School Employees Health Benefits Program Medical Plan
Request For Proposal: Garden State Health Plan
Scope of Work/Technical Capabilities

Event	Date	Time
Vendor's {Bidder's} Electronic Question Due Date	June 30, 2021	2:00 PM
Quote Submission Date	July 20, 2021	2:00 PM
Contract Award Date	August 25, 2021	TBD
Coverage Effective Date	January 1, 2022	

Dates are subject to change. All times contained in the Request For Proposal refer to Eastern Time. All changes will be reflected in Bid Amendments to the Request For Proposal posted on www.nj.gov/treasury/pensions

Request For Proposal Issued By

State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
Trenton, New Jersey 08625-0230

Using Agency/Agencies

State of New Jersey
Department of the Treasury
Division of Pensions and Benefits

Date: **07/13/2021**

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INFORMATION FOR VENDORS {BIDDERS}

NOTICE:. ***The Vendor {Bidder} is advised to thoroughly read all sections, as many have been revised, and follow all instructions contained in the RFP documents.***

1.1 PURPOSE AND INTENT

This RFP is issued by the Division of Pension and Benefits (DPB), Department of the Treasury as administrator for the School Employees' Health Benefits Commission (Commission). The purpose of this RFP is to solicit Quotes from qualified Vendors {Bidders} to provide an Integrated Delivery Network Program for the Garden State Health Plan for the School Employees' Health Benefits Program (SEHBP).

The plan shall include all the benefit levels as outlined in the Scope of Work/Technical Capabilities document.

By submitting a proposal to the State of New Jersey for the Garden State Health Plan identified in this RFP, Vendor {Contractor} is agreeing to abide by and administer all the Administrative Requirements outlined in the Administrative Requirements Document. Submission of proposal assumes Vendor {Contractor} compliance.

Vendor {Contractor} must affirimateively confirm via written statement Vendor {Contractor} agrees to all parameters set forth in the Scope of Work (SOW) and Administrative Requirements documents. Deviations will not be accepted and may only be considered if mutually agreed upon during the contracting phase as an enhancement to current protocols.

Vendors {Bidders} intending to submit a quote should refer to the Administrative Requirements Document for full details on what must be included in any Quote submission.

The goal with this RFP is to contract with Vendors {Contractors} that will drive meaningful changes in the delivery of healthcare, clinical quality improvements and meaningful cost reductions in the SEHBP. The SEHBP Garden State Health Plan (GSTHP) will provide patient centered healthcare with excellent access to cost effective, highly integrated healthcare services. The SEHBP GSTHP seeks to partner with New Jersey integrated health systems and providers who will deliver integrated care, centered on the patient. The SEHBP GSTHP is seeking to move closer to direct provider contracting within the State of New Jersey and providing members with direct access to many of the curated high-quality healthcare providers found in the State. The State is intent on taking bolder actions that focus on mitigating the total cost of care for the SEHBP and its Members, while driving improvements in the overall health of the SEHBP population.

As a result of this RFP, the SEHBP expects to:

- Enhance value-based payment models for sustainable, high-quality, cost-effective health plan programs and options demonstrating movement away from fee-for-service models
- Partner with Vendors {Contractors} committed to the ongoing whole person health and well-being of Members and reduced health disparities
- Innovate for better management of the drivers of risk scores through comprehensive data analytics and integrated care delivery models

Successful Respondents will propose a health care plan available to the Active and Early Retiree population through at minimum, the 2024 plan year. However, nothing in the RFP limits the

SEHBP's ability to change the plan design benefits during the annual plan year renewal (Please see Scope of Work/Technical Capabilities section 1.1.2).

1.1.1 BASELINE EXPECTATIONS

Baseline expectations are the minimum necessary service and performance objectives and standards the SEHBP will expect of Vendor {Contractors} beginning January 1, 2022. These baseline expectations include, but are not limited to, the following:

A. **Alignment with SEHBP Strategic Goals:** SEHBP expects well-articulated and successfully demonstrated services, programs and resources to support its strategic goals.

B. **Innovation and Partnership for the Future:** Demonstration that Vendor {Contractor} offers flexibility and innovation to address future goals and collaborative approaches for the Active and Early Retiree Population.

C. **Commitment to Value-based Payment to Reduce Costs and Improve Quality of Care for SEHBP Members:** Catalyze payment reform with providers by paying for value, reducing cost, reducing waste, and recognizing providers for improvement in the delivery of quality care.

D. **Care Delivery and Management Outcomes:** SEHBP expects the Vendor {Contractor} to employ equitable, clinically evidenced, high-touch, creative and innovative care delivery and care management models, leveraging advances in technology and multiple communications modalities, to improve Member health that is both equitable and specifically addresses the diverse Active and Early Retiree population. Programs should include aspects that mitigate negative Member Social Determinants of Health.

E. **Targeting Health Disparities in Vulnerable Populations:** SEHBP seeks a collaborative and proactive partnership to target health disparities for the most vulnerable populations including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Vendor(s) {Contractor(s)} are expected to integrate quality and disparities metrics into standard reporting and demonstrate a commitment to expansion and/or customization of current and future programs that address recognized disparities within the SEHBP Member population to reduce variation in quality of care for all members.

F. **Coordinated and Integrated Care:** SEHBP expects Vendor {Contractor} to provide integrated, member-centric clinical care, across the full health care continuum, to the Active and Early Retiree Population to provide comprehensive care, reduce errors, and eliminate waste and reduce inefficiencies.

1.1.2 NATURE OF THE SEHBC PROGRAM AND POSSIBLE PLAN DESIGN CHANGES:

Public Law 2011, Chapter 78 (Chapter 78), created the School Employees' Health Benefits Plan Design Committee (the Plan Design Committee), which is responsible for reviewing the SEHBP plan designs, and developing any changes therein that are determined to be cost effective and in the mutual best interests of the State, participating Local Employers, Employees, Retirees, and their Dependents. As such, the awarded Vendor {Bidder} shall be able to replicate all aspects of

the Garden State Health Plan as outlined in the Scope of Work/Technical Capabilities document .

Because of Chapter 78, the Plan Design Committees may make benefit design changes during the term of this contract that are not contemplated by this RFP or the current Plan. In the event of any such change, appropriate changes to the contract shall be made pursuant to Section 5.20 of the Administrative Requirements document.

The intent of this RFP is to award Master Blanket Purchase Orders (Blanket P.O.s) to those responsible Vendors {Bidders} whose Quotes, conforming to this RFP are most advantageous to the SEHBP price and other factors considered. The SEHBP may award any and all price lines. The SEHBP, however, reserves the right to separately procure individual requirements that are the subject of the Blanket P.O. during the Blanket P.O. term, when deemed to be in the SEHBP's best interest.

The SEHBP may award to one (or more) qualified Vendors {Bidders} for any or all services included in this RFP.

The State of NJ Standard Terms and Conditions (SSTC) accompanying this RFP will apply to all Blanket P.O.s made with the State of New Jersey. These terms are in addition to the terms and conditions set forth in this RFP and should be read in conjunction with them unless the RFP specifically indicates otherwise.

In light of the dangers posed by Coronavirus disease 2019 ("COVID-19"), the State of New Jersey is currently, and for the foreseeable future, under a Public Health Emergency and State of Emergency. Therefore, during the Public Health Emergency, and 90 days thereafter, the State reserves the right to change Request for Proposal requirements, language, policies, meeting attendance, submission requirements, and vendor responsibilities prior to the award date of this contract. Any changes in the RFP requirements, scope, or bidder expectations will be communicated formally through Bid Amendment.

Furthermore, the final contract assignment and policy number will be assigned after award of the contract and Vendor shall cooperate with the appropriate state agencies to generate such contract number.

<u>IMPORTANT NOTES:</u> This RFP is NOT requesting Quotes for:

- **The SHBP/SEHBP Medicare Advantage plans currently administered by Aetna Inc. (T3093-SHBP and SEHBP Plans-Medicare Advantage Plans)**
- **The SHBP/SEHBP Prescription Drug Plan currently administered by Optum Rx. (T2679-Employee Benefits: Pharmacy Benefit Management)**
- **The SHBP Active, Early Retiree, and Medicare Supplement and SEHBP Medicare Supplement plans currently administered by Horizon (T2846–State Health Benefits Program and School Employees Health Benefits Program Plans)**

This RFP is only requesting bids for the SEHBP Active and Early Retiree population.

1.2 BACKGROUND

The State Health Benefits Program (SHBP) was created in 1961 by the NJ State Health Benefits Program Act, N.J.S.A. 52:14-17.25 et seq., to provide health insurance coverage to State Employees. The SHBP also includes Local Education groups governed under the School Employees' Health Benefits Program (SEHBP).

Program	Description Summary
SHBP	The State Health Benefits Commission (SHBC) is charged with establishing health benefits programs for State and qualified local Employees, Retirees, and eligible dependents and promulgating regulations, as necessary, to administer the Act.
SEHBP	The School Employees' Health Benefits Program (SEHBP) was established in 2007 by the School Employees' Health Benefits Program Act, N.J.S.A. 52:14-17.46 et seq., to provide health coverage to qualified Local Education Employees, Retirees, and eligible Dependents.
Self-Insured Preferred Provider Organizations (PPOs)	The SEHBP currently contracts with Horizon Blue Cross Blue Shield of New Jersey (Horizon) to administer the PPO plans, and currently there are three possible Plan Designs; PPO10, PPO15, and NJ Educator's Health Plan (NJEHP). SEHBP added a new plan in 2020, NJEHP for Active and Early Retiree Employees. **These plans are not covered by the Scope of this RFP.** As part of this RFP, the SEHBP added a new plan titled the Garden State Health Plan which the SEHBP is requesting proposals for.
Fully Insured Medicare Advantage Plans	All Medicare-eligible Members enrolled in the Aetna Legacy HMO, HMO1525, PPO10, and PPO15 plans are enrolled in Medicare Advantage plans. The SEHBP Medicare Advantage plans are not covered by the scope of this RFP.
Prescription Drug Plans	The State requires that all Employees participating in SEHBP Plans have access to prescription drug coverage. The prescription drug plans are not covered by the scope of this RFP.
NJWELL	NJWELL is a program administered by the SEHBP medical vendors for certain Active Employees and Retirees.

DPCMH Program	DPCMH is a pilot program introduced by resolution of the SEHBP PDC's for employees and their dependents enrolled in non-HMO plans designed to provide comprehensive primary care services. The current medical vendors have contracted with DPCMH providers through organizations R-Health, Paladina, and Sanitas.

Outlined in the chart below is the current enrollment of the SEHBP population by Three-Digit Zip Code within the State of NJ.

SEHBP Employee Enrollment as of December 2020		
Total - All NJ Zips	**Education Actives**	**Education Early Retirees**
070	11,457	1,242
071	1,010	226
072	227	64
073	547	74
074	6,807	645
075	1,201	97
076	7,210	368
077	5,050	878
078	2,480	576
079	1,491	216
080	5,067	2,219
081	649	182
082	1,997	635
083	670	514
084	295	43
085	825	393
086	312	312
087	3,780	876
088	2,249	924
089	148	51
NJ Total	**53,472**	**10,535**
Total - Out of State	**Education Actives**	**Education Early Retirees**
PA	449	610
NY	572	127
All Other Areas	58	1,761
Out of State Total	**1079**	**2498**

Vendors {Bidders} interested in the current Blanket P.O. specifications and pricing information may review the current Blanket P.O. (Enter T2846) at www.njstart.gov by following these steps:

Go to: www.njstart.gov

Select “Contract & Bid Search”
Select “Contracts/Blankets”
Under “Contract/Blanket Description” type in (Enter T2846), Click “Find It”
The current Blanket P.O’s will appear under “Results”.

Vendors {Bidders} are cautioned that this RFP presents a significant departure from the requested scope of services covered in the last procurement of medical plan services in 2019 and this new RFP addresses current requirements for a subset of the total population.

2.0 DEFINITIONS

2.1 GENERAL DEFINITIONS

The following definitions will be part of any Blanket P.O. awarded or order placed as a result of this RFP.

All-Inclusive Hourly Rate – An hourly rate comprised of all direct and indirect costs including, but not limited to: labor costs, overhead, fee or profit, clerical support, travel expenses, per diem, safety equipment, materials, supplies, managerial support and all documents, forms, and reproductions thereof. This rate also includes portal-to-portal expenses as well as per diem expenses such as food.

Best and Final Offer or BAFO – Pricing timely submitted by a Vendor {Bidder} upon invitation by the Division after Quote opening, with or without prior discussion or negotiation.

Bid Amendment – Written clarification or revision to this RFP issued by the Division. Bid Amendments, if any, will be issued prior to Quote opening.

Business Day – Any weekday, excluding Saturdays, Sundays, State legal holidays, and State-mandated closings unless otherwise indicated.

Calendar Day – Any day, including Saturdays, Sundays, State legal holidays, and State-mandated closings unless otherwise indicated.

Change Order – An amendment, alteration, or modification of the terms of a Blanket P.O. between the State and the Vendor(s) {Contractor(s)}. A Change Order is not effective until it is signed and approved in writing.

Cooperative Purchasing Program – The Division's intrastate program that provides procurement-related assistance to New Jersey local governmental entities and boards of education, State and county colleges and other public entities having statutory authority to utilize select State Blanket P.O.s issued by the Division, pursuant to the provisions of N.J.S.A. 52:25-16.1 et seq.

Days After Receipt of Order (ARO) – The number of calendar days 'After Receipt of Order' in which the using agency will receive the ordered materials and/or services.

Director – Division of Pension and Benefits, Department of the Treasury

Discount – The standard price reduction applied by the Vendor {Bidder} to all items.

Division – The Division of Pension and Benefits.

Evaluation Committee – A committee established, or Division staff member assigned by the Director to review and evaluate Quotes submitted in response to this RFP and recommend a Blanket P.O. award to the Director.

Firm Fixed Price – A price that is all-inclusive of direct cost and indirect costs, including, but not limited to, direct labor costs, overhead, fee or profit, clerical support, equipment, materials, supplies, managerial (administrative) support, all documents, reports, forms, travel, reproduction and any other costs.

Joint Venture – A business undertaking by two (2) or more entities to share risk and responsibility for a specific project.

Master Blanket Purchase Order (Blanket P.O.) – The Blanket P.O. consists of the State of NJ Standard Terms and Conditions (SSTC), the RFP, the responsive Quote submitted by a responsible Vendor {Bidder} as accepted by the State, the notice of award, any Best and Final Offer, any subsequent written document memorializing the agreement, any modifications to any of these documents approved by the State and any attachments, Bid Amendment or other supporting documents, or post-award documents including Change Orders agreed to by the State and the Vendor {Contractor}, in writing.

May – Denotes that which is permissible or recommended, not mandatory.

Must – Denotes that which is a mandatory requirement.

No Bid – The Vendor {Bidder} is not submitting a price Quote for an item on a price line.

No Charge – The Vendor {Bidder} will supply an item on a price line free of charge.

Project – The undertakings or services that are the subject of this RFP.

Quote – Vendor's {Bidder's} timely response to the RFP including, but not limited to, technical Quote, price Quote, and any licenses, forms, certifications, or other documentation required by the RFP.

Request For Proposal (RFP) – This series of documents, which establish the bidding and Blanket P.O. requirements and solicits Quotes to meet the needs of the Using Agencies as identified herein, and includes the Request For Proposal, State of NJ Standard Terms and Conditions (SSTC), State-Supplied Price Sheet, attachments, and Bid Amendments.

Retainage – The amount withheld from the Vendor {Contractor} payment that is retained and subsequently released upon satisfactory completion of performance milestones by the Vendor {Contractor}.

Revision – A response to a BAFO request or a requested clarification of the Vendors {Bidders} Quote.

Shall – Denotes that which is a mandatory requirement.

Should – Denotes that which is permissible or recommended, not mandatory.

Small Business – Pursuant to N.J.A.C. 17:13-1.2, "small business" means a business that meets the requirements and definitions of "small business" and has applied for and been approved by the New Jersey Division of Revenue and Enterprise Services, Small Business Registration and M/WBE Certification Services Unit as (i) independently owned and operated, (ii) incorporated or registered in and has its principal place of business in the State of New Jersey; (iii) has 100 or

fewer full-time employees; and has gross revenues falling in one (1) of the three (3) following categories: For goods and services - (A) 0 to $500,000 (Category I); (B) $500,001 to $5,000,000 (Category II); and (C) $5,000,001 to $12,000,000, or the applicable federal revenue standards established at 13 CFR 121.201, whichever is higher (Category III); For construction services: (A) 0 to $3,000,000 (Category IV); (B) gross revenues that do not exceed 50 percent of the applicable annual revenue standards established at 13 CFR 121.201 (Category V); and (C) gross revenues that do not exceed the applicable annual revenue standards established at CFR 121.201, (Category VI).

State – The State of New Jersey.

State Contract Manager or SCM – The individual, as set forth in Section 8 of the Administrative Requirements document, responsible for the approval of all deliverables, i.e., tasks, sub-tasks or other work elements in the Scope of Work. The SCM cannot direct or approve a Change Order.

State-Supplied Price Sheet – The bidding document created by the State and attached to this RFP on which the Vendor {Bidder} submits it Quote pricing as is referenced and described in the Administrative Requirements Section 4.4.5.

Subtasks – Detailed activities that comprise the actual performance of a task.

Subcontractor – An entity having an arrangement with a Vendor {Contractor}, whereby the Vendor {Contractor} uses the products and/or services of that entity to fulfill some of its obligations under its State Blanket P.O., while retaining full responsibility for the performance of all [the Vendor's {Contractor's}] obligations under the Blanket P.O., including payment to the Subcontractor. The Subcontractor has no legal relationship with the State, only with the Vendor {Contractor}.

Task – A discrete unit of work to be performed.

Unit Cost – All-inclusive, firm fixed price charged by the Vendor {Bidder} for a single unit identified on a price line.

Vendor {Bidder} – An entity offering a Quote in response to the Division's RFP.

Vendor {Contractor} – The Vendor {Bidder} awarded a Blanket P.O. resulting from this RFP.

2.2 BLANKET P.O.-SPECIFIC DEFINITIONS/ACRONYMS

Active Employee – A Member of the State, Local Government, or Local Education group that is not a Retiree.

Accountable Care Organization (ACO) – **ACO's** are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients.

Adjudication – The process by which the Vendor {Contractor} reviews health benefits Claims, determining the eligibility of the claimant and the services and the applicable amount of coverage.

Administrative Services Only Fee (ASO Fee, Administrative Fee) – Fee for services paid by the State to the Vendor {Contractor}. The ASO Fee is the only compensation due the Vendor

{Contractor} under the Blanket P.O., unless otherwise mutually agreed to by the Vendor {Contractor} and the SCM (e.g., Recovery Services Fees). The Vendor's {Contractor's} monthly compensation is a function of the Vendor's {Contractor's} ASO Fee multiplied by the number of participating public Subscribers enrolled in a medical plan with the Vendor {Contractor} during the applicable month.

Advocates – Qualified health care experts who assist Members with various aspects of their health plan including but not limited to navigating the health system for the Member and the Member's family, as well as answering questions about the health plan at issue.

ARC – Identification of Members in State enrollment files by employment status as either Active, Retired, or COBRA. These categories are listed by the first letter of each category (A, R or C). The State uses the "ARC TYPE" designation to demarcate a Member's employment status on the file.

Balanced Budget Act (BBA) of 1997 – An omnibus legislative package enacted by the United States Congress, using the budget reconciliation process, and designed to balance the federal budget by 2002. In order to reduce Medicare spending, the Act reduced payments to health service providers such as hospitals, doctors, and nurse practitioners. Some of those changes to payments were reversed by subsequent legislation in 1999 and 2000.

Behavioral Health – A Member's condition with regard to their emotions, behaviors, and biology (including common health conditions such as anxiety, obesity, heart disease, diabetes) and the way such conditions connect to overall well-being.

Benefit Effective Date – Date on which the Member is eligible for services provided by the Vendor {Contractor}. The Benefit Effective Date for each Member is included in the daily Plan Eligibility File.

Birthday Rule – The plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

Blanket P.O. Effective Date – The commencement date of the Blanket P.O.

Capitation – Method of paying for healthcare services on the basis of the number of patients who are covered for a specific service over a specified period of time rather than the cost or number of services that are actually provided.

Case Management (CM) – A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Care Management - A set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminate duplication, and helping patients and caregivers more effectively manage health conditions.

Chapter 330, P.L. 1997 – A law that provides health benefits under the SHBP or SEHBP to police officers and firefighters of a Local Employer who retire after 25 years of service, or on a disability,

and who do not receive any payment towards Retiree health coverage from their employers. If eligible, the State will pay 80 percent of the cost of the least expensive SHBP/SEHBP plan offered and the Retiree then pays the remainder for the plan selected. A qualified Retiree to whom Chapter 330, P.L. 1997 applies may enroll at the time of retirement or when becoming eligible for Medicare.

Chapter 375 – A reference to the Public Laws of 2005 enacted January 12, 2006, and effective May 12, 2006, to permit coverage of an adult child of an Employee or Retiree under certain conditions. The legislation requires the SHBP to provide for an election of coverage by a child, following the termination of their dependent coverage due to age, until their 31st birthday. After the enactment of the SEHBP in 2008, this provision for an election of continued coverage for certain adult children of an Employee or Retiree also applies to SEHBP Members.

Chapter 78 – Public Law 2011, Chapter 78 created the State Health Benefits Plan Design Committee and the School Employees' Health Benefits Plan Design Committee (the Plan Design Committees).

Chronic and Complex Care Management (CCM) – A set of activities designed to more effectively assist patients and their caregivers in managing medical conditions and co-occurring psychosocial factors. The goal of CCM is to improve the patient's health status and reduce the need for hospital care.

Claim – An itemized statement of services and costs from a health care Provider or facility submitted for payment.

Claim Fiduciary – A named fiduciary having the authority and responsibility to adjudicate Claims in accordance with the provisions of the plan. In the event of a Member appeal for review of a denied Claim**,** the Claim Fiduciary makes the final determination as to whether the Claim is covered. Fiduciary responsibility will be retained by the State.

Claim Record – All documents, records, reports, data, including data recorded by the Vendor {Contractor} in its data processing systems, directly related to the receipt, processing and payment of Claims and all Claim histories.

Centers of Excellence (COE) - Tight network of quality surgeons in their specialty who agree to pre-negotiated bundled payments for pre-planned, non-emergent, non-elective surgeries (I.E.- knee, hip, spine, cardiac, etc.)

Centers for Medicare & Medicaid Services (CMS) – A part of the U.S. Department of Health and Human Services. CMS oversees many federal health care programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

CMS Reimbursement/Fee Schedule – A complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, durable medical equipment, prosthetics, orthotics, and supplies.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – A Federal law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage.

Coinsurance – A percentage of the total cost paid by the Member.

Commissions – See "State Health Benefits Commission" and "School Employees' Health Benefits Commission."

Concierge Claim Management Services – Services designed to provide individual case level services, which ensure that the correct and/or appropriate doctor, treatment and care are provided at the ideal time which can greatly improve health outcomes.

Coordination of Benefits (COB) – The process by which a health insurance company determines if it should be the primary or secondary payer of medical Claims for a patient who has coverage from more than one health insurance policy, and ensures that the payments of both plans do not exceed 100% of the covered charges.

Copayment – Fixed dollar amount paid by the Member to the Participating Provider.

Cross-Plan Offsetting - A practice of recouping alleged overpayments to a provider for services rendered to patients in an employer-sponsored health plan by withholding payments due to the same provider for services rendered to patients in a different employer-sponsored health plan.

Crisis Intervention – Psychological care used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems with the intent of minimizing potential long-term psychological trauma.

Current Procedural Terminology (CPT) - Medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes are used in conjunction with ICD-9-CM or ICD-10-CM numerical diagnostic coding during the electronic medical billing process.

Dependent(s) –Dependents include an Employee's or Retiree's spouse, partner in a civil union couple, and the Employees'/Retirees' children under the age of 26 years. For State Employees and Retirees, Dependents also include an Employee's domestic partner as defined in section 3 of P.L. 2003, c. 246 (N.J.S.A. 26:8A-3). In addition, a Local Employer that has elected to participate in the SHBP/SEHBP may, by resolution, elect to include domestic partners as eligible Dependents, but is not required by statute to provide such coverage. Children include stepchildren, legally adopted children and children placed by the Division of Child Protection and Permanency in the Department of Children and Families, provided they are reported for coverage and are wholly dependent upon the Employee for support and maintenance. Covered children attaining age 26 who are not capable of self-support due to mental illness or incapacity or a physical disability may also qualify for continuation of coverage. A person enlisting or inducted into military service is not considered a Dependent during the military service. Note: The DPB classifies adult children enrolled in the SHBP/SEHBP under the provisions of Chapter 375 as Subscribers, not as Dependents.

Diagnosis Related Groups (DRG) – DRGs are assigned by a "grouper" program based on ICD code diagnoses, procedures, age, sex, discharge status, and the presence of complications of comorbidities. DRGs have been used by CMS since 1982 to determine how much Medicare pays

a hospital for each admission, under the premise that patients within each DRG are clinically similar and are expected to use the same level of services. There are approximately 760 DRGs recognized by CMS. For admissions paid on other bases, the grouper programs consolidate all Claims for an admission and assign them to a DRG so we can compare payments for a uniformly defined unit of service: the entire hospital admission.

Digital Navigation – Mobile technological support for Members to access care and appropriate treatment programs, which offer the potential to promote better health and help people to achieve a healthier lifestyle.

Direct Contracting – When employers with a self-funded contract negotiate with providers other than their current carrier models-lowering healthcare costs through improved discounts from the carrier, improved quality and member experience, and or a collaborative approach with providers to value-based care.

Direct Primary Care Medical Home (DPCMH) – A primary care practice that assumes contractual responsibility for providing comprehensive primary care services, including preventive care, episodic sick care, basic urgent care, disease management medication management, basic procedures, health and wellness coaching, immunizations, and lab/draw collections, as well as coordination of comprehensive specialist, hospital, and outpatient services.

Discount – The difference between the list rates charged for health care services by the Provider and the contractually determined reimbursement rate between the Provider and the Vendor {Contractor}. These discounts may differ based on plan type, as well as specific Vendor {Contractor} arrangements.

Disease Management– Programs developed to identify and categorize patients (especially those with chronic conditions) and to direct these patients towards a specific treatment protocol.

Division of Pensions and Benefits (DPB) – The using agency that has issued this RFP.

Early Retiree – A Member of the State or Local Employer group (which includes Local Government and Local Education) that is retired, under 65 years of age, and not yet eligible to enroll in Medicare.

Employee – SHBP/SEHBP eligible individual of a participating State or Local Employer, including a Local Government or Local Education Employer.

Evidence-Based Guidelines – Guidelines which ensure that individual clinical expertise and the best available external clinical research is integrated into the decision-making process for patient care.

Explanation of Benefits (EOB) – A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

External Independent Review Organization (IRO) – A review of a plan's decision to deny coverage for, or payment of, a service by an independent third-party not related to the plan.

FAIR Health - A non-profit database to be utilized by the Vendor {Contractor} to identify the reasonable and customary allowance for out-of-network services.

Half-MDC – Refers to surgical or medical aggregations of DRGs within any MDC. Within each MDC there are surgical and non-surgical (Medical) admissions (e.g. heart failure, but no procedure).

Health Care and Education Reconciliation Act ("HCER Act") – A law that was enacted by the 111th United States Congress, by means of the reconciliation process, in order to amend the Patient Protection and Affordable Care Act. The HCER Act is divided into two titles, one addressing health care reform and the other addressing student loan reform.

Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.A. 1301 et seq. (HIPAA) – The law developed by the Federal Department of Health and Human Services that provides uniform Federal privacy protection standards for consumers by protecting patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. The law also provides consumers with access to their medical records and more control over how their personal health information is used and disclosed.

Health Maintenance Organization (HMO) – Managed healthcare system that has participating physicians, and facilities that provide comprehensive medical services.

Health Savings Account – Tax-advantaged spending account to which both the employer and employee can contribute funds that can be used to pay for employee medical expenses not covered by the health plan, available to Members in federally qualified HDHPs only.

High-Deductible Health Plan (HDHP) – A healthcare benefit arrangement that requires that enrolled employees and retirees (and their dependents) satisfy a deductible that is typically much larger than other plan option deductibles prior to the plan paying any benefits. The HDHP may include a Health Savings Account (if it is determined to be a federally-qualified HDHP) to which the plan sponsor and/or the employee may contribute funds on a pre-tax basis that can be used to pay for medical eligible expenses, both prior to and after satisfying the deductible.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Legislation that led to the Privacy Rule standards meant to address the use and disclosure of Protected Health Information (PHI), which includes individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

Identification Card – Wallet-size card issued by the Vendor {Contractor} identifying the individual named thereon as a Member of the Plan.

Individually Identifiable Health Information – Is defined in a manner consistent with HIPAA and generally means the subset of health information that identifies a Member, including but not limited to a Member's name, address, Social Security number, Member identification number, and telephone number, or any other data for which there is a reasonable basis to believe would the information can be used to identify the individual.

Integrated Delivery Network (IDN) – an organization that owns and operates a **network** of one or more healthcare facilities with a goal of logical integration of the delivery (provision) of health care as opposed to a fragmented system or a disorganized lack of system.

Live Navigation – Telephonic support for Members for Claims, clinical, or health care questions. Advocates are able to help Members solve their questions or concerns and connect them to the appropriate programs and resources if necessary. Advocates will also proactively engage

Members when there is an opportunity to improve decisions, health or outcomes and help them seamlessly navigate the health care system.

Local Education Employers (Local Education) – Public employer for SEHBP purposes including, but not limited to local school district, regional school district, county vocational school district, county special services school district, jointure commission, educational services commission, State-operated school district, charter school, county college, any officer, board, or commission under the authority of the Commissioner of Education or of the State Board of Education.

Local Employer - Public employers, including both Local Education and Local Government Employers such as counties, municipalities and authorities, including independent State authorities not designated as "State employers" for SHBP purposes, local school district, regional school district, county vocational school district, county special services school district, jointure commission, educational services commission, State-operated school district, charter school, county college, any officer, board, or commission under the authority of the Commissioner of Education or of the State Board of Education, and any other public entity which is established pursuant to authority provided by Title 18A of the New Jersey Statutes.

Local Government Employers (Local Government) – Public employer for SHBP purposes including, but not limited to, counties, municipalities, and authorities (including certain State authorities with independent purchasing authority that permits them to elect coverage other than that provided by the SHBP).

Major Diagnostic Categories (MDCs) – Major Diagnostic Categories are categories of conditions like Pregnancy or Musculoskeletal. The MDCs aggregate DRGs by similar type of service in broader categories.

Mass Communication – Any communication with the intent to impart and exchange information on a large scale to a wide range of Members.

Medicare – Medicare Part A and Part B, together, are called Original Medicare. Through the Center for Medicare & Medicaid Services, the United States government set up Original Medicare to cover a wide range of medical expenses for individuals 65 and older and individuals with certain disabilities.

Medicare Advantage (MA) – A type of Medicare health plan offered by a private company that contracts with Medicare to provide a substitute for Part A and Part B Medicare benefits.

Medicare Retiree – A retired Member of the State, Local Government, or Local Education group that is 65 years of age or older, or otherwise qualified to enroll in Medicare due to health status, and is currently enrolled in Medicare. Eligible Retirees may enroll in a Self-insured Medicare Supplement plan or a Fully Insured Medicare Advantage Plan. Where relevant, the term Medicare Retiree is used to distinguish Medicare Supplement Retirees. The Medicare Advantage plans are not applicable to this RFP.

Medical Director – Physician charged with the direction and management of the Vendor's {Contractor's} medical and clinical activities.

Medical Management – Umbrella term that encompasses overall health management including Disease, Care, and Case Management functions that are designed to modify consumer and Provider behavior to improve the quality and outcome of healthcare delivery.

Member – Employees, Early Retirees, Medicare Retirees, Employees on approved leaves of absence, enrolled Dependents, and qualified beneficiaries under COBRA, Chapter 375, or similar state health benefit continuation laws who meet the conditions for eligibility in the SHBP/SEHBP and are enrolled in the plan. This does not include non-eligible family members of employees. Members are Individuals within the meaning of HIPAA.

Mental Health – A Member's condition with regard to their psychological and emotional well-being.

Narrow Networks – Network alternatives that contract with a limited number of providers to maximize purchasing power, leverage and improve quality of care.

National Committee for Quality Assurance (NCQA) – An independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

Network Provider –A hospital, clinic, supplier of tangible medical goods, health care professional, or group of health care professionals who provide services to patients that have directly, or through a third party, entered into a written agreement with the Vendor {Contractor} to provide one or more health care services to persons who have enrolled in one of the offered Plans. Network designation may differ based on which Plan the Member is enrolled (e.g., PPO, HMO, Tiered Network).

Network Provider Contract – Written agreement directly or indirectly through a third party, between the Vendor {Contractor} and a Network Provider or facility, requiring the Network Provider or facility to perform specific services and to fulfill certain obligations in accordance with the terms of that agreement.

NJWELL – A voluntary Wellness Program established by the SHBP and SEHBP Plan Design Committees through which Employees and their eligible spouses participate in various wellness activities and earn points that are redeemed for gift cards.

NJWELL Enrollee – any Employee that is engaged in the wellness platform in the NJWELL plan year through completion of one or more of point-achieving activities.

Open Enrollment – A period of time each year when individuals can sign up for health insurance. If health insurance is not elected during the annual open enrollment period, the next opportunity for enrollment would be the next open enrollment period or a qualifying event.

Outcomes Based Metrics – Metrics designed to measure the change in health of an individual, group of people, or population that is attributable to an intervention or series of interventions.

Out of Hospital Prescription Drugs –Drugs covered in accordance with the Medical Plan offering.

Out-of-Network Shared Savings – A Recovery Services program intended to reduce the charge for out-of-network services and provide balance billing protection to Members.

Out-of-Network Provider – New Jersey based providers and facilities, as determined by the plan administrator, whom are not within Bidder's proposed network offering. Out-of-Network provider will only be covered at an In-Network benefit if prior authorization is received or on an emergency or urgent basis pursuant to N.J.A.C.11:24-5.3. Otherwise, the Out-of-Network benefit will be as illustrated as described in Chapter 44.

Out-of-State Provider – Non-New Jersey based providers and facilities, as determined by the plan administrator. Out-of-State services will be paid 100% by the covered person and subject to Reference Based Pricing support. The plan will only cover Out-of-State services at an In-Network benefit if a covered person receives prior authorization to utilize an Out-of-State provider or receives medically necessary services at any health care facility on an emergency or urgent basis pursuant to N.J.A.C.11:24-5.3.

Participating Employers – New Jersey public employers other than the State, that have elected to participate in the State's health benefits programs in accordance with the law and rules governing the SHBP/SEHBP.

Patient Protection and Affordable Care Act (PPACA) – The federal law with the goal of providing rights and protections that make health coverage more fair and easy to understand, along with subsidies (through "premium tax credits" and "cost-sharing reductions") to make it more affordable.

Per Employee Per Month (PEPM) – Refers to the average cost of services charged by the Vendor {Contractor} on a Subscriber basis for a one-month period.

Plan – Specific plan under the SHBP/SEHBP such as the PPO, HMO, HDHP, Tiered Network, or Medicare Supplement plans.

Plan Benefits – Healthcare and other ancillary services available to Members rendered in accordance with the Plan.

Plan Design Committees – The State Health Benefits Plan Design Committee and the School Employees' Health Benefits Plan Design Committee created by Public Law 2011, Chapter 78, which are responsible for reviewing the SHBP and SEHBP plan designs, respectively, and developing any changes therein.

Plan Document – Document which describes the benefits, limitations and rights afforded to Members under the Plan, typically the Plan Handbook and/or Summary Program Description.

Plan Eligibility File – File created by the DPB and transmitted to the Vendor {Contractor} listing the names and other pertinent information necessary for the Vendor {Contractor} to enroll a Subscriber and that Subscriber's Dependents into the Plan, to terminate enrollment, or to make changes to existing Subscriber records. The DPB is solely responsible for all enrollment/eligibility determinations.

Plan Payment Method – The type of payment system the insurance provider coordinates payment (DRG, Per Diem, Bundles, AGP/APC).

Plan Year – A twelve-month period, i.e., January 1 through December 31. The SHBP/SEHBP plan year for benefit purposes is a calendar year. Rate-setting also occurs on a calendar year basis.

Per Member Per Month (PMPM) – Refers to the average cost of services charged by a Contractor on a Member basis for a one-month period.

Preferred Provider Organization (PPO) – Managed healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for Members to use designated healthcare providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by healthcare providers who are not part of the PPO network.

Premium – The monthly fee that is generally paid to an insurance carrier to provide health coverage for fully-insured plan options.

Primary Care Provider (PCP) – Physician engaged in general practice, family practice, internal medicine or pediatrics who, in general, provides basic health services to and arranges specialized services for those Members. In accordance with the standards of the Vendor {Contractor}, the term may also encompass nurse practitioners/clinical nurse specialists operating within the scope of their respective licenses.

Prior Authorization – The process of obtaining certification or authorization by completing a review of clinical appropriateness against pre-established criteria from the Vendor {Contractor} for specified services. Failure to obtain prior authorization can result in a financial penalty to the Member.

Programs – State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Protected Health Information (PHI) – Any information that, if disclosed, would identify an individual Member, including but not limited to **Individually Identifying Health Information**, medical histories, test and laboratory results, mental health conditions, and health insurance information.

Provider – A hospital, clinic, supplier of tangible medical goods, health care professional, or group of health care professionals who provide services to patients.

Public Health Service Act, as amended ("the PHS Act") – The Act that gave the United States Public Health Service responsibility for preventing the introduction, transmission and spread of communicable diseases from foreign countries into the United States.

Pursue and Pay – A coordination of benefits approach designed to determine the primary and secondary liability before a Claim is paid.

Recovery Services – Programs intended to recoup the Claims cost associated with (1) subrogated Claims where a third party may be liable for the cost of the care received; (2) handling recoveries of workers compensation liens; (3) out-of-network Claims negotiations processes; and (4) erroneous billing of hospitals or providers.

Reference Based Pricing (RBP) – Limit eligible charges to a reference price based on a percentage of Medicare price or cost.

Residential Care – Treatment centers where patients are housed and supervised around the clock while receiving treatment and observation.

Retiree - A Member of the State or Local Employer group that is retired. A Retiree could be an Early Retiree and not yet eligible to enroll in Medicare, a Medicare Retiree that is over 65 years of age enrolled in Medicare (with ability to enroll in either Self-Insured Medicare Supplement or Fully Insured Medicare Advantage Plan). Where relevant, the term Early Retiree is used to distinguish this subset of Retirees while the term Medicare Retiree is used to distinguish the subset of Retirees enrolled in the Self-Insured Medicare Supplement plans. The Medicare Advantage plans are not applicable to this RFP.

Retiree Wellness Program – A Program offered to a small number of State Retirees. The program provides for early detection and intervention to address health risks, encourages the development of healthy lifestyles, provides reminders for tests and screenings, and offers guidance to those struggling with chronic disease. The retiree premium contribution is waived through participation.

Return on Investment (ROI) – A metric to measure, per period, rates of return on money invested in a program in order to decide the cost effectiveness of the program offered.

School Employees' Health Benefits Program (SEHBP) – The health benefits program established pursuant to N.J.S.A. 52:14-17.46.1 et seq.

(S)tate, (E)ducation, or (L)ocal Government (SEL) – Employers that participate in the SHBP/SEHBP are categorized by the following types of employer: State, Education, or Local Government Employer. State employers include State agencies and State colleges and universities. Education employers include Local Employers such as county colleges and boards of education. Examples of Local Government Employers include counties, municipalities, and authorities (including certain State authorities with independent purchasing authority that permits them to elect coverage other than that provided by the SHBP). State employers are required to participate in the SHBP. Local Employers, including Education and Local Government Employers can elect to participate in the SEHBP/SHBP.

State Health Benefits Commission/School Employees' Health Benefits Commission (Commissions) – The entities created by N.J.S.A. 52:14-17.27 and N.J.S.A. 52:14-17.46.3 charged with overseeing the SHBP/SEHBP. The DPB administers the SHBP/SEHBP pursuant to N.J.S.A. 52:14-17.25 and N.J.S.A. 52:14-17.46.1.

State Health Benefits Program (SHBP) – The health benefits program established pursuant to N.J.S.A. 52: 14-17.25 et seq.

Subscriber – An Employee, Retiree, survivor, COBRA beneficiary or Chapter 375 Member enrolled in the SHBP/SEHBP by the DPB.

Substance Use Disorder – A condition in which the use of one or more substances leads to a clinically significant impairment or distress.

Summary of Benefits and Coverage (SBC) – A simple and standardized comparison document required by the Patient Protection and Affordable Care Act (PPACA). All health plans are required

to produce a Summary of Benefits and Coverage based on a uniform template and customized to reflect the plan's unique terms.

Summary Plan Description (SPD) – Document which describes all of the Plan details, limitations, exclusions and appeal processes relative to each of the Plan options.

Targeted Outreach – The use of technology to prioritize Member experience and engagement by targeting care coordination, after identifying gaps in patient care through data research, health assessments, medication adherence, etc.

Telehealth – The use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services.

Telemedicine – The delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider, and in accordance with the provisions of P.L. 2017, c. 117 (N.J.S.A. 45:1-61 et seq.). "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Third Party Application – The software program administered by the Vendor {Contractor} for member engagement activities.

Three-Digit Zip Code – A group of numbers that are added to a postal address to assist the sorting of mail by identifying a geographic location. The first three digits of a zip-code identify the region of the United States and the central post office facility in that region.

Tiered Network Plan – A two-tiered medical plan currently offered by the SHBP. Tiered Network Plan enrollees who use Tier 1 Providers have lower out-of-pocket cost-sharing than enrollees who use Tier 2 providers. Services such as hospice, maternity, and inpatient mental health/substance use disorder are covered at no cost when provided by a Tier 1 Provider. The Tiered Network Plans do not cover out-of-network benefits. The Network/Claims Vendor {Contractor} contracts with Tier 1 providers for better discounts, pay-for-value contracts, and strong outcomes requirements.

TPA (Third Party Administrator) – A vendor that can, but is not limited to, conducting Claims administration, network management, and Claims processing for a third-party organization.

Transparency– Making available to the public, in a reliable, and understandable manner, information on the health care system's quality, efficiency and consumer experience with care, which includes price and quality data, so as to influence the behavior of patients, providers, payers, and others to achieve better outcomes (quality and cost of care).

Utilization Management (UM) – A set of techniques used by health insurance carriers to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care both prior to and post-provision.

Wellness Program – A program offered by an employer to employees and their dependent spouses that provides rewards for taking specific steps to measure and improve their health and wellbeing.

3.0 SCOPE OF WORK

The Vendor {Contractor} shall provide services as described in the Scope of Work. A Subcontractor or other partnership may be utilized to fulfill services outlined in this section. Note, Vendor {Contractor} and Subcontractor(s) shall be required to administer all aspects of the RFP.

SEHBP expectations for a successful vendor partnership include, but are not limited to, the following:

A. **Alignment with SEHBP Strategic Goals:** SEHBP expects well-articulated and successfully demonstrated services, programs and resources to support its strategic goals.
B. **Innovation and Partnership for the Future:** Demonstration that Vendor {Contractor} offers flexibility and innovation to address future goals and collaborative approaches for the Active and Early Retiree Population.
C. **Commitment to Value-based Payment to Reduce Costs and Improve Quality of Care for SEHBP Members:** Catalyze payment reform with providers by paying for value, reducing cost, reducing waste, and recognizing providers for improvement in the delivery of quality care.
D. **Care Delivery and Management Outcomes:** SEHBP expects the Vendor {Contractor} to employ equitable, clinically evidenced, high-touch, creative and innovative care delivery and care management models, leveraging advances in technology and multiple communications modalities, to improve Member health that is both equitable and specifically addresses the diverse Active and Early Retiree population. Programs should include aspects that mitigate negative Member Social Determinants of Health.
E. **Targeting Health Disparities in Vulnerable Populations:** SEHBP seeks a collaborative and proactive partnership to target health disparities for the most vulnerable populations including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Vendor(s) {Contractor(s)} are expected to integrate quality and disparities metrics into standard reporting and demonstrate a commitment to expansion and/or customization of current and future programs that address recognized disparities within the SEHBP Member population to reduce variation in quality of care for all members.
F. **Coordinated and Integrated Care:** SEHBP expects Vendor {Contractor} to provide integrated, member-centric clinical care, across the full health care continuum, to the Active and Early Retiree Population to provide comprehensive care, reduce errors, and eliminate waste and reduce inefficiencies.

3.1.1 CLAIMS ADMINISTRATION AND RECOVERY

3.1.1.1 CLAIMS ADMINISTRATION

The Vendor {Contractor} shall provide claims administration with a minimum of the following capabilities and procedures:

A. Process Claims for services incurred on or after the Benefit Effective Date;

B. Maintain current, complete, and accurate records of all Claims and correspondence associated with each Claim. Each Claim shall, upon receipt, be immediately assigned an appropriate tracking number which will remain with the Claim until it can be reviewed for completeness before adjudication;

C. Maintain and utilize CMS reimbursement schedule or other nationally-recognized data of prevailing health care charges for purposes of determining usual, reasonable and customary allowances as identified by the SEHBC or PDC as appropriate;

D. Maintain and utilize software containing edits to identify and track Members by services received, whether those services are in network and/or out of network, level of care assigned, and conditions treated;

E. Maintain and utilize software containing edits to identify and track providers by services rendered and Claim dollars received;

F. Request in writing from the Provider, Commissions, or Member, whatever additional information essential to the accurate coding and subsequent determination of benefits is necessary for the disposition of the Claim;

G. Maintain systems edits and critically examine charges for all services that appear aberrant, excessive or fraudulent and conduct an examination of all such services with the Provider, when determined to be necessary and appropriate through an exercise of reasonable business judgment. Contractor {Vendor} shall disclose any actions taken, or funds recovered, to DPB;

H. Offer New Jersey-based, Out-of-Network coverage with reference-based pricing vendor support with a robust member legal support program and vendor claim negotiation support with reimbursement level mutually agreed upon with the SEHBP;

I. Cover Out-of-State services at an In-Network benefit only if a covered person receives prior authorization or receives medically necessary services at any health care facility on an emergency or urgent basis pursuant to N.J.A.C.11:24-5.3. Any services rendered by providers or facilities located outside of the State of New Jersey will not be covered by the plan and will be paid 100% by the covered person but shall also be provided with Reference Based Pricing vendor negotiation support, unless defined as emergency or urgent service pursuant to N.J.A.C.11:24-5.3.

J. Vendor {Contractor} shall be required to set the Claims threshold reviews (and not use auto adjudication) for any Claim over $5,000 or a subsequent mutually agreed to lower threshold based on financial accuracy performance. Financial Accuracy shall be 99.3% of higher in conformity with the Performance Standards set forth in Attachment D

K. Investigate Claims and medical services to determine medical necessity, appropriateness of care, over and under-utilization of medical services, and existence of other coverage;

L. Verify Member eligibility before paying;

M. Timely and accurately process all Claims received in conformity with the Claims Adjudication Accuracy Performance Standard of 98.0% of greater as set forth in Attachment D;

N. Review and process all Claims submitted and issue reimbursement as per the contract with the Network Provider and the Blanket P.O. with the SEHBP, as appropriate, within the time parameters set forth in the Performance Standards, Attachment D;

O. Issue electronic funds transfers or benefits checks to Providers and facilities as appropriate and to non-contracted Providers and facilities or Members in a timely manner;

P. Accept electronically-transmitted Claims and facilitate coordination of those Claims with the respective Plan;

Q. Develop, in conjunction with the SCM, all materials used to communicate with Members such as Claim forms and form letters necessary to administer the Network/Claims aspect of the Plan;

R. Prepare communication materials jointly with the SCM, as required;

S. Ensure that the Network Providers are prohibited from balance billing Members for charges for periods of confinement not approved by the Vendor {Contractor};

T. Ensure that in-network hospitals perform pre-admission review, concurrent review, discharge planning, and retrospective review, and ensure that the existence of concurrent review and discharge services will be transparent to the Member;

U. Conduct account-specific audits (separate from routine Claim office audits) of its own office(s) and those of affiliated organizations and Subcontractors for DPB to ensure accurate processing;

V. In accordance with standards established by the Commissions or by law (including, but not limited to the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, P.L. 2018, c.32 (N.J.S.A. 26:2SS-1 et seq.)), review denied Claims that are appealed by a Member and:

    1. Make a full and fair review of each Claim;
    2. Notify each Member in writing of each Claim that has been denied;
    3. Inform the Member of the right to appeal to a subcontracted External Independent Review Organization (IRO) as required by Federal law after exhausting the Vendor's {Contractor's} internal appeals process; and
    4. Provide a monthly report to the DPB on all appeals referred to the IRO and the outcome of those appeals;

W. Comply with all internal review timelines required by Federal law which are subject to change during the term of this Blanket P.O. (See Chart of Time Limits for Appeals attached to this RFP as Exhibit 9);

X. Provide representatives for all Commission meetings (generally held bi-monthly) where appeals may be heard, including having appropriate medical professionals attend all Commission meetings when requested by DPB or either Commission. This responsibility shall continue after expiration or termination of the Blanket P.O. for any Claims that may go before the Commissions that were administered or adjudicated by the Vendor {Contractor} during the term of the Blanket P.O.;

Y. Administer all aspects of the external review and appeal process required under PPACA for all non-Grandfathered plans;

Z. Verify that all requirements of the U.S. Department of Health and Human Services, with regard to HIPAA-mandated electronic data interchange (EDI) for Claims transactions are met;

AA. Provide medical professionals including a physician with specialized expertise if needed, to serve as witnesses (including participation in witness preparation, discovery and testimony at hearing or trial) in all hearings or trials concerning disputed Claims. This responsibility shall continue after expiration or termination of the Blanket P.O. for any Claims that may be subject to hearing or trial that were administered or adjudicated by the Vendor {Contractor} during the term of the Blanket P.O.

In the event the Vendor {Contractor} wholly or partially denies a Claim, the Vendor {Contractor} shall provide an EOB that describes in detail the amount of benefits payable or benefits denied and the manner in which the determination has been made in accordance with the provisions of the Plan.

The Vendor {Contractor} shall include a notice to the Member of the right to an appeal of the denied Claim. This notice shall include (i) all information required by the Plan and applicable laws, and (ii) the appropriate name and address for Members to contact for requests for review of Claims or denied appeals.

All Administrative Fees shall assume the State will be the Claim Fiduciary.

The Vendor {Contractor} shall notify DPB, in writing, of any material change or modification to the system, protocols and procedures, location, or personnel utilized for Claims adjudication or Claims processing, prior to implementation, if the change or modification would:

A. Affect the Vendor's {Contractor's} ability to perform one or more of its obligations this Blanket P.O.;

B. Be visible to the SEHBP or its Members; or

C. Put the Vendor {Contractor} or the Plan(s) in non-compliance with the provisions or substantive intent of the Plan(s).

3.1.1.2 CLAIMS RECOVERY, COB, AND SUBROGATION

The Vendor {Contractor} shall charge for Recovery Services in the following Manner:

A. Any and all recoveries received for workers compensation or third party subrogation shall be paid to the State by the Vendor {Contractor}. Third party Subcontractor fees for workers compensation and third-party subrogation may be charged to the State with no additional fees assessed by the Vendor {Contractor}.

B. Bill eligible Recovery Services, excluding those for workers compensation or third party subrogation, as a percentage of the savings recovered; and

C. Recovery Services shall be capped at an annual amount the State would be required to pay, on a per employee per year (PEPY) basis based on employee months for all eligible Recovery Services combined.

3.1.1.2.1 CLAIMS RECOVERY

The Vendor {Contractor} shall make a reasonable effort to recover:

A. Claim amounts overpaid or paid in error and refund the recoveries to DPB or credit these recoveries against any amounts payable by the DPB. The Vendor {Contractor} may pursue the overpayment with the Provider and/or Member as appropriate; and

B. Claims paid in error when the Member has been involved in a workplace accident. Reasonable efforts include, but are not limited to: asserting liens, appearing in Workers' Compensation court to recover liens and corresponding with Member's attorney.

C. The Vendor [Contractor} shall notify the DPB of any litigation initiated to recover overpayments. Any compromise of a recovery shall be approved by the DPB or Commission as appropriate.

D. Any Claims overpaid based on Vendor {Contractor} error shall be sole financial responsibility of the Vendor {Contractor}. The Vendor {Contractor} shall notify the State of any such overpayment within ten (10) days. In the event that the State has already transferred funds to the Vendor {Contractor} due to such overpayment, by the Vendor {Contractor} to the provider, the State's account shall be credited within ten (10) days of the transfer or ten (10) days of discovering the overpayment, whichever is earlier. It is the sole responsibility of Vendor {Contractor} to rectify and reimburse the State for any and all overpayments.

With regard to recovery of overpayment to Members, the Vendor {Contractor}:

A. Shall never pursue legal remedies such as dunning or placing liens for overpayment, except liens involving a workplace accident and involving Workers' Compensation coverage that are permitted according to law; and

B. After reasonable attempts are made to recover the overpayment, may deduct the overpayment from future payments to the Member unless the overpayment was the result of an error of the Vendor {Contractor}, in which case, the overpayment will be immediately absorbed by the Vendor {Contractor} and will not be charged to the Programs, or to the Member;

C. With regard to recovery of overpayment to providers, the Vendor {Contractor} shall not engage in cross-plan offsetting except when to do so would solely benefit the SEHBP, and any overpayments made to a provider by the Vendor {Contractor} on behalf of the SEHBP shall solely be recovered for the benefit of SEHBP.

3.1.1.2.2 COORDINATION OF BENEFITS (COB)

The Vendor {Contractor} shall:

A. Inquire through, the Member, and any other appropriate means as to the existence of other group medical coverage, coordinate payment of Claims with other payers, and ensure that COB is administered in accordance with the aggressive Pursue and Pay process;

B. Inquire of the Member whether a third party may be liable for the cost of the care received, and, if so, request that the identity of the third party, and the name of the third party's insurer/payer, for purposes of instituting subrogation;

C. Actively and aggressively pursue the Plan(s)' right of subrogation to recover Claim payments from third parties; and

D. Make payments to the Centers for Medicare and Medicaid Services (CMS) and/or any state Medicaid agencies to the extent CMS determines that the Plan(s) should have been the primary payer for services rendered by a Provider.

3.1.1.3 CLAIMS SUBROGATION

The Vendor {Contractor} shall disclose, and fully account to DPB, any and all funds received as a recovery of an overpayment or incorrect payment. Monies recovered outside of the State for a Claim or lien shall be fully disclosed, accounted for, and credited to the Programs' claims account.

The Vendor {Contractor} shall:

A. Abide by the provisions of N.J.S.A. 26:2J-11.1, which provides for the continuation of services for covered Members for four (4) months after the termination of the Blanket P.O.

B. Bill all capitation fees as Claims and include identifiers within the Claims files to understand each separate component included.

C. Provide on-line inquiry access for DPB to the Vendor's {Contractor's} Claim payment system; and

D. Assign a contact for the SCM to telephone concerning Claims paid.

3.1.2 MEMBER SERVICES

3.1.2.1 MEMBER CALL CENTER

The Vendor {Contractor} shall:

A. Provide a call center with a dedicated customer-service unit and a toll-free telephone line to provide answers to Member and Provider inquiries on Claims processing;

B. Staff the customer service telephone line with live personnel Monday through Friday at a minimum from 8:00 a.m. to 6:00 p.m. Eastern Time (ET) each business day, excluding State holidays;

C. Ensure that its call center meets the Performance Standards set forth in Attachment D;

D. Provide multilingual speaking service representatives (English and Spanish are mandatory, other languages shall be provided upon request from DPB); and

E. Receive and handle all calls that require the attention of a clinician.

F. Maintain a recording or written record of all customer service telephone conversations for use by the SEHBP in the event of Member Disputes. Recordings will be maintained for the length of the contract, or if a dispute is in process, until the dispute is resolved whichever is greater.

G. Vendor {Contractor} shall equip member call center representatives with transparency (cost and quality) tools in order to facilitative and guide members to the appropriate site of care.

3.1.2.2 IDENTIFICATION CARDS

The Vendor {Contractor} shall:

A. Produce Member Identification Cards (ID Cards) for Members;

B. Mail ID cards to Members within ten (10) calendar days of the receipt and processing of a subscriber's eligibility record or a change warranting the production and release of a new Member Identification Card. One (1) ID card shall be sent to a Subscriber with individual coverage or two (2) ID cards to a Subscriber with employee/spouse/partner, parent/child, or family coverage;

C. Adhere to the format of the ID Card approved by the SCM;

D. Reissue ID cards in the event that the Committees make a change to a plan, in the same manner as set forth in this section, unless another approach is agreed upon by the Vendor {Contractor} and the SCM in writing;

E. Be responsible for the cost to reproduce ID cards (including priority shipping) in the event of Vendor {Contractor} related errors or Vendor {Contractor} initiated changes;

F. Provide replacement ID cards to Members at no cost or additional fee, which may be printed from the Vendor's {Contractor's} website.

A Network Provider may ask any person claiming entitlement to Plan Benefits to identify himself/herself by presenting his or her Membership Identification Card. The Vendor {Contractor} shall meet all requirements listed above.

3.1.2.3 WEBSITE, MOBILE CAPABILITIES, AND TRANSPARENCY

The Vendor {Contractor} shall provide SEHBP Members with 24-hour on-line access to web-based information. Vendor {Contractor} website shall be accessible to Members 24 hours a day, 7 days a week, 365 days a year (subject to routine downtime for maintenance, repair or other interruptions.) All outages in excess of one (1) hour shall be reported to the SCM.

The Vendor's {Contractor's} website shall be live by October 1, 2021 and include Member access to the following:

A. Ability to check on the status of Claims;

B. Explanation of Benefits (EOBs);

C. Order replacement ID cards;

D. Print temporary ID cards;

E. Claim and appeal forms; and

The Vendor's {Contractor's} website should, in addition to the requirements above, include Member access to the following, if requested by the SCM:

A. Provider information;

B. Provider directories;

C. Benefit plan summaries; and

D. Educational information.

The Vendor's {Contractor's} website shall offer a transparency tool to Members to allow for access to Provider pricing and quality information for various procedures and local facilities. Transparency tool may be an in-house solution or subcontracted to a qualified Third-Party Administrator.

Vendor {Contractor} shall describe in detail how your organization defines quality in your transparency information. Vendor {Contractor} shall provide detail how your organization measures quality among your provider partners.

3.1.3 COMMUNICATIONS

The Vendor {Contractor} shall have the capability to, if requested by the State:

A. Provide an annual communications calendar to the SCM. All Member communications shall be provided to the SCM in advance of distribution for review and approval;

B. Provide educational materials in a variety of formats (i.e., print, webinar, and video) for annual enrollment and other needs. All Member communications material should be written at a 5th grade level. The Vendor {Contractor} shall transmit communication materials in Spanish on a case-by-case basis, if requested in writing by the SCM; and

C. Provide co-branding and customization of communications materials in conjunction with DPB.

D. Work with DPB to develop language detailing Program benefits for the SEHBP member handbooks and other plan documents, as needed.

E. Review communications developed by DPB and provide comments and feedback in a timely manner, as requested.

3.1.4 ACCOUNT MANAGEMENT

The Vendor {Contractor} shall:

A. Create and identify an account management team for the State, who will be fully engaged during the implementation, which should consist of the following individuals (or individuals with equivalent titles and authority):

1. Account Executive;
2. Account Manager;
3. Clinical Account Executive (with specific expertise in clinical programs);
4. Health Management (Wellness and Disease Management) Program Lead;
5. Financial Analyst;
6. IT Analyst;
7. Claims Analyst;
8. Executive Sponsor; and
9. Eligibility Consultant.

The roles of Account Executive and Account Manager shall be designated to the administration of this Blanket P.O.

B. Provide representatives for Commission and/or Plan Design Committee meetings (generally bi-monthly and monthly, respectively);

C. Meet with the DPB and DPB-designated consultants on at least a monthly basis, and meet with DPB and other DPB vendors as requested by DPB;

D. Provide an on-site, comprehensive annual review of SEHBP performance, including analyses of the Vendor's {Contractor's} satisfaction (or lack thereof) of each Financial Guarantee and Performance Standard, projected changes that may be occurring in the Vendor's {Contractor's} Services, and trending and forecasting information;

E. Provide an on-site, comprehensive annual review of SEHBP performance, including analyses of the Vendor's {Contractor's} satisfaction Financial Guarantees, projected changes that may be occurring in the Vendor's {Contractor's} Services, and trending and forecasting information; and

F. Provide a thorough Plan analysis on an annual basis and make specific recommendations for Plan design changes, Program changes, etc. All such recommendations shall focus on decreasing clinical risks and decreasing the SEHBP costs, while taking into account Member disruption and access. Where relevant, the recommendations shall be accompanied by spreadsheets identifying specific cost savings (or increases) and information related to Member disruption.

G. Develop an annual satisfaction survey, in conjunction with the DPB, and transmit same to a statistically significant sample of Members. The Vendor {Contractor} shall be responsible for tallying the responses of the survey and presenting the results to the DPB. The Vendor {Contractor} shall provide all individual survey responses to the DPB, if requested by the

SCM. The Vendor {Contractor} shall maintain a member satisfaction rate of 85% or greater in compliance with the standards set up in the Performance Standard Attachment D; and

H. Provide account management and/or Member services support for, and attendance at, annual enrollment meetings.

I. Utilize project management practices that comply with Project Management Institute standards and/or project management best practices to ensure deadlines are met and Vendor {Contractor} actions remain within the scope of the Blanket P.O.

3.1.4.1 ACCOUNT EXECUTIVE

The Account Executive shall:

A. Have decision making authority for the Blanket P.O.;

B. Ensure satisfactory administration of all aspects of the Blanket P.O.

C. Coordinate resources to meet the needs of the State, and act as a facilitator toward that end;

D. Ensure that DPB procedures and directives are followed concerning marketing, attendance at health fairs, timeliness, and accuracy of materials available to Members, reporting (financial and other), and other procedural and contractual requirements;

E. Be accessible to DPB at all times during normal business hours (the State is agreeable to the Account Executive's designee or an appropriate Account Management Team member representing the Account Executive for this item);

F. Update contact information for the Account Management Team as appropriate, including key contact information (office, fax and cell phone numbers, email, and physical mailing addresses) for each Account Management Team member;

G. Attend all meetings as assigned or requested by DPB;

H. Communicate effectively and professionally, conducting and facilitating meetings with agendas;

I. Fully inform the DPB of changes of key staff members, Vendor {Contractor} policies that may affect the Blanket P.O., pending mergers, investigations or inquiries by regulatory, state or federal agencies, or new financial arrangements with other contractors or subcontractors that may have a material effect on the State medical program, i.e., loss of providers or other third-party vendors;

J. Fully inform DPB of changes of new financial arrangements with other contractors or subcontractors that may have a material effect on the Plan(s) and/or Member(s);

K. Notify the State at a minimum 15 business days in advance of any proposed change being made to Account Management Team; and

L. Address issues or problems as they arise, work to resolve problems, and communicate solutions to DPB.

The State reserves the right to request a new Account Management Team member or entire Account Management Team at any time, and have its request honored by the Contractor in a timely manner. Additionally, the State shall have the right to interview any new Account Management Team members before they are assigned to the State.

3.1.5 LOCAL EMPLOYER SUPPORT

The Vendor {Contractor} shall:

A. Provide Local Employers with experience reports as requested, pursuant to N.J.S.A. 52:11-17.37a and

B. Track and report the experience reports provided to employers and report to the State on a monthly basis; and

C. Support initiatives to recruit Local Employers to join the SEHBP on a regular basis in conjunction with the DPB. Local Employer recruitment includes but is not limited to outreach to local employer groups, union leaders, etc.

3.1.6 NETWORK MANAGEMENT

The Vendor {Contractor} shall:

A. Provide for access to medical care and health services that satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care and services;

B. Not require members to elect a Primary Care Physician (PCP) in order to seek care. A PCP referral shall not be required for a member to seek care from a Specialist or receive other services.

C. Provide a High-Quality Integrated Delivery Network in New Jersey focused on providing patient centered health care in an affordable manner;

D. Maintain a New Jersey-only network of providers that are focused on high quality care. Providers out-of-network shall be paid based on a reference-based pricing vendor claim negotiation and legal support approach. Out-of-State providers will not be covered by the plan and will be paid 100% by the covered person. The plan will only cover Out-of-State services at an In-Network benefit if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis pursuant to N.J.A.C.11:24-5.3.;

E. Maintain a network of Providers offering primary, specialty, ancillary, and institutional services sufficient, at a minimum, to provide or arrange for the provision to Members the services described in the respective Plan Document;

F. Verify initially and routinely thereafter (at least every three (3) years) that all contracted facilities are appropriately licensed by the State in which they operate. The Vendor

{Contractor} shall also verify initially and routinely thereafter (at least every three (3) years) professional education, training, quality of care, licenses and other credentials for each Network Provider and where applicable the admitting and other privileges granted by a facility to each Network Provider;

G. Provide at least 45 days advance written notification to the SCM of any change in Provider networks that will affect a 1.0% or greater change in the number of Providers in the network or a disruption that would impact 3.0% or greater of the Members. The Vendor {Contractor} shall also notify Members of disruption based on:

- If facility Provider, communication shall be sent to all Members within the Three-Digit Zip Code; or
- If physician Provider, communication shall be sent to all affected Members.

H. Require that each licensed Network Provider maintain professional liability (medical malpractice) insurance with limits of at least $1 million for each occurrence and $3 million in the aggregate, except where in any identified geographic area, other professional liability coverage limits are appropriate and usual for the Network Provider's clinical specialty and/or services in that Network Provider's geographic area. It is the Vendor's {Contractor's} responsibility to ensure that the insurance is valid at the time of credentialing and to recheck credentials routinely thereafter in accordance with the National Committee for Quality Assurance (NCQA) standards;

I. Monitor, evaluate, and take action to address improvements in the quality of health care delivered by all Network Providers through the implementation of a continuous quality assurance program which is satisfactory to the State and which shall be reported on and presented to the State on at least an annual basis during rate renewal presentations;

J. Disclose to the State and its designated consultant the method utilized to determine quality within the providers network;

K. Continually explore methods of Provider payment reform and emerging market trends to ensure the best possible financial results for SEHBP;

L. Require that in-network providers notify Members in writing when referrals are made to out-of-network providers. The SEHBP and all Members shall be held harmless for the extra cost of out-of-network Claims in excess of the in-network charge if the Member was not notified in writing that the referral was to an out-of-network provider;

M. Ensure that the Member and the Plan, as appropriate, will be charged the lower of the Provider's billed charges and the Vendor's {Contractor's} discounted or negotiated rate with a Provider or rate agreed to by the State and the Provider. The Vendor {Contractor} understands and agrees that the Vendor's {Contractor's} discounted or negotiated rate with a Provider applicable to the SEHBP shall be consistent, or less than, the Vendor's {Contractor's} comparable network commercial book of business; and that the Vendor {Contractor} shall not utilize or apply a discounted or negotiated rate schedule that is distinct and materially different from the Vendor's discounted or negotiated rate with a Provider, unless fully disclosed and agreed to by the State.

The Vendor {Contractor} shall ensure that in determining the amount of any payment to a Member or amount billed to the Plan, the Member or the Plan, as appropriate, shall receive one hundred percent (100%) of any discounted or negotiated rates or payment arrangements, any price adjustments/rebates/refunds, and any retroactive or supplemental payments or credits negotiated by the Vendor {Contractor} or its affiliates, agents, or subcontractors. No separate arrangement that returns fees or otherwise compensates the Vendor {Contractor} based upon the volume of Members and/or services rendered to Members shall be permissible, except as mutually agreed otherwise by the State and the Vendor {Contractor}; and

N. Ensure that 100% of all prescription medication rebates or other financial incentives collected by the Vendor {Contractor} on behalf of the SEHBP for prescription medications acquired and administered under the medical plan shall be passed back to the State. The Vendor {Contractor} is not permitted to retain a percentage of rebates or financial incentives. The rebates and financial incentives shall be passed back to the State on at least a quarterly basis.

3.1.6.1 OUT-OF-NETWORK MANAGEMENT

The Vendor {Contractor} shall provide an Out-of-Network solution that enables members to seek care outside of the network with an understanding of cost and member liability.

The Out-of-Network solution shall be based upon a reference-based pricing model directed by the SEHBP. The vendor shall provide an in-house Reference Based Price (RBP) and legal support solution or contract with a qualified Third-Party Administrator.

3.1.7 PROVIDER NETWORK ACCESS STANDARDS AND QUALITY ASSURANCE

The Vendor {Contractor} shall provide a network of primary, specialty, and ancillary care providers. The Vendor {Contractor} shall:

A. Ensure its network is comprised of a sufficient number of licensed Providers that will provide basic comprehensive health care services and are accepting new patients;

B. Ensure its network contains other health professional staff, including but not limited to, licensed nurses and other professionals available to Members to provide basic health care services in accordance with the standards listed in the chart below; and

C. Ensure geographic access and availability standards for its PPO networks' physicians and facilities as outlined in the chart below. Urban, Suburban, and Rural classifications shall be based on United States Census Department classifications as determined by GeoNetworks software.

	Number of Providers Available	Miles from Employees Residence – Urban	Miles from Employees Residence – Suburban	Miles from Employees Residence – Rural

Adult Physicians (PCPs, Family Practice, General Practice, General Internal Medicine)	2	5	8	20
General Pediatricians	2	5	8	20
Obstetricians/Gynecologists	2	5	8	20
Specialists (exclude Ob/Gyn and Pediatricians)	2	5	8	20
Acute Care Hospitals	1	5	10	20
Psychiatric Residential and Substance Abuse Care Facilities	2	5	10	20

Specialist access criteria shall be met independently for each individual Specialist type. Areas of medical “Specialists” include, but are not limited to, the following:

A. Cardiology;

B. Dermatology;

C. Endocrinology;

D. Gastroenterology;

E. General surgery;

F. Neurology;

G. Oncology;

H. Ophthalmology;

I. Oral surgery;

J. Orthopedics;

K. Otolaryngology;

L. Psychiatry;

M. Psychology; and

N. Urology.

3.1.7.1 PROVIDER AND FACILITY AVAILABILITY STANDARDS

The Vendor {Contractor} shall:

A. Provide a network of qualified PCPs including the following categories:

1. Licensed physicians who have successfully completed a residency program accredited by the American Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics;
2. Licensed medical specialists to be designated as a primary care physician for certain plan Members who, due to health status or chronic illness, would benefit from medical care management if an exception is made;
3. Nurse Practitioners/Clinical Nurse Specialists certified by the New Jersey Board of Nursing, or similarly licensed by the state in which care is being rendered, in advanced practice categories comparable to family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics; and in hospitals or other facilities;
4. Physician Assistants licensed by the State of New Jersey Board of Medical Examiners or a state other than New Jersey in which care is being rendered, which licenses physician assistants; and
5. Certified Nurse Midwives registered by the State of New Jersey Board of Medical Examiners or another state other than New Jersey, in which care is being rendered, which grants such certification.

B. Demonstrate that its network of PCPs is sufficient to ensure that the following criteria are met:

    1. Emergencies are triaged immediately through the PCP or by a hospital emergency room through medical screening or evaluation;
    2. Preventive routine care shall be available within eight (8) weeks;
    3. Symptomatic/non-urgent acute care shall be available within three (3) business days;
    4. Routine care shall be available within ten (10) business days;
    5. Urgent care shall be available same day or within 24 hours; and
    6. Physicians shall have a reliable 24 hour per day/7 day per week answering service, a machine with a beeper, or a paging system to address after hours care.

C. Maintain contracts or other arrangements acceptable to DPB with institutional Providers which have the capability to meet the medical needs of Members and are geographically accessible.

D. Cover medically necessary trauma services with all Level I or Level II trauma centers designated by the New Jersey Department of Health as such, and in states other than New Jersey where such a designation exists. The Member shall not be balanced billed for any covered trauma services provided by such designated trauma centers.

The Vendor {Contractor} may request, and may be granted relief from, the time and mileage requirements as stated above in Section 3.1.7 where it can document that appropriate access to alternative sites is available. Such documentation shall address travel accommodations and travel times, financial hardship placed on families, and other logistical details as requested by the SCM.

3.1.7.2 MENTAL HEALTH/SUBSTANCE USE DISORDER NETWORK AVAILABILITY

The Vendor {Contractor} shall:

A. Provide a network of health care Providers, including physicians, counselors, social workers, and specialists, for the high quality treatment of mental health and substance use disorder issues based in settings including, but not limited to, the following:

1. Inpatient hospital;
2. Outpatient hospital;
3. Day/partial hospitalization;
4. Residential care;
5. Pediatric care;
6. Short-term therapy; and
7. Crisis intervention;

B. Ensure that its mental health and substance use disorder Provider network is of sufficient capacity to meet the treatment needs of Members and are accepting new patients;

C. Demonstrate that its mental health and substance use disorder Provider network is sufficient to ensure that the following criteria are met:

1. Symptomatic/non-urgent acute care, including physical or virtual access, reasonable accommodations and culturally competent communications shall be available within five (5) business days;
2. Urgent care shall be available same day or within 24 hours; and
3. Licensed Providers (MD, PhD, LCSW, LPC, NP, PA) shall have a reliable 24 hour per day/7 day per week answering service, mobile capabilities, or a monitored paging system to expedite after hours care.

D. Maintain contracts or other arrangements acceptable to DPB with mental health and substance use disorder providers which have the capability to meet the medical needs of Members and are geographically accessible.

3.1.7.3 MENTAL HEALTH/SUBSTANCE USE DISORDER QUALITY ASSURANCE STANDARDS

The Vendor {Contractor} shall:

A. Ensure that it closely coordinates care planning and management with State Employee Assistance Programs for Members seeking care through such programs and coordinate services with the employee assistance programs upon request from the Division within 24 hours of notification;

B. Ensure that the mental health/substance use disorder care planning and management is coordinated with the Vendor's {Contractor's} care planning and management for all other illnesses;

C. Provide continuous 24 hour per day/7 day per week toll-free telephone or mutually agreed upon access for Members to qualified, professional personnel for the intake, assessment, and referral to services of Members seeking assistance;

D. Ensure that its protocols for mental health and substance abuse intake, assessment, referral to service, and the services of its providers equal or exceed generally accepted industry standards;

E. Ensure that it uses the most recent edition of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders

3.1.7.4 PLAN SPECIFIC REQUIREMENTS

For plan specific requirements, the Vendor {Contractor} shall act as the Claim administrator and network manager for the distinct Garden State Health Plan benefit design offered to the SEHBP. The Vendor {Contractor} shall:

A. Administer Plan Benefits;

B. Provide Members with access to health services, including hospitalization, medical, surgical services, and other covered health care services;

C. Ensure that its Plans have the standard components of a health plan;

D. Reimburse the in-network services according to the discount agreement with network providers;

E. Charge the Member copayments or coinsurance for most in-office services and for other specialized services such as diagnostic tests, use of emergency rooms, etc.; and

F. Subject out-of-network Provider services to deductibles and coinsurance based on a mutually agreed upon reimbursement strategy chosen by the appropriate body governing the SEHBP.

3.1.7.5 HACS AND NEVER EVENTS

Neither Vendor {Contractor}, nor SEHBP, nor Members shall pay for “hospital acquired conditions” (HACs) or Never Events as identified by Medicare guidelines. Vendor {Contractor} shall agree to add language to its provider, ambulatory surgical center, facility and hospital contract that:

A. Prohibits the hospital from charging Vendor {Contractor} or an SEHBP Member for HACs identified by Medicare guidelines;
B. Requires hospitals to adopt the “Guidelines for Non-Payment of Serious Adverse Events”; and
C. Requires hospitals to participate in the Adverse Events Reporting Program for Hospitals.

3.1.8 HEALTH MANAGEMENT

The Vendor {Contractor} shall provide fully integrated services for health management program:

A. A single web portal through which the Member can access information, programs, tools and resources on all health-related programs;

B. Integrated operations from the Members’ perspective including, for example, seamless referrals between programs;

C. Integrated customer service with a single point of contact for resolving issues posed by DPB, as the client, as well as those presented by individual Members; and

D. Coordination of all communication deliverables, including proactive health promotion messages to subsets of the population to provide education and awareness of applicable programs and to the entire population to increase awareness of the relationship between lifestyle behaviors and health risks.

3.1.8.1 IMPROVED QUALITY OF CARE AND LOWER COSTS

The Vendor {Contractor shall ensure that all network arrangements include quality and cost considerations in all provider and facility selection criteria when designing and composing networks. Quality considerations may include clinical quality, patient safety and patient experience.

3.1.8.2 PRICE AND QUALITY VARIATION

Vendor {Contractor} shall measure price and quality variation within its network and establish methods to share price and quality information with Members in a usable format. Vendor {Contractor} shall actively engage Members to utilize price and quality tools; reporting annually on utilization and proposing detailed solutions and timelines for increased Member use.
Vendor {Contractor} shall disclose, upon request, the following:

A. The factors it considers in assessing the relative unit prices and total costs of care;
B. The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;
C. How such factors are used in the selection of providers or facilities in networks available to Members; and
D. The identification of specific hospitals and their distribution by cost deciles or describe other ways providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Vendor {Contractor} that are expended in each cost decile. Respondent understands that it is the desire and intention of SEHBP to expand this identification process to include other providers and facilities in future years.

3.1.8.3 HEALTH MANAGEMENT PROGRAMS

Subject to the following, the Vendor {Contractor} shall employ an UM program to ensure appropriateness of care and to control Provider abuse. UM will apply to services for both in-network and out-of-network treatment.

The Vendor {Contractor} shall provide in house or through the Integrated Delivery Network system a voluntary Case Management (CM) program which should include, but need not be limited to, the following:

A. Short term, Chronic and Complex Care Management (CCM), and specialty case management;

B. High cost complex case management (unique Members with Claims > $50,000);

C. Pre-admission counseling; and

D. Post-discharge counseling.

The Vendor {Contractor} shall have in place at a minimum the follow strategies for Care Management Engagement:

A. Culturally competent Motivational interviewing;
B. Teaching Member self-management skills;
C. Multiple attempts using different methods to engage Members'
D. Cross-training to support multi-condition management; and
E. Identification of and coordination with community supports.

To encourage participation and provide access for Members who work during normal business hours, Vendor's {Contractor's} care coordination and management program staff, including practitioners will be available to work with Members, at minimum, in the evening from 5:00pm to 7:00pm Eastern Time.

The Vendor {Contractor} shall provide a Disease Management (DM) program to the State. The DM program should include, but need not be limited to, the following chronic conditions:

A. Asthma;

B. Diabetes;

C. Congestive Heart Failure;

D. Coronary Artery Disease;

E. Chronic Obstructive Pulmonary Disease;

F. High Cholesterol;

G. Hypertension; and

H. Low Back Pain/Musculoskeletal.

3.1.8.4 CENTERS OF EXCELLENCE (COE)

Vendor {Contractor shall provide or be willing to develop COE's for specific conditions/procedures.

Vendor {Contractor} shall report:

A. How Members with conditions that require highly specialized management are managed by providers with document special experience and proficiency based on volume and outcome data, such as Centers of Excellence;

B. The basis for inclusion of such COE's;

C. The method used to promote members' usage of these COE's;

D. The utilization of these COE's;

3.1.8.5 WELLNESS

Subject to the following, the Vendor {Contractor} shall coordinate with the State of New Jersey's current medical vendor to provide the NJWELL Wellness Program. The Vendor's {Contractor's} NJWELL program support shall include, at a minimum, the following services:

A. Online Health Assessment;

B. Support for onsite and Physician Attestation forms for biometric screenings that consist of a blood test for cholesterol and glucose, a blood pressure reading, and a body mass index (BMI) measurement;

C. Telephonic health coaching for lifestyle management that includes coaching on physical activity, nutrition, weight management, stress, tobacco cessation;

The Vendor {Contractor} shall prominently display the "NJWELL" logo on all wellness program materials.

The Vendor {Contractor} shall work collaboratively with DPB's NJWELL team as well as any other medical vendor(s) also administering the NJWELL program to plan biometric screening events, coordinate communication campaigns, make strategic suggestions, etc.

3.1.9 STATE-SPECIFIC OBLIGATIONS

3.1.9.1 COORDINATION WITH STATE PBM

The SEHBP Prescription Drug plan is administered separately by a Prescription Benefits Manager (PBM). The Vendor {Contractor} shall:

A. Accept Prescription Drug data from the administrator of that plan and send medical data to that administrator to enable optimal use of data for disease and care management, at no additional cost to the State;

B. Coordinate prescription drug Claims with the State's PBM for Member reimbursement under the High-Deductible Health Plan options, since prescription drugs and medical Claims have a combined deductible and Out-Of-Pocket (OOP) maximum under those options. Outline any online capabilities to provide integrated accumulator product;

C. Accept prescription drug claim feeds from the PBM for claim management and send the PBM medical Claim feeds to facilitate the PBM's claim management operations;

D. Coordinate prescription drug claims with the State's PBM for Member reimbursement under the PPO Plan for Local Employees who are enrolled in PPO plans that provide a coinsurance benefit for prescription drugs, since prescription drugs and medical Claims have a combined Out-Of-Pocket (OOP) maximum under some of the PPO plan options,

and accept prescription drug claim feeds from the PBM and process the claim payment for such claims.

3.1.10 COORDINATION WITH STATE PROGRAMS

The Vendor {Contractor} may be requested to work with Point Solution Vendors that the SEHBP has previously or is currently contracted with providing services to members.

3.1.11 TELEMEDICINE

The Vendor {Contractor} shall provide coverage, or subcontract through a capable party for medically necessary services provided through Telemedicine and Telehealth on the same basis as, and at a Provider reimbursement rate that does not exceed the Provider reimbursement rate that is applicable, when the services are delivered in-person in New Jersey, pursuant to Chapter 117, P.L. 2017 (N.J.S.A. 45:1-61 et seq.).

The Vendor {Contractor} shall be prepared to work with the State on innovative and complementary approaches to managing the most challenging and routine clinical situations through Telehealth and Telemedicine solutions, including addressing challenges and gaps in care in Behavioral Health care services.

3.1.12 HIPAA COMPLIANCE

The Vendor {Contractor} shall ensure safeguarding of all data in accordance with State and Federal statutes, regulations, and policies pertaining to the confidentiality of Member information. Such statutes, regulations and policies include, but are not limited to the Privacy Regulations Adopted by the US Secretary of Health and Human Services pursuant to HIPAA and the Balanced Budget Act (BBA) of 1997 governing the protection of patient information.

The Vendor {Contractor} shall:

A. Have policies and procedures for the protection of Member Personal Health Information (PHI) and avoidance of security breaches under HIPAA and HITECH;

B. Have established breach notification procedures in the event of a release of PHI;

C. Complete and submit a HIPAA Business Associate Agreement within ten (10) business days after the Blanket P.O. award;

D. Maintain processes, systems, and reporting in full compliance with federal and State requirements;

E. Be compliant with HIPAA for acceptance of Claims transactions in the applicable industry standard NCPDP format; and

F. Be solely responsible for any fines related to non-compliance.

3.1.13 PPACA COMPLIANCE

The Vendor {Contractor} shall:

A. Ensure the Plan's continuing compliance with requirements, including, but not limited to, sending notifications of changes in the federal regulations to the State and its Subscribers;

B. Support embedded and non-embedded out of pocket maximums and/or deductibles. Certain individual cost sharing limits set by the PPACA will apply on a per individual basis, regardless of whether an individual is covered under an individual or family plan;

C. Take primary responsibility for the development of the Summary of Benefits and Coverage (SBC) and incorporate carve-out prescription drug information at no cost to the State; and

D. Charge based on actual cost the expense of retaining outside vendors for appeals required by PPACA (e.g. IRO) to the Programs.

3.1.14 OPEN ENROLLMENT AND ELIGIBILITY

The Vendor {Contractor} shall support the annual Open Enrollment period established by the Commissions. The support includes:

A. Provision of materials to employers and Subscribers;

B. Attendance at health benefits fairs;

C. Health benefits presentations; and

D. Support any special open enrollment period when requested by the SCM.

All materials shall be approved by the SCM prior to use or distribution.

During the term of this Blanket P.O., the Vendor {Contractor} or any affiliate or subsidiary shall not solicit or try to induce a participating Local Employer to enter into an agreement for any type of medical coverage provided under this Blanket P.O. The Vendor {Contractor} shall not use any information obtained as a result of this Blanket P.O., including information on Participating Local Employers, Subscribers, Dependents, and Claim experience, for any purpose other than processing Claims and providing such other services as are required under this Blanket P.O. In the event the Vendor {Contractor} or any affiliate or subsidiary receives from a participating Local Employer (or any entity that is, or may be, acting on its behalf) a request for a Quote and/or a request for Claim information for coverage of the type being provided under this Blanket P.O., the Vendor {Contractor} shall advise the DPB in writing of the request. Claim information shall not be released without prior DPB approval.

3.1.15 COVERAGE TO DISABLED MEMBERS

The Vendor {Contractor} shall extend health benefits at no cost to totally disabled Members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those Members who are totally disabled on the date their coverage terminates, regardless of

hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition.

The extension period shall end on the earliest of:

A. Date the total disability ends;

B. The end of the calendar year after the one in which coverage ends;

C. The date on which the person becomes covered under any replacement Plan established by the employer.

3.1.16 FINANCIAL ACCOUNTING

Payment by Vendor {Contractor} of any amount payable under the Plan shall be made by checks drawn by Vendor {Contractor} payable through a bank or via electronic fund transfers to providers.

The Vendor {Contractor} shall request reimbursement for claim checks that have cleared its bank account and for electronic fund transfers the Vendor {Contractor} has paid to providers. The Vendor {Contractor} will be reimbursed for claim checks and electronic fund transfers to providers that have cleared the Vendor's {Contractor's} bank account by the Vendor {Contractor} transmitting the total amount cleared via email or facsimile machine to DPB by 11:00 a.m., ET daily, to determine the total amount that will be funded by wire transfer to the Vendor's {Contractor's} designated bank on the same day. The transmission shall include a breakdown between State and Local Employer amounts. If the amount to be funded is not provided by the Vendor {Contractor} to DPB by 11:00 a.m. ET, it shall be added to the next wire transfer and no charges shall be assessed against the Programs. Vendor {Contractor} must provide backup reporting of claims and checks cleared in order to reconcile for audit purposes.

Should the State fail to provide funds in a timely manner to the bank selected by the Vendor {Contractor} for the daily payment of checks cleared by the bank or for cleared electronic transfers paid by the Vendor {Contractor} to large institutions and other medical facilities, the Vendor {Contractor}, after timely notice, may cease disbursement of benefit payments until the requested funds have been provided. The Vendor {Contractor} shall provide five (5) Business Days' notice of the State's failure to provide the deposit of said funds and the notice shall be provided by 1) telephone, 2) e-mail, and 3) in writing via facsimile machine, or in writing by overnight delivery to the SCM and the person(s) with responsibility for receiving these notifications identified by the State.

The Vendor {Contractor} agrees that, if in the normal course of business, it, or any other organization with which the Vendor {Contractor} has a working arrangement, chooses to advance any funds that are due to any provider, affiliate or Subcontractor, the cost of such advance shall not be charged back to the Programs except the DPB shall reimburse the Vendor {Contractor} as set forth in this RFP.

The Vendor {Contractor} shall disclose, fully account for, and remit to the DPB any and all funds received by it as the result of a recovery of an overpayment or incorrect payment, rebates, or subrogation of a claim or lien. All discounted or negotiated rates or payment arrangements, all price adjustments and refunds, and all retroactive or supplemental payments or credits negotiated with regard to covered services received by Members shall be remitted to DPB as disclosed and

established by the Pricing Sheet submitted by the Vendor {Contractor}. Administrative Services Only (ASO) fees shall take into consideration this provision.

Administrative Fees will be payable to the Vendor {Contractor} by the State within thirty-one (31) days after the beginning of the monthly coverage period based on the State's Plan Eligibility File. Administrative fees and other charges will be wired to a bank selected by the Vendor {Contractor}.

The Vendor {Contractor} shall not charge DPB for a Claim payment that is greater than the actual amount paid by the Vendor {Contractor} to the Provider, or thereafter negotiated with the Provider on account of the Claim. The Vendor {Contractor}shall not retain amounts paid by DPB for a Claim(s), which amount is subsequently negotiated down or reduced by the Vendor {Contractor} as part of an agreement or negotiation between the Vendor {Contractor} and the Provider (e.g., multiple procedure discounts, retention reallocation, etc.). The Vendor {Contractor} shall submit to the SCM an itemization of the charges and fees (other than Claim payments) and credit for services provided in the administration of the Plan.

3.1.17 TECHNICAL INTERFACE WITH STATE

DPB will process all health benefit enrollments, changes and terminations for Active Employee, Retiree, COBRA and Chapter 375 Members and send the processed information to the Vendor {Contractor} each business day via Connect-Direct Secure Plus from IBM Sterling Software for update of SEHBP records to ensure the Vendor {Contractor} has the most current and accurate eligibility information. This daily file, in a Positive Transaction Reporting format is referred to herein as the Plan Eligibility File.

The Vendor {Contractor} shall, unless otherwise directed by the State:

A. Accept, process, and report any errors or omissions back to DPB daily;

B. Accept and update the Plan Eligibility File each business day at 12:00 a.m. ET;

C. Send the SCM a Daily Return File before 8:30 am ET on the second (2nd) business day after the transmission. All errors or omissions shall be reported daily to the SCM; and

D. Retain at least 12 months of the daily send files for review and audit purposes.

In the event of a transmission or other failure, the Plan Eligibility File may be sent by the State during business hours. When determined necessary by the State in its sole discretion, the Vendor {Contractor} shall accept multiple Plan Eligibility Files in a single day, on a Saturday and/or Sunday, or on a State holiday. In these instances, files may be sent at any time of the day seven (7) days per week, but will only be processed on business days.

The Vendor {Contractor} shall ensure that its file acceptance processing and operations, at a minimum:

A. Support termination from one experience group and enrollment in another experience group in the same day;

B. Accept Plan Eligibility File effective dates up to six (6) months into the future;

C. Ensure secure transmission of all necessary and appropriate information to any other organization it has contracted with to perform any services applicable to the provision of benefits under the Plan;

D. Accept the entire Plan Eligibility File and only process those fields in which the resident information has been added, deleted or changed;

E. Provide a Daily Return File that lists the number of enrollments, terminations, all changes effectuated, all errors that prevented proper processing of any enrollment, termination or change on the Plan Eligibility File, and detailed records for the unprocessed transactions and the Commission-specified reason codes as set forth in Exhibit 5 (Daily Return File Transmission Layout);

F. Support a peak daily transmission activity of approximately 7,000 record sets within the Plan Eligibility File;

G. Store history information by Member with the Social Security Number (SSN) as the access key;

H. Accept alternative sequence numbers in lieu of actual SSNs for newborns and foreign nationals;

I. Support retroactive enrollments and terminations of up to one (1) year for Members;

J. Store dependent information as sent in the Plan Eligibility File and only pays Claims for those dependents actively covered on the file and flags all dependent Claims denied based on ineligibility for reporting to the SCM;

K. Ensure that only DPB-originated eligibility information and changes will be reflected on the Plan records contained in Vendor's {Contractor's} files;

L. Provide edits/security to ensure the integrity of the data on the Vendor's {Contractor's} files;

M. Allow for replacement of its current employer file with a new employer file supplied by the SCM on a monthly basis (the layout for the employer file is attached as Exhibit 6);

N. Report to the SCM, within one (1) business day of discovery, all events or conditions adversely affecting the processing of enrollment or Claims;

O. Have on-line access for DPB or other State personnel to the Vendor's {Contractor's} enrollment system for inquiry and enrollment maintenance;

P. Maintain its records so Members are categorized by one of three employer types: State, Local Educational Employer or Local Government Employer ;

Q. Categorize Members enrolled by employment status as an Active, Retired, COBRA, or Chapter 375 Member (ARCO);

R. Have a response time not exceeding 2-3 seconds per transaction for inquiry and update access; and

S. Have separate levels of access for inquiry and update capabilities.

The Vendor {Contractor} shall report the following routine operating data daily to the SCM:

A. Batch enrollment counts (received, processed, not processed);

B. Detail of batch enrollment data successfully processed;

C. Detail of batch enrollment data unsuccessfully processed;

D. ID cards produced;

E. Rejected ID cards; and

F. Changes made by Vendor {Contractor} to Member's records not on the Plan Eligibility File.

The Vendor {Contractor} may rely on information furnished to it by the State in the Plan Eligibility File and written communications by the SCM. The State will accept responsibility for Claims based on inaccurate information provided to the Vendor {Contractor} by the State in the Plan Eligibility File and written communications by the SCM. Notwithstanding the State's responsibilities set forth in this paragraph, the Vendor {Contractor} shall work in partnership and in good faith with the State to minimize the negative impact to any Member that results from inaccurate information furnished to it by the State in the Plan Eligibility File or other written communication by the SCM.

The Vendor {Contractor} shall ensure that it resolves and/or accommodates all data processing problems and changes within a time period mutually agreed upon, and that all required changes are implemented in a timely manner. The SCM will identify how the technical priorities will be set. All changes shall be tested between DPB and the Vendor {Contractor} prior to implementation.

The Vendor {Contractor} shall ensure that its personnel participate in monthly, or as necessary, IT system status meetings in Trenton. Participation may be in-person or telephonically at the discretion of the SCM. Such Vendor {Contractor} personnel includes but is not limited to, the Account Executive, IT, Eligibility and Claims Managers. The meetings will focus on open IT problems and/or changes and all issues associated with them.

3.1.18 START-UP/CONVERSION

Prior to the Benefit Effective Date of January 1, 2022 the Vendor {Contractor} shall:

A. Initiate work to establish a data interface with the DPB for the transmittal and receipt of required data elements;

B. Convert Member and employer file information from the previous Vendor {Contractor}, if applicable, and issue identification cards;

C. Conduct an audit reconciling the DPB's master file information with Vendor {Contractor} eligibility file information within one (1) week of conversion;

D. Be able to transmit data to and receive data from the DPB conforming to specific file formats;

E. Be able to support file transfer for determination of Member eligibility and benefits, medical summary, Claims history, and client service history. All systems shall assure confidentiality by an incorporated and well-designed security program. DPB reserves the right to require Vendor {Contractor} to support file transfer with additional vendors, as needed, in order to support DPB initiatives. Integration shall include real time information system linkages with SCM, as applicable. File transfer is currently performed in SNA/SDLC environment, using Connect-Direct Secure Plus from IBM Sterling Software, however this is in the process of being sunset. Following the sunset, future file transfer shall be completed in conjunction with the State's benefits administration platform – currently Businessolver.

F. Resolve all problems/changes in a timely manner. All changes generated by DPB or the Vendor {Contractor} shall be tested between the DPB and the Vendor {Contractor} prior to implementation.

The Vendor's {Contractor's} implementation services shall minimally meet the following requirements:

A. The implementation team shall meet with the DPB within five (5) business days after Blanket P.O. award. An implementation project manager shall be assigned, as well as a project team including, at a minimum, account management, clinical and information systems. All key project staff shall attend all implementation meetings and conference calls. State project staff will provide access and orientation to the plans and necessary information, as requested by the Vendor {Contractor};

B. Provide its transition plan to the SCM 60 days after Blanket P.O. award. The plan shall include at least:

    1. Proposed approach to transition;
    2. Tasks and timeline for transition;
    3. Documentation update procedure during transition; and
    4. Member communication strategy, including Open Enrollment Strategy;

C. Plan benefit design shall be accurately loaded to and testing successfully completed in the Vendor's {Contractor's} database at least 45 calendar days before the 1/1/22 Benefit Effective Date. The State or its designated consultant(s) will conduct a quality review of the plan design to be loaded in the Claim system prior to the effective date. All information needed for this on-site review shall be provided to allow for the review of the Claims administration system in a test environment that would be the "live" Claim processing system;

D. Be equipped to receive the State's Plan Eligibility File within thirty (30) days prior to the Benefit Effective Date;

E. Be equipped to receive the Plan's Claim data files from incumbent Vendors {Contractors} thirty (30) calendar days prior to the Benefit Effective Date. The file shall be tested with the Vendor's {Contractor's} Claim system and plan benefit design, and be ready for Claim payment by the Benefit Effective Date;

F. Member ID card design shall be available for approval by the State at least 45 calendar days prior to the Benefit Effective Date;

G. Member ID cards shall be mailed in a manner such that Members are reasonably anticipated to receive them at least seven (7) calendar days before the Benefit Effective Date;

H. Toll-free telephone number, customer service unit, and website shall be operational ninety (90) calendar days prior to the Benefit Effective Date as determined by the SCM; and

I. Ensure that all Members currently undergoing treatment for any therapeutic condition will be transitioned into the new plan without any disruption in therapy or exposure to any additional health risks through Provider identification and coordination with vendor care management services. Loading of detailed historical plan documentation and Member Claim history shall be completed in all instances where data is available from the previous Vendor {Contractor}.

3.1.19 AUDITS

Audits are designed to ensure: contract compliance; the proper functioning of the interface system; proper payment of Claims including but not limited to the application of SEHBP benefits and Plans, plan eligibility, coordination of benefits, correct allocation of Claims according to SEHBP experience groups and efficient and effective medical management.

DPB reserves the right to review and audit all records associated with the administration of the Plan, including all records held by any Subcontractor or related organization or held by any entity that is a member of the Vendor {Contractor} group of companies. Audits shall be conducted during the normal business hours after providing the Vendor {Contractor} with no fewer than 30 days written notice. In addition to routinely scheduled audits, an audit may be conducted any time if DPB has a reasonable and good faith belief that a situation exists that will result in harm to the SEHBP. Routine audits shall be conducted at least every three (3) years. The results of any review or audit are for the exclusive use of DPB and the SEHBP.

The Vendor {Contractor} shall cooperate in the administration of all audits performed by or on behalf of DPB, on various aspects of the administration of the Plan, including but not limited to:

A. Claims processing;
   Medical Case, Care, Disease and Utilization Management; and
B. Enrollment data.

All reviews or audits may be performed by DPB or any designees chosen by DPB, other than a designee whose action would reasonably be considered by the Vendor {Contractor} to be a conflict of interest. The findings of any designee authorized to perform a review of the audit shall be presented in a written report to the SCM. The Vendor {Contractor} has the right to read the report prior to submission to the SCM and Vendor's {Contractor's} written comments pertinent to the audit, if furnished, shall be submitted to the SCM with the audit as a supplementary statement.

The Vendor {Contractor} shall:

A. Conduct statistically valid routine audits and control inspections of randomly selected Claims under the Plan;

B. Report quarterly on such audits to comply with the Performance Standards shown in Attachment D of this RFP;

C. Conduct, on request, eligibility audits between the DPB's master file and the Vendor's {Contractor's} eligibility files. The frequency of the audits will be established by DPB. The Vendor {Contractor} shall be able to accommodate various cutoff dates which may apply to specific experience groups. Currently, eligibility audits are conducted quarterly;

D. Annually submit to the SCM its American Institute of Certified Public Accountants' Statement on Standards for Attestation Engagements (SSAE) No. 16, as well as a report of the actions taken to deal with any weaknesses or deficiencies identified in the SSAE No. 16.

3.1.20 RECORD RETENTION

A. Subject to applicable law, Claim Records shall at all times be the property of the Programs. The Vendor {Contractor} has the right to possession and use of Claims Records during the term of the Blanket P.O. and to maintain Claims Records following the termination of the Blanket P.O., as necessary to comply with its obligations under the Blanket P.O. or as mandated by law. Upon request, data shall be provided in a mutually agreeable format;

B. Subject to applicable law, all documents, records, reports, data, including data recorded by the Vendor {Contractor} in its data processing systems, directly related to the receipt, processing and payment of Claims and all Claim histories ("Claim Records") shall at all times be the property of the Programs.

C. The Vendor {Contractor} shall have no interest in, nor have any obligation to provide any aggregate Claim or payment data maintained or copied by the Vendor {Contractor} for its own uses outside of the scope of the Blanket P.O. Such information may not be used for any purposes which may be deemed by the Programs as detrimental to the Programs;

D. All Claim Records and other records possessed by the Vendor {Contractor} as Claims administrator under the Blanket P.O. shall be retained in accordance with applicable federal and State record retention requirements, but in any case, shall be kept and retrievable for no less than seven (7) years. Records shall be retained for two (2) years on-line from the date of service or from the date final payment is made on the Claim, whichever is later;

E. If DPB notifies the Vendor {Contractor} a Claim has become the subject of litigation, the Vendor {Contractor} shall preserve all records pertaining to the Claim and provide the SCM all Claim information related to that Claim as necessary for litigation purposes and participate as fact or expert witnesses. If an expert witness is necessary, then one shall be provided at a reasonable, customary and mutually agreed upon hourly fee. This provision shall survive termination of the Blanket P.O.;

F. The Vendor {Contractor} shall defend, at its own expense, litigation arising from or related to their actions or inactions, under this Blanket P.O.;

G. In addition, all documents, records, reports, data, including data recorded by the Vendor {Contractor} in its data processing systems, directly related to the receipt, processing and payment of Claims and all Claim histories ("Claim Records") shall promptly be made available to the State.

H. The provisions of this Section shall survive the termination of this Blanket P.O. or termination of coverage of a Member and shall bind the Commissions and the Vendor {Contractor} so long as they maintain any Personally Identifiable Information; and

I. Vendor {Contractor} shall prepare all filings necessary and appropriate to comply with the New York Health Care Reform Act of 1996, as appropriate for those Members residing in New York, as well as all other applicable State or federal requirements.

3.1.21 RATE RENEWAL AND REVISION SERVICES

The Vendor {Contractor} shall:

A. Participate in the State's rate renewal process annually, including but not limited to a Pre-Renewal meeting, a Renewal meeting, and the presentation of rates to the Commissions;

B. Provide a renewal packet as requested by DPB and its designated consultants; and

C. Develop cost projections upon renewal and cost projections for proposed benefit changes as requested, to understand current Care Management, Disease Management and UM strategies.

3.1.22 REPORTING REQUIREMENTS

The Vendor {Contractor} shall report to the SCM on all required modifications to the Plan's benefit provisions and/or administrative procedures for compliance with federal or State enacted legislation and, upon request, provide an estimated cost associated with same.

The Vendor {Contractor} shall cooperate with State personnel and consultants on all areas of reporting, including the setup and ongoing maintenance of interfaces to securely send data file feeds on at least a monthly basis to the State's designated consultant(s).

The Vendor {Contractor} shall cooperate with State personnel and consultants on all areas of reporting, including the setup and ongoing maintenance of interfaces to securely send data file feeds in real-time to any designated third party by the SCM.

The Vendor {Contractor}, as part of the award of services, shall provide an annual refresh of the data provided in the Discount Workbook, Attachment B of the RFP, to the SCM and designated consultant(s) in order for the SCM to understand any changes in network discounts.

Data files shall be provided electronically in an agreed upon format along with a corresponding data dictionary and explanations for any data codes. Vendor {Contractor} should also notify the State and the consultants at least 6 months in advance of any anticipated changes in the monthly data feed. This advance notice shall also be accompanied with an updated new test file under the new format with the updated data dictionary.

In addition, all customer service, medical and network management, and reporting services shall be continued for a period of a minimum of twelve (12) months following Plan termination. The Vendor {Contractor} shall not charge any additional fees at termination for these services.

Required reports are as follows:

A. **Monthly Paid Claim Summary Report** – On a monthly basis, a report of all Claims paid in the month along with the incurral year and with a rolling prior 12 months of past paid Claims including the past month (the report shall also include any reconciliation or adjustment for overpayment collected in the prior 12 months of past paid Claims), by the following variables:

    1. Employer type (i.e., State, Local Education, Local Government);
    2. Employee type (i.e., Active, Early Retire, Medicare Retiree);
    3. Payment type (i.e., medical Claim, network identifier, capitation payment, prescription drug claim);
    4. Place of service identifier (i.e. inpatient facility, outpatient facility, urgent care, emergency room, office visit, etc.); and
    5. Plan Option (i.e. PPO10, PPO15, etc.)
    6. Plan Payment Method (DRG, Per Diem, Bundled, APG/APC) or as requested by the State.

B. **Quarterly Enrollment Summary Report** – On a quarterly basis, a report of enrollments split into the following variables:

    1. Month of the quarter, rolling past twelve months (including the past quarter);
    2. Employer type (i.e., State, Local Education, Local Government); and
    3. Employee type (i.e., Active, Early Retire, Medicare Retiree);
    4. Plan Option (i.e. PP10, PPO15, etc.); and
    5. Tier Option (i.e. Single, Employee+Spouse, etc.)

C. **Quarterly Utilization Report** – On a minimum of a quarterly basis, develop and present virtually or in-person a report that shows cost and utilization patterns (by Employer Type, Employee Type, and split by PPO/HMO/Tiered), identifies trends in in-network Claims, and compares Plan experience with Vendor's {Contractor's} book of business and other public sector clients. The Vendor {Contractor} shall also provide ad-hoc reports as necessary and ensure accessibility to DPB personnel for review and manipulation of Claims data for generation of ad hoc reports;

D. **Quarterly Engagement Report** – On a minimum of a quarterly basis, develop and provide a report that shows the Member engagement results including but not limited to actual engagement results and compare Plan experience with Vendor's {Contractor's} book of business and other public sector clients including comparisons to those similarly situated but without Navigation/Advocacy Services. Vendors {Contractors} shall also have the ability to provide ad-hoc reports as necessary and ensure accessibility to DPB personnel for review and manipulation of claims data for generation of ad hoc reports;

E. **Operations Report** – On a daily basis, a report of plan enrollment that shows:

1. Nightly enrollment updates of additions, changes and terminations;
2. Enrollment errors reported on a weekly or on an ad hoc basis; and
3. Results of a quarterly audit of enrollment;

F. **Fraud Reports** – Develop a semi-annual report and provide to the DPB and the Department of Law & Public Safety, Office of the Attorney General, upon request, information concerning any case of fraud or suspected fraud that impacts the SEHBP including:

1. Fraud cases investigated and closed (no fraud involved);
2. Fraud cases currently under investigation; and
3. Fraud cases confirmed and disposition of findings.

Such information shall also be made available to the DPB and the Department of Law & Public Safety, Office of Attorney General, upon request at any time. If the Vendor {Contractor} has information concerning any case of fraud or suspected fraud that potentially impacts the SEHBP in an amount greater than $50,000, then the Vendor {Contractor} shall notify the SCM within five business days of commencement of investigation and shall keep the SCM informed of any material developments including settlement, dismissal, or resolution.

G. **Annual Review** – Annually, within 60 days after the completion of each calendar year, the Vendor {Contractor} shall meet with the SCM, other State personnel, and consultants to review the Plan's Claim experience. The review topics may include, but need not be limited to, the following:

1. Summary by reporting division – Displays Claims incurred and estimated IBNP by Programs delineated by State, Local Government and Local Education Employers and by Active Employees, Early Retirees, and Medicare Retirees;
2. Summary of Medical trend recommendations delineated by State, Local Government, and Local Education Employers and by Actives, Early Retirees, and Medicare Retirees;
3. Claimant characteristics (demographics);
4. Experience by diagnostic grouping, type of service, and claimant cost by age/gender;
5. Large Claims report (>$250,000); and
6. Plan utilization compared to Vendor's {Contractor's} book of business and other public sector clients;
7. Medical management initiatives; and
8. Effectiveness of Case, Disease and Utilization management programs.

H. **Quarterly Performance Reporting** – Report in a manner established by DPB on all Performance Standards. Vendor {Contractor} shall provide detailed reporting, 45 days after the end of the quarter, necessary for DPB or any designee chosen by DPB to independently evaluate Performance Standards results.

I. **Quarterly Reporting on Clinical Programs** – Report in a manner established by DPB on all clinical programs and related engagement of DPB Members. Vendor {Contractor} shall provide detailed reporting, 45 days after the end of the quarter, necessary for DPB or any designee chosen by DPB to independently evaluate the report.

J. Vendors shall provide monthly reporting of all inadvertent out-of-network services broken down by individual Claims, total dollars requested, and status of outstanding Claim; in accordance with P.L. 2018, CH. 32.

K. **Annual Financial Guarantee Reporting** – Report in a manner established by DPB on all Financial Guarantees (Medical ROI and Claim Target and Financial Guarantee). Vendor {Contractor} shall provide detailed reporting, 45 days after the end of the 3-month run off period for the Plan Year, necessary for DPB or any designee chosen by DPB to independently evaluate Financial Guarantees (Medical ROI and Claim Target and Financial Guarantee) results.

L. The Vendor {Contractor} shall provide monthly reporting of all inadvertent out-of-network services broken down by individual Claims, total dollars requested, and status of outstanding Claim; in accordance with P.L. 2018, CH. 32 (N.J.S.A. 26:2SS-1 et seq.).

3.1.23 FINANCIAL REPORTS

The Vendor {Contractor} shall provide the financial reports as follows:

A. **Banking Reconciliation** – Develop and provide monthly banking reconciliation reports, made available to DPB on or before the tenth (10th) day of the succeeding month;

B. **Daily Reports** – Notification of the daily total of checks cleared, including an additional monthly billing for any capitation due. This information may be provided by facsimile or telephone followed by details in an agreed-upon electronic format. It shall be reported before 11:00 a.m. ET each business day. The Vendor {Contractor} shall ensure that its daily notification includes the State and Local Employer breakdown of the daily total of checks cleared along with State and Local Employer breakdown of additional monthly billing for any capitation due;

C. **Monthly Reports** – Develop and provide the following reports on a CD or make them available for downloading from a secure Web site in Microsoft ACCESS format no later than the tenth (10th) day of the following month:

1. List of checks cleared by account type (Paid Detail Register);
2. Summary of electronic fund transfers;
3. Summary of paid Claims; and
4. Issued by un-cleared checks.

The Vendor {Contractor} shall ensure the monthly report meets, at a minimum, the following requirements:

1. A total matching the sum of the wire transfers made to the Vendor's {Contractor's} bank account;
2. Listing of cleared checks in SSN/subscriber identification number order which includes the check number, check issue date, amount of the check and the applicable data elements;
3. Listing of monthly electronic fund transfers that includes the date funds are transferred, payee name, Subscriber ID, amount of fund transfer, monthly total,

applicable data elements including the transfer number, transfer date, payee name (last, first, mi.), amount of the transfer and monthly grand total (the totals should match the total amount wired including a full and complete listing of all debits and credits); and;

4. Totals segregated between the State and participating Local Government and Local Education Employers.

D. **Annual Reports** – Provide an estimate of incurred unpaid claims, actual administrative fees (separately for each Administrative Fee Component) and actual amounts of outstanding checks as of June 30 of each year. The reports and estimate shall be broken down by participating Local Education Employers and provided to the Commissions by June 20 of each year. Bank reconciliation and other related reports are the Vendor's {Contractor's} responsibility.

The Vendor {Contractor} shall comply with the State of New Jersey Unclaimed Property laws and regulations in regard to escheated unclaimed monies and provide DPB with an annual report identifying any outstanding checks more than twelve months from the date of issue. The report shall be used for escheat purposes and should conform to the reporting formats required by the State's Unclaimed Property Unit.

3.1.24 FINANCIAL GUARANTEES

The Vendor {Contractor} shall provide the financial guarantees as follows:

The following financial guarantees are applicable to this Blanket P.O.:

A. **Inpatient unit cost guarantee** – Vendor {Contractor} shall guarantee the growth in the average cost per admission will not exceed the guaranteed annual percentage for the length of the Blanket P.O. including any extension years.

B. **Professional unit cost guarantee** – Vendor {Contractor} shall guarantee that that the growth in the average cost per procedure will not exceed the guaranteed annual percentage for the length of the Blanket P.O. including any extension years.

C. **Outpatient discount guarantee** – Vendor {Contractor} shall guarantee that the discount as calculated through the book-of-business claim experience submitted in Attachment B will increase by no less than the guaranteed annual percentage for the length of the Blanket P.O. including any extension years. Service types include the following categories: Emergency Room, Surgery, Radiology, Pathology, Ancillary, and Other.

The inpatient unit cost guarantee and the outpatient discount guarantees shall be provided and measured separately for Southern New Jersey, Northern New Jersey, and non-New Jersey Claims based on the following type of service: Inpatient, Outpatient, and Professional.

If the Vendor {Contractor} fails to meet the above outlined financial guarantee(s), then the proper percentage of Administrative Fee due and owing under the Blanket P.O. for each evaluation period, as described below, shall be returned to the State in a manner acceptable to the SCM. The Administrative Fee will be measured as total Administrative Fees paid by the State for the applicable population for which the guarantee was missed.

If the Vendor {Contractor} fails to meet its guarantee, then the proper percentage of Administrative Fee due and owing under the Blanket P.O. for each evaluation period shall be returned to the State in a manner acceptable to the SCM. The Administrative Fee will be measured as total Administrative Fees paid by the State for the applicable population for which the guarantee was missed.

If the Vendor {Contractor} fails to meet its guarantee, then the Administrative Fee due and owing under the Blanket P.O. for each evaluation period shall be forwarded in a manner acceptable to the SCM. The Administrative Fee will be measured as total Administrative Fees paid by the State for the navigation/advocacy programs.

All guarantees will be based on an evaluation period equal to SEHBP Claims incurred in a calendar year and paid through March of the following year. All guarantees shall be in place for the length of the Blanket P.O., including extension years.

All Financial Guarantees will be based on an evaluation period equal to SEHBP Claims incurred in a calendar year and paid through March of the following year.

3.1.25 ADMINISTRATIVE FEE REQUIREMENTS

The Administrative Fee has the following requirements:

A. Fees are mature and assume that no further administrative expenses would be charged to the Plan at termination. Upon Blanket P.O. award, the Vendor {Contractor} shall be required to administer the Plan for a minimum of twelve months at plan termination and continue to process all Claims incurred before Plan termination;
B. In addition, all customer service, medical and network management and reporting services shall also be required for a period of a minimum of twelve months at Plan termination. No additional fees shall be charged at termination for these services;
C. Fees shall be guaranteed for the duration of the initial term of the Blanket P.O. (i.e., calendar years 2022 through 2024). Fees for contemplated extension years (i.e., calendar years 2025 and 2026) will increase by the lesser of 5% or the change in the urban CPI-U as of September of the year prior to the Calendar Year;
D. Fees will be based on the aggregate enrollment with the Vendor {Contractor}
E. The Vendor {Contractor} shall include network access fees, if any, in the Administrative Fee and cannot add any such fees to Claim charges.
F. All split contracts, where a Member is enrolled in a Medicare Advantage plan (which will be procured separately) shall be billed at 50% of the total Administrative Fee for that particular plan type.

3.1.26 MANAGEMENT OVERVIEW

The Vendor {Bidder} shall set forth its overall technical approach and plans to meet the requirements of the RFP in a narrative format. This narrative should demonstrate to the State that the Vendor {Bidder} understands the objectives that the Blanket P.O. is intended to meet, the nature of the required work, and the level of effort necessary to successfully complete the Blanket P.O. This narrative should demonstrate to the State that the Vendor's {Bidder's} general approach and plans to undertake and complete the Blanket P.O. are appropriate to the tasks and subtasks involved.

Mere reiterations of RFP tasks and subtasks are strongly discouraged, as they do not provide insight into the Vendor's {Bidder's} approach to complete the Blanket P.O. The Vendor's {Bidder's} response to this section should be designed to demonstrate to the State that the Vendor's {Bidder's} detailed plans and approach proposed to complete the Scope of Work are realistic, attainable and appropriate and that the Vendor's {Bidder's} Quote will lead to successful Blanket P.O. completion.