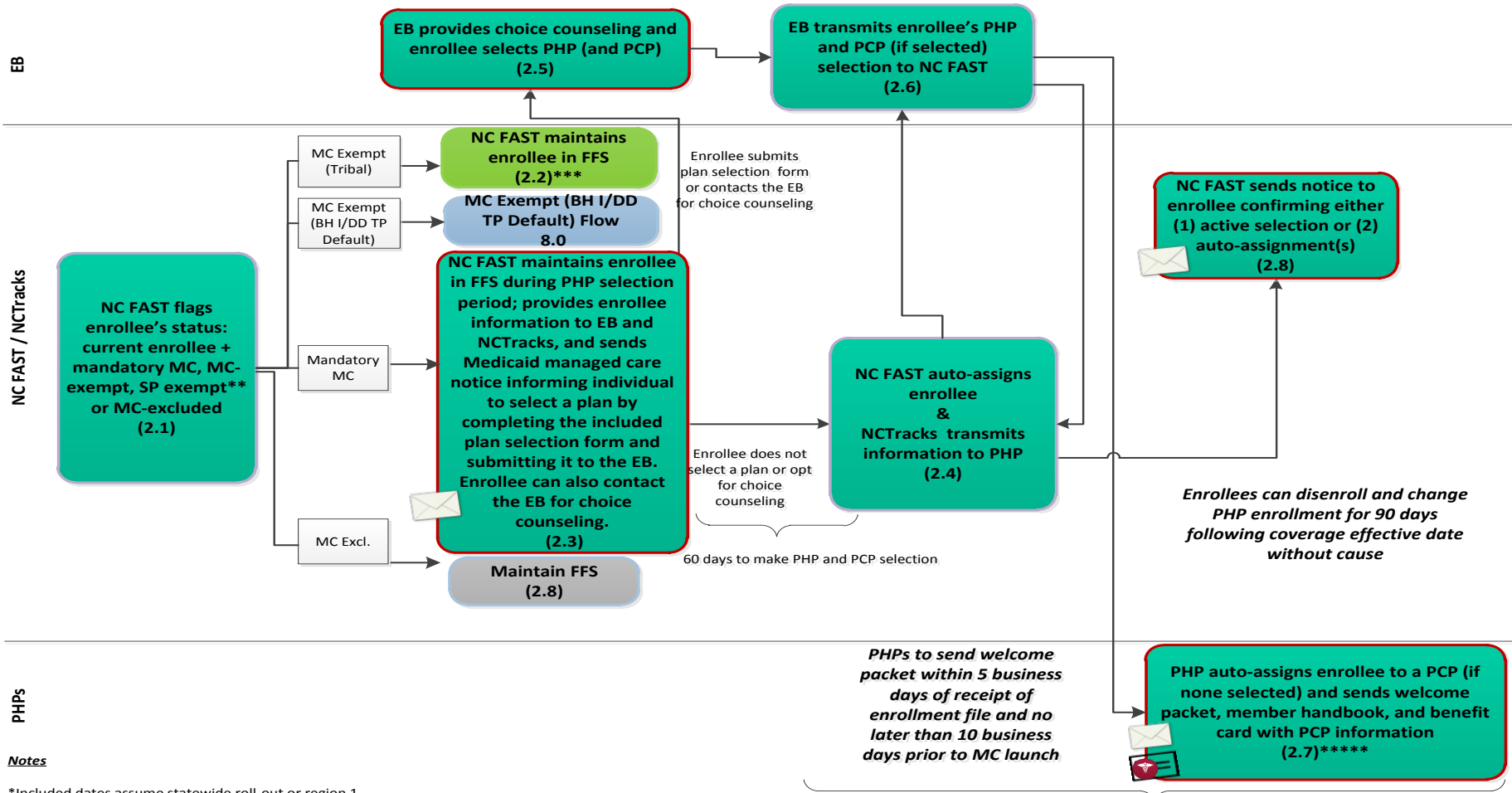
## ATTACHMENT J: PROPOSED MANAGED CARE ELIGIBILITY AND ENROLLMENT PROCESS FLOWS

### Process Flow: Enrollment into Medicaid PHP (Pre-BH I/DD TP Launch 7/1/2019-7/1/2021) (1a) New Medicaid Applicant



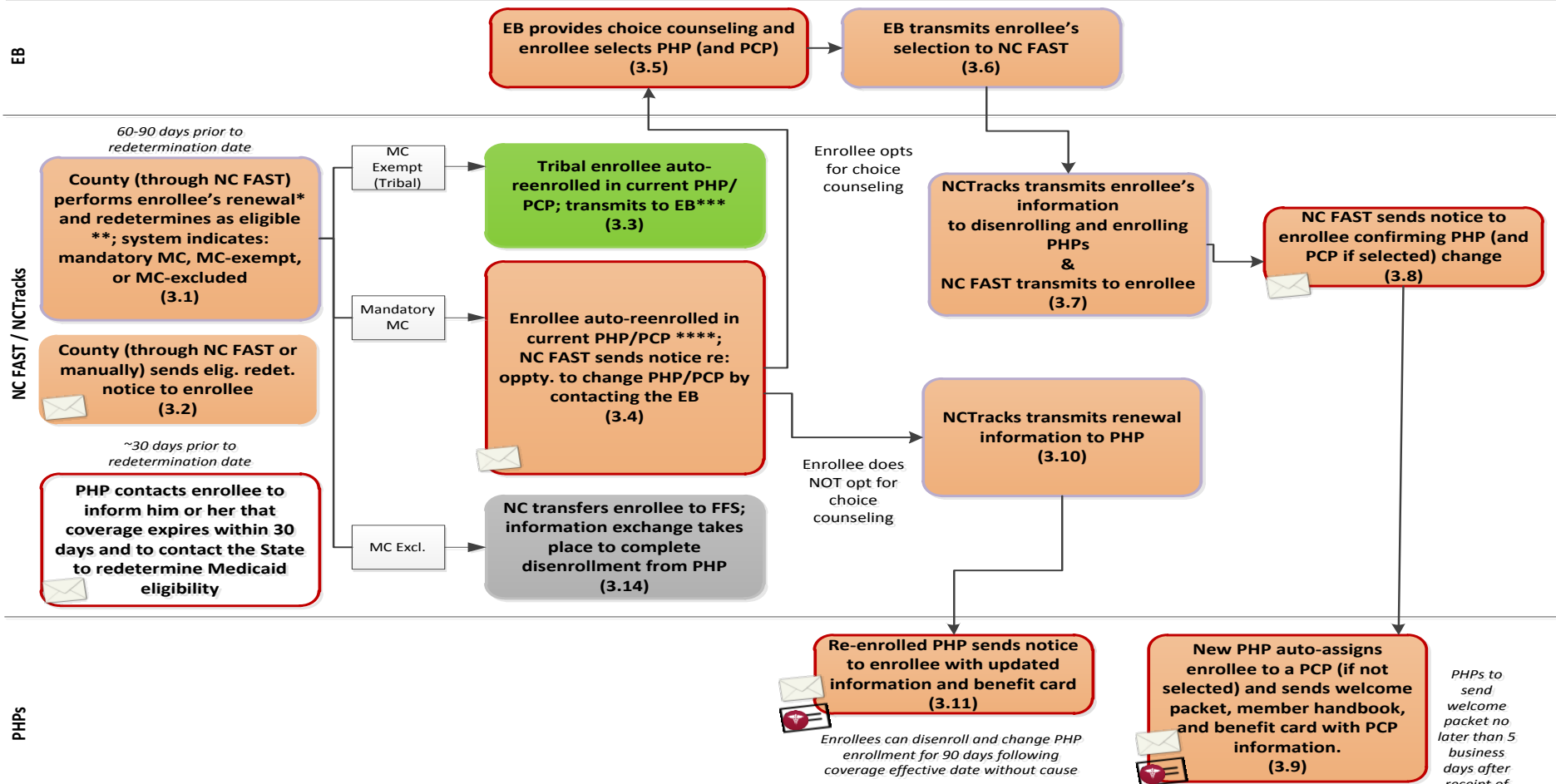
## Process Flow: Enrollment into Medicaid PHP

### (2) Current FFS Medicaid Enrollees Transitioning to MC: Managed Care Conversion\*



## Process Flow: Enrollment into Medicaid PHP

(3) Renewing Medicaid Managed Care Enrollees in Year 2 and Beyond



### Notes:

\*-Includes ex parte redet. based on available data and redet. completed via pre-populated form. Individuals renewed ex parte may have more time to select plan prior to coverage renewal date.

\*\*-.If redetermined ineligible for Medicaid, information exchanges takes place to complete disenrollment from PHP

\*\*\* DHHS will send a tribal enrollee a notice that inform him or her of opportunity to change PHP/PCPs or revert to FFS

\*\*\*\*If enrollee's current PHP drops from program, individual must select new plan or be auto-assigned to new plan (processes follow 1.4 through 1.8)

## ATTACHMENT K: MANAGED CARE AUTO-ASSIGNMENT ALGORITHM

The Department must develop auto-assignment algorithms to be used for every beneficiary who is determined Medicaid eligible and did not select a PHP during their choice period or Medicaid application process; the auto-assignment algorithm may be used in other instances deemed appropriate by the Department or as required by state or federal law; the Department, at its sole discretion, may choose to not use the auto-assignment algorithm.

- 1) The auto-assignment algorithm for the cross-over population is defined according to the following components in this order:
  - a) Whether beneficiary is a member of a special population (e.g. foster care, BH I/DD TP eligible, or tribal),
  - b) Beneficiary's geographic location,
  - c) Historic provider-beneficiary relationship,
  - d) Plan assignments for other family members, and
  - e) Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors per PHP to be used as guides.
- 2) The auto-assignment algorithm for new beneficiary's enrolled after cross-over open enrollment is defined according to the following components in this order:
  - a) Whether the beneficiary is a member of a special population (e.g. foster care, member of federally recognized tribes or behavioral health intellectual/developmental disability (BH I/DD) tailored plan (TP) eligible),
  - b) Plan assignments for other family members,
  - c) Beneficiary's geographic location,
  - d) Previous PHP enrollment during previous 12 months (for those who have "churned" on/off Medicaid managed care), and
  - e) Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors per PHP to be used as guides.
- 3) Auto-assignment may also be used in the following instances:
  - a) Redetermined Medicaid managed care beneficiaries.
  - b) Renewing Medicaid managed care beneficiaries whose plans have been discontinued based on the same auto-assignment algorithm used for new beneficiaries.
  - c) Beneficiaries who lose but then regain Medicaid eligibility within a three-month period to the Beneficiary's previous PHP unless the PHP is not offered in the region or the beneficiary indicates in writing that he or she wishes to enroll in another PHP. If the PHP is not offered, the beneficiary will be auto-assigned based on the same auto-assignment algorithm used for new beneficiaries.
  - d) Beneficiaries who have been disenrolled upon PHP request will be assigned to a new PHP based on the same auto-assignment algorithm used for new beneficiaries. The beneficiary cannot be reassigned to the PHP requesting disenrollment.

## ATTACHMENT L: ENROLLMENT BROKER REPORTING REQUIREMENTS

Reporting requirement	Frequency	Description
<b>1. Implementation</b>		
a. Initial upload of eligibility file	Once	The initial Medicaid and NC Health Choice eligibility file uploaded to the EB Platform in advance of the open enrollment period.
b. Accurate upload of eligibility file	Once	The file upload of the eligibility file with no errors or data rejections.
c. EB Integration of Consolidated Provider Directory	Once	The accurate Provider Directory is implemented and available per the Implementation Plan.
<b>2. Enrollment</b>		
a. Number of active enrollments initiated and processed during open enrollment and plan selection periods	Weekly and monthly	i. By mail, call center, in-person enrollment and web-based enrollment platform ii. By population type (e.g. cross-over, new beneficiary, redetermination, special population) iii. By PHP selected
b. Number of Beneficiaries actively selecting a AMH or PCP during the open enrollment and plan selection periods	Weekly and monthly	i. By mail, call center, in-person enrollment and web-based enrollment platform; ii. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
c. Average length of time for processing plan selection requests	Weekly and monthly	i. By mail, call center, in-person enrollment and web-based enrollment platform ii. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
<b>2. Beneficiary requested disenrollment</b>		
a. Number of without cause disenrollments: requests	Weekly and monthly	i. By disenrolling PHP ii. By new PHP selection iii. By without cause reason
b. Number of without cause disenrollments: denials	Weekly and monthly	i. By disenrolling PHP ii. By without cause reason iii. By reason for denial
c. Number of without cause disenrollments: approvals	Weekly and monthly	i. By disenrolling PHP ii. By new PHP selection iii. By without cause reason iv. Average length of time for to effectuate disenrollment
d. Number of without cause disenrollments: in process	Weekly and monthly	i. By disenrolling PHP ii. By new PHP selection

		iii. By without cause reason
e. Number of with cause disenrollments: in process	Weekly and monthly	iv. By disenrolling PHP v. By new PHP selection vi. By with cause reason vii. By urgent vs non-urgent medical need
f. Number of with cause disenrollments: requests	Weekly and monthly	viii. By disenrolling PHP ix. By new PHP selection x. By with cause reason xi. By urgent vs non-urgent medical need
g. Number of with cause disenrollments: denials	Weekly and monthly	i. By disenrolling PHP ii. By with cause reason iii. By reason for denial iv. By urgent vs non-urgent medical need
h. Number of with cause disenrollments: approvals	Weekly and monthly	i. By disenrolling PHP ii. By new PHP selection iii. By with cause reason iv. By urgent vs non-urgent medical need v. Average length of time to effectuate disenrollment (in days)
<b>3. PHP Requested Disenrollment</b>		
a. Number of PHP requested disenrollments: Requests	Weekly and monthly	i. By requesting PHP ii. By reason for request
b. Number of PHP requested disenrollments: Denials	Weekly and monthly	i. By requesting PHP ii. By reason for request iii. By reason for denial
c. Number of PHP requested disenrollments: Approvals	Weekly and monthly	i. By requesting PHP ii. By new PHP assignment iii. Average length of time to effectuate disenrollment (in days)
d. Number of PHP requested disenrollments: in process	Weekly and monthly	iii. By requesting PHP iv. By reason for request
<b>4. State Initiated Disenrollment</b>	Weekly and monthly	i. Number processed ii. Breakdown by reason (e.g. system error or PHP program departure)
<b>5. Disenrollment due to Loss of Eligibility or Death</b>	Weekly and monthly	i. Number processed ii. Breakdown by reason (e.g. death, loss of eligibility due to incarceration or long-term NF stay)
<b>6. Call Center</b>		
a. Number of calls received	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population) ii. By day of week/time of day

b. Number of calls answered	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population) ii. By type of call (e.g. address change, enrollment, disenrollment) iii. By day of week/time of day
c. Number of calls in the queue at peak times	Weekly and monthly	
d. Language assistance requests provided by the call center	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population) ii. Number of calls associated with each language iii. Percentage of incoming calls requiring language line assistance (overall and per language) iv. By language requested
e. Average time to answer call initially	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
f. Length of time it takes the call to reach a live person	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
g. Average length of call	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
h. Abandonment rate/number of calls abandoned	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
i. Average wait time to abandon	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
j. Average wait time after call transfer	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
k. Number of outbound calls	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
l. Calls on hold	Weekly and monthly	i. By population type (e.g. cross-over, new beneficiary, redetermination, special population)
m. First Call Resolution	Weekly and monthly	Call hat are resolved on the first interaction with the caller.
n. Call center agents (locally/overflow call center)	Weekly and monthly	
o. Referrals	Weekly and monthly	i. Number of and reason for referrals to State-operated call centers

		<ul style="list-style-type: none"> <li>ii. Number of and reason for referrals to county DSS and PHHS offices</li> <li>iii. Number of and reason for referrals to PHPs</li> <li>iv. Number of and reason for referrals to Ombudsman</li> </ul>
p. Call Center Outage	When a Caller Center Outage occurs	The time of the outage, duration, and root-cause of the outage.
<b>7. Customer Service Satisfaction Surveys</b>	Monthly	Member satisfaction data based on the defined surveys.
<b>8. Website</b>	Monthly	<ul style="list-style-type: none"> <li>i. Number of visits and page views</li> <li>ii. Number of PHP searches processed</li> <li>iii. Number of AMH/PCP searches requested</li> <li>iv. Number of emails/secure messages received through the website</li> <li>v. Average response time for email/secure message responses</li> <li>vi. Average response time for email confirmations following PHP selection</li> </ul>
<b>9. Mailings</b>	Monthly	<ul style="list-style-type: none"> <li>i. Number of requests for member education materials to be sent by mail</li> <li>ii. Number of mail requests fulfilled within 30 calendar days</li> </ul>

## ATTACHMENT M: ANTICIPATED CONTRACT REQUIREMENTS AND IMPLEMENTATION SCHEDULE

The following represents the current *anticipated dates* for activities, deliverables, and implementation of services based on a Contract Effective Date of May 31, 2018. Adjustments will be made with the successful Enrollment Broker awarded the contract at the commencement of services based on the actual Contract Effective Date.

Key milestone/deliverable	Due date	Tentative date
<b>Contract effective date</b>	The date Contract is fully executed by the Parties as provided in the Notice of Award	May 31, 2018
<b>Implementation plan</b>	Contract effective date + thirty (30) calendar days	June 30, 2018
<b>Disaster contingency and recovery plan</b>	Contract effective date + thirty (30) calendar days	June 30, 2018
<b>Outreach and education campaign strategy</b>	Contract effective date + thirty (30) calendar days	June 30, 2018
<b>Enrollment related systems documentation</b>	Contract effective date + thirty (30) calendar days	June 30, 2018
<b>System interface plan</b>	Contract effective date + thirty (60) calendar days	July 30, 2018
<b>Call center phone number acquired</b>	Contract effective date + sixty (60) calendar days	July 30, 2018
<b>Customer service training and evaluation module complete</b>	Contract effective date + ninety (90) calendar days	August 29, 2018
<b>Member education materials</b>	Cross-over open enrollment period – ninety (90) calendar days	October 8, 2018
<b>Samples of language, accessibility and culturally competency materials</b>	Cross-over open enrollment period – ninety (90) calendar days	October 8, 2018
<b>Submission of materials for cross-functional training of non-EB staff</b>	Cross-functional training of non-EB staff – 30 days	October 8, 2018
<b>Readiness review</b>	Forty-five days prior to EB Start Date	To be determined
<b>EB Process/Policies</b>	Forty-five days prior to EB Start Date	To be determined
<b>EB Services for Managed Care Go-Live Date</b>	January 1, 2019 or date defined by Department	January 1, 2019
<b>Cross-functional training of non-EB staff</b>	Cross-over open enrollment period – 60 days	November 2, 2018
<b>Phase 1, cross-over open enrollment period</b>	PHP effective date – one hundred-five (105) calendar days	March 15 – May 15, 2019
<b>Annual report</b>	January 1, 2019 + twenty (20) calendar days	Annual

## ATTACHMENT N: BUSINESS CONTINUITY MANAGEMENT PROGRAM

Business Continuity Management Program Sample Template. To be completed with guidance and in coordination with the Department after the Contract Effective Date.

Doc. Version No.	
Date Prepared	
Prepared By	
Division Director Signature	
Date Approved	

### INTRODUCTION

*(Who is this document for?) This document is intended for use by management, the business owner, technical experts, and business continuity staff who interact with this system. It provides a strategy for business recovery and work around procedures should the system and its infrastructure fail. Possible events taken into account in developing this plan are disasters, both natural and man-made, up to and including complete destruction of the facility*

### PLAN OBJECTIVES

*This business recovery plan:*

- Captures the essential aspects of the business process supported by the system.
- Documents a way to continue business should the system fail.
- Documents the business recovery procedures for return to operational status.
- Documents a way to convert back to business as usual after the system is available.

### SYSTEM OVERVIEW

*How does this application/system operate and what does it do?*

### COMMUNICATION PLAN

#### ***Notification***

*When the application is unavailable, who is notified and how??*

### ROLES, RESPONSIBILITIES AND AUTHORITY

***List areas of support and roles of each.***

***Example:***

**Application Support:**

*An Application analyst is responsible for the following:*

**Hardware Support**

*A MaPS Systems Engineer is responsible for the following:*

**Database Support**

*A DBA is responsible for the following:*

**Business Recovery Services Vendor for Distributed Platforms:**

- Describe services of business recovery vendor, if applicable.

**Cross References**

*None*

**PLAN INITIATION**

***Criteria for Restoration of the Business Process due to a Business Disruption***

*The business recovery procedures described in this contingency plan will be invoked when one or more of the following takes place:*

- 1.
- 2.

**BUSINESS RECOVERY PROCEDURES**

**Section I: Application Support**

**Staffing**

(The staff that needs to be involved in the recovery process.)

**Equipment and Components**

(The equipment and components should be listed in their entirety including quantities and attributes. This is all of the hardware that the business unit must supply. This includes all necessary equipment particular to this application.)

## Procedures

(Include plans for acquiring, replacing, and alternate siting of any equipment needed.)

## Software and Data Backup Procedures

(This is all of the software that the business unit must supply and how it is backed up.)

## Software and Data Recovery Procedures

(How the software in the above procedure is restored.)

## Succession Plan

### *Application Support Order of Succession:*

Name	Title	Area Code and Phone Number

## Vendor List

### *Suppliers:*

Vendor	Product/Service/Commodities	Area Code and Phone Number

## Section II: Hardware Support

### ***Staffing***

(The staff that needs to be involved in the recovery process.)

## Equipment Types

(Equipment and type)

## Client Equipment:

Document any specialty equipment for the client, if any. Consider if workstation equipment requirements should be listed here or are included in a different section of the Business Continuity Plan.

## Application Equipment

Document, if any.

## Equipment Recovery Procedures

How is equipment recovered?

## Software and Data Backup Procedures

The following steps will be taken to begin the business backup process:

Document procedures.

## Software and Data Recovery Procedures

The following steps will be taken to begin the business recovery process:

Document procedures.

## Succession Plan

*Hardware Support Order of Succession:*

Name	Title	Area Code and Phone Number

## Vendor List

*Hardware Services Suppliers:*

Vendor	Product/Service/Commodities	Area Code and Phone Number