INFORMATION FOR EVALUATION

- *Provide a response to each item/question in this section. Prospective Contractor may expand the space under each item/question to provide a complete response.*
- ***Do not** include additional information if not pertinent to the itemized request.*

	Maximum RAW Score Available
1 – PROSPECTIVE CONTRACTOR EXPERIENCE	
1.A Prospective Contractor Profile and Experience	
1.A.1 Describe your company's experience with similar projects and services. Include a description of a project where your company has at least five (5) years of experience administering a comprehensive program to a population similar in size to the population described in this RFP, or commensurate experience and how much of that experience is related to state/federal.	5 points

We have over 160 years of experience in providing quality, reliable services to businesses, individuals and the government. Founded in 1853 in Hartford, CT, we entered the group health insurance business in 1936. Our first group hospitalization contract was issued in 1937. We introduced our first major medical product in 1951, our first dental plan in 1957 and our first stand-alone vision product in 2009.

We are one of the nation's leading diversified health care benefits companies, serving approximately 38 million people with information and resources to help them make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including:

- **Medical**
- **Pharmacy**
- **Dental**
- **Vision**
- **Behavioral health**
- **Stop Loss**
- **Medical management capabilities and health care management services for Medicaid plans**
- **Workers' compensation administrative services**
- **Health Information technology services**

Our customers include:

- **Employer groups**
- **Individuals**
- **College students**
- **Part-time and hourly workers**
- **Health plans**
- **Health care providers**
- **Governmental units**
- **Government-sponsored plans**
- **Labor groups**
- **Expatriates**

For over a century and a half, the Aetna name has stood for integrity, reliability and trust. We have helped generations of members by helping them to get access to the health care services they need to live healthy lives.

Experience

For over 25 years, we have worked with one of our largest clients to create and administer a model that gives its 100,000+ members the resources needed to empower better decision-making and improved productivity, supported by a seamless service experience.

The custom model that we built includes a multi-pronged approach to helping members achieve their best health:

1) **Interactive portal to provide benefits education and plan modeling**
2) **Customized communications with virtual interactions and mobile health tools**
3) **Innovative network solutions with Accountable Care Organizations (ACOs), targeted provider recruitment, and associated unit cost improvement**
4) **Integrated services solution across one platform for multiple products – Medical, Pharmacy, Dental, and Vision**

Milliman, Inc. has been providing actuarial services to clients for over 60 years. Founded in 1947 and incorporated in 1957, Milliman is owned and managed by approximately 400 principals and has approximately 2,800 employees located in 54 offices in principal cities worldwide. Milliman provides a full range of actuarial and other consulting services to our clients in the areas of Employee Benefits & Investment Consulting, Healthcare, Property & Casualty insurance, as well as Life Insurance & Financial Services. Milliman services a variety of clients including those in the State and Federal environment and has worked with these types of clients since it was founded in 1947.

1.A.2 Describe your experience in providing multiple health services in a "bundled" capacity. **We have over 160 years of experience in providing quality, reliable services to businesses, individuals and the government. This includes bundled services. Founded in 1853 in Hartford, CT, we entered the**	5 points

	group health insurance business in 1936. Our first group hospitalization contract was issued in 1937. We introduced our first major medical product in 1951, our first dental plan in 1957 and our first stand-alone vision product in 2009.	
1.A.3	Specifically describe your experience or your subcontractor's experience and how each experience is directly related to the work that will be performed under this Scope of Work. **We don't provide company histories or organization ownership structures for our subcontractors. There is no direct interface between the customers and subcontractors. We are responsible for our subcontractor's performance. In addition, we remain liable for contracted services performed by our company, if we subcontract those services to another organization.** **We are liable for services we subcontract to a subsidiary, affiliate or another organization. We assume the responsibility for the performance of our subcontractors. In addition, we remain liable for contracted services performed by our company, including those services subcontracted by our company to another organization. We have provided our proposed list of subcontractors in the Proposed Subcontractors Form. We have been working with each of these subcontractors for years.**	5 points
1.A.4	Describe your company's experience with, and ability to establish and maintain, a Network that effectively accommodates a minimum of 150,000 – 160,000 Members. **We have years of experience successfully serving customers with memberships ranging from 10 to 500,000. With more than 650,000 physicians and 5,600 hospitals in our networks, we have one of the largest, fully integrated networks in the country. We drive competitive discounts and overall network costs and quality through many innovative initiatives, including provider transparency and steering consumers to the right physicians and care with strong results.**	5 points
1.A.5	Provide examples of any newsletters, reviews, or other informative publications that your company publishes for routine distribution to accounts. Provide this in electronic format only, preferably on a flash drive, CD's are also acceptable. **Please refer to *Comm Materials 1.pdf, Comm Materials 2.pdf*, and *Comm Materials 3.pdf* located in the Additional Requested Attachments section of our proposal response.**	5 points
1.A.6	Disclose any of the following as applicable during the past five (5) years; indicate if none of these conditions are applicable: • List and summarize any resolved (including by settlement), pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. • List all of insurance Market Conduct examinations and findings. • List any contract for services that your company has had that was terminated, and indicate the reason for termination, such as, for convenience, nonperformance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions. List any occurrences where your company has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.	5 points

- List anydamages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by your company under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP, including any state or federal regulatory penalties imposed for any reason. Include the estimated cost of that incident to your company with the details of the occurrence.

Aetna and its affiliates are routinely involved in non-material litigation, administrative investigations, and at times, proceedings with various regulatory agencies regarding the administration of health and dental plans. Most of these situations involve a single claim for benefits or payment for provider services.

Due to the size of our business, *non-material* government, regulatory or administrative investigations, proceedings, complaints, lawsuits or other legal proceedings naturally flow from disputes that arise out of the sensitive nature of services provided by a managed care organization.

We report all material litigation in our public filings and on www.aetna.com. We are willing to discuss individual cases if there's a specific area of concern.

1.A.7 What processes are in place to on-board new/current subcontractors and/or technology operating on platforms different than the Prime Contractor's? — 5 points

What we do for each subcontractor varies. Our offshore subcontractor claim processors receive the same training and the work is subject to identical security, quality and audit standards, as our U.S.-processed business. At no time do physical claims leave our closed systems. Our claim vendors don't make medical necessity decisions or carry out clinical claim review.

In addition, our systems that our subcontractors use for claims processing functions are set up so that subcontractors can't print claims or email outside of our email system.

We require subcontractors to comply with the Aetna Code of Conduct. We also require applicable subcontractor employees to complete our annual Business Conduct and Integrity (BCI) training.

Our code of conduct covers the following topics:

- **Conflict of interest**
- **Record keeping and use of our property and resources**
- **Fraud, dishonesty and criminal conduct**
- **Protecting member and other confidential information**
- **Business and trade practices**
- **Government contracts**
- **Employment practices and work environment**
- **Securities transactions**
- **Interacting with the media, the government or an outside party or organization**
- **Intellectual property**

1.A.8 Describe insurance the firm carries including the type of insurance, the amount of coverage, any deductible and coinsurance amounts, and the provider. — 5 points

REDACTED

REDACTED	
1.A.9 Provide a copy of your certified financial audit results from an independent auditor for 2015, 2016, and 2017 with copies of supporting documents. **Please refer to *2015 Report.pdf, 2016 Report.pdf*, and *2017 Report.pdf* located in the Additional Requested Attachments section of our proposal response.**	5 points
1.A.10 Are you currently a Qualified Health Plan (QHP), as defined by CMS? If so, how long have you had your QHP status? If not, have you ever been a QHP? Explain the reasons for participation or non-participation as a QHP. **Yes. Aetna Life Insurance Company (ALIC) is an approved Medicare Advantage Organization with a Medicare contract. We began offering MA PPO under ALIC in 2006.**	5 points
2 – GENERAL ADMINISTRATION	
2.A Administration, Staffing, End of contract Transition	
2.A.1 Describe your proposed staffing plan and your process for maintaining a staffing level of your proposed staffing plan. **Our goal is to be your trusted advisor. That's why we support you with a strong account team that consists of an executive sponsor, account executive and account manager.** **Your account management team works in close consultation with you to:** • **Understand your needs and act as a true strategic partner** • **Solve challenges to plan administration** • **Demonstrate the value of the programs and services purchased** • **Make sure that the pricing of existing and new services is compatible with your goals and objectives** • **Provide the right data and information to help you better understand and manage your benefits plan**	5 points

Roles and responsibilities

You'll be supported by a core account management team that consists of:

- **Heather Curis, Account Executive – Heather works with you to create your benefit program strategy and gather the right resources within our company to support it. Heather has overall responsibility for our partnership with you.**

- **Eva Bedran, Plan Sponsor Liaison – Eva will act as a single point-of-contact to your HR staff for claim and benefit related issues. Eva will maintain an on-going relationship with your HR staff to meet your changing needs. Eva will be responsible for reporting and analysis of your service experience.**

- **Nita Stallard, Account Manager – Nita is your day-to-day contact. She is responsible for building and maintaining a strong relationship with you. That means communicating with you on a regular basis, overseeing operational services for you, connecting all areas of Aetna to ensure commitments are kept, and managing day-to-day services to make sure we provide you with quality service.**

- **Jim Bostian, Executive Sponsor – Jim works jointly with your account team to coordinate your health and wellness strategy. This includes participating in year-end/quarterly reviews.**

- **Mark Quinn, Client Solutions Leader– Mark has overall responsibility for your account executive and account manager. He is responsible to make sure commitments are being met by the account team and ensures strategy and quarterly business review processes are occurring.**

Single point of contact

Heather Curis, your account executive, is your single point of contact. She coordinates inquiries and projects specific to network, administration, reporting and underwriting.

Both Heather and Nita are your liaisons between EBD and Aetna. They serve as a conduit for information to those areas within Aetna that support the administration of your employee benefits program. While your account team may not have direct authority to make all commitments on behalf of Aetna, they work with the appropriate areas on your behalf to secure commitments when appropriate.

Your extended service team

While your account team is your primary advocate within our organization, you'll also be supported by an extended service team. This includes your designated eligibility consultant and billing consultant. It also includes your Plan Sponsor Liaison, who is your direct line into claims and member services.

Your account team works closely with your entire service team to help them understand your:

- **Plan strategy**
- **Service level expectations**
- **Company culture**

Your service team takes great pride in learning your culture, strategy and overall expectations. The team uses this information whenever they interact with your employees and their families, so that they can help them understand and use the benefits that are available to them.

Customer approval of account team members
We strive to make sure you are completely satisfied with the assigned team and the services they provide.

We continually welcome your feedback on the account team. We address any and all of your concerns quickly and efficiently so that potential issues don't have the chance to escalate.

Milliman: Milliman's proposed staffing plan assigns qualified individuals to the key roles designated in the RFP (Primary Actuary, Secondary Actuary, Primary Consultant, Secondary Consultant) supported by primary and secondary actuarial analysts and primary and secondary data analysts. Assigning a secondary person to each role helps ensure continuity of high-quality service when turnover occurs. When turnover does occur, we will immediately assign a qualified team member from among our large staff of qualified actuaries consultants and analysts.

2.A.2 Describe your plan for recruiting and training staff to meet the minimum staff requirements as set forth in the RFP, and your plan for retaining these staff members.

5 points

Our account management teams aren't just passionate about helping you achieve your benefit goals – they're also informed and prepared. That's because we invest significant resources in them to ensure they have the skills to turn your goals into results.

E.E. Cammack Group School

For many of our account executives and account managers, training begins with our E.E. Cammack Group School.

The E. E. Cammack Group School is a sales and account management training program that recruits and hires early-in-career professionals. We teach industry basics and provide real-world business experience.

The program includes:

- **Intensive class-room based study**
- **On-the-job training with business mentors and the best sales people in the industry**
- **Opportunities to network with, and learn from, our senior leadership**

Our group school began in 1924. Since then 104 classes have graduated from this prestigious program. Today, alumni hold high-profile positions at Aetna and many other leading companies within the health care industry.

Initial training

We provide our account teams with a variety of training programs designed to help team members enhance their knowledge base and develop their consulting skills.

We offer a mix of instructor-led and online courses. The programs cover topics such as:

- **Products and services**
- **Financial and underwriting concepts**
- **Reporting capabilities**
- **Compliance and health care reform**

• **Presentation and communication skills** **We continually review and update our training programs as needed. All of our account management teams are licensed in their resident state.** **<u>Ongoing training and development</u>** **In an ever-evolving health care market, change is inevitable. But we don't just keep up with the change – we help create it. In order for our account teams to be on the forefront of innovation, we need to educate them at a pace that's equally as fast.** **Through our ongoing training program, we make sure your account team is informed of our latest innovations and strategies. We also teach our teams how to help you with your benefit strategy through strategic thinking, ideation sessions, and tools to support these processes.** **<u>Milliman</u>: Milliman already has multiple staff members that meet the qualifications of the Primary/Secondary Actuary and Primary/Secondary Consultant roles as well as a large number of supporting actuaries and analysts. Should we lose any personnel assigned to this team that cannot be replaced from within the team, we can draw from the many qualified actuaries and consultants within Milliman to keep the team in line with expected levels of experience and expertise.**	
2.A.3 Describe in detail how the proposed Key Personnel's experience and qualifications relate to their specific responsibilities. Include individual resumes for the key personnel to be assigned to the project if the Prospective Contractor is awarded the Contract. Or, if your company plans to determine specific staff at a later date, describe the qualifications and number of years of experience your company will require for each Key Personnel position. Confirm resumes for Key Personnel will be provided prior to Implementation and your understanding that the EBD will have the right to approve or request alternatives for all Key Personnel. **Please refer to Key Personal Bios located in the Samples and Brochures section of our proposal response.**	5 points
2.A.4 Describe your plan for substitution or replacement of Key Personnel. **If we receive negative feedback on the account team, we immediately take corrective action. If you are unhappy with an account team member's performance, we work quickly to address and fix any problems. The team member's manager monitors progress and solicits feedback until all issues have been resolved to your satisfaction. We may remove the account team member if deemed necessary.**	5 points
2.A.5 Describe any and all subcontractors listed on your Proposed Subcontractors Form, the tasks for which they will be responsible, and your plan for supervision and corrective action, if needed. Include the following for each: • Name and address of the outsourced/subcontracted agent • Scope of work the outsourced/subcontracted agent will perform • Organizational and length of relationship to Contractor	5 points

Subcontractor	Scope of Services	Location	Doing Business with Aetna Since
American Specialty Health, Inc. (ASH)	Wellness services for members participating in customer buy-up plans.	San Diego, CA	2006
Arna Marketing Group, Inc.	Printing and mailing of Medicare materials, annual notice of change, disability wallet card mailings, diagnosis mailings (i.e. diabetes, lower back pain, asthma, hypertension) utilizing Aetna member data, or other ad-hoc or one-time mailings. Formulary summary change (FSC) and annual notice of change (ANOC) monthly letter mailings.	Tolland, CT; Branchburg, NJ	2006
Change Healthcare	Handles payment to provider initiated by member via our member website. Member website includes a payment frame from Change Healthcare to capture the consumer credit card or checking account information and their agreement to pay the provider.	Nashville, TN	2002
Cotiviti	Overpayment recovery for data mining, duplicate payments, provider credit balance.	Wilton, CT; Conshohocken, PA; Atlanta, GA	2000
Conduent (formerly Xerox)	Intake services: mailroom, imaging, data entry, X-ray handling, medical, dental, encounters, referrals, CATS and correspondence. Overpayment recovery for hospital credit balance review, HMO claims, call center services - PDP, FSA, SRC, ETech/SSHL, recertification. Print fulfillment.	Lexington, KY, Florham Park, NJ ; multiple service locations	2000
DiversiMed, Inc.	Overpayment recovery for hospital bill audit.	Tampa, FL	2006

	Eliza Corporation	**Telephone outreach programs for Aetna members (flu vaccination program, HSA education and enrollment support, claim receipt confirmation), Aetna Medicare members and Medicare prospects.**	**Beverly and Danvers, MA**	**2005**		
	End-Game Strategy, Inc.	**Overpayment recovery - data mining - HMO (Second Pass)**	**Berlin, CT**	**2010**		
	Equian	**Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment..**	**Warrenville, IL; Indianapolis, IN**	**2004**		
	EquiClaim, Inc.	**Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit)**	**Lombard, IL**	**2000**		
	Express Scripts	**Provides pharmacy benefit management services to Coventry. This requires receipt and assimilation of Rx benefit specifications from Coventry health plans and eligibility enrollment information from IDX, processing of Rx claims at retail and direct points-of-service, providing mail-order Rx fulfillment, and transmission of reporting for all activity back to Coventry.**	**Fair Lawn and Piscataway, NJ**	**2013**		
	Health Management Systems (MedRecovery Management LLC is now part of HMS)	**Overpayment recovery for workers' compensation**	**Buffalo, NY**	**2009**		
	Iron Mountain, Inc.	**Records archiving, retrieving, transportation, and destruction services**	**Boston, MA (headquarters); multiple service locations**	**1995**		

JP Morgan Chase Bank	**HSA transactions with high deductible plans; electronic funds transfer for large case pensions.**	**New York, NY**	**2005**	
OmniClaim, Inc.	**Overpayment recovery for implant and DRG services for the Northeast and North Central region.**	**Woburn, MA**	**2009**	
Optum Insights LLC	**Overpayment recovery - hospital credit balance, audit complete (healthcare data solutions), coordination of benefits, data mining, RX overpayment recovery**	**Franklin, TN**	**1996**	
Quest Diagnostics	**Determine individual health risk factors resulting in a personal summary report or personalized health action plan. Quest Diagnostics Blueprint for Wellness Fasting Venipuncture** **Heart & Glucose Panel; blood testing; metabolic syndrome testing - will draw blood and measure other metabolic tests - includes data processing and result communication.**	**Lenexa, KS; Madison, NJ**	**2010**	
Rawlings Company, LLC	**Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.)**	**La Grange, KY**	**1996**	
Source One Direct, Inc.	**Production of plastic and paper identification cards. Printing of contracts, postcards and booklets for Aetna National Customer Operations.**	**Atlanta, GA**	**2001**	
Standard Register	**Printing and mailing services, Rx Check mailings (not actual checks), Medicare**	**Salt Lake City, UT; Tolland, CT; Grove City, OH**	**2009**	

		enrollment (post open enrollment), utilizing Aetna member data.		
	Teladoc	**Resolve medical issues 24/7 through the convenience of phone or video consultations. Provides patients with access to national network of physicians who can diagnose, treat and prescribe medication for many common medical issues.**	**Lewisville, TX; Purchase, NY**	**2011**

2.A.6 Describe your process for maintaining staff capable of identifying, investigating, and resolving reviews and appeals.

5 points

Customer service representatives (CSRs) attempt to resolve all member complaints at the point of contact. If a CSR is unable to resolve a complaint, they forward it to a Customer Resolution Team (CRT) for handling and, if needed, to the appropriate business area for investigation and response.

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element. We continuously monitor and maintain staff accordingly.

2.A.7 Explain how problems with work under the Contract will be escalated both in your company and to EBD to resolve any issues in a timely manner.

5 points

We will work with EBD to make sure any problem that may arise will be escalated to the appropriate departments and contacts within our company and EBD and resolved in a timely manner. If given the opportunity, we are willing to discuss this further with EBD.

2.A.8 Describe your plan for developing and implementing training material for all staff, including subcontractors.

5 points

Our service center teams are the key to successful member interactions. We routinely assign a plan sponsor liaison for each customer. As a result, familiarity with each customer's business enables our teams to provide the highest level of service to both members and the customer. Much of our success is a result of the extensive training we provide our staff specific to each customer's plan of benefits, their culture and any other information the customer believes would help us serve them and their employees most effectively. We always welcome the customer's involvement in this training.

Every CSR completes an 18-week training program. Delivered through classroom lecture and computer-assisted instruction, the training program covers:

- **Benefit determination**
- **Claim review**
- **Eligibility information**
- **System navigation**
- **Communication**
- **Documentation**
- **Soft skills training**

This training may incorporate different training approaches that introduce more interactive

application-based learning opportunities. Along with classroom lecture and computer-assisted instruction, we use learn by discovery methods, including review of previously recorded calls and mock-up call scenarios. **We build changes that occur because of policy, system or product releases into the new hire curriculum within five working days. The content consists of our proprietary systems training, health care, policy and a proven customer service skills training.** **We conduct call quality reviews for our new trainees during two separate phone labs. The labs are five weeks, which includes one week of phone lab after benefit and eligibility training and three weeks of phone lab after additional classroom time spent on claim status training. We also provide one-on-one coaching on a weekly basis during the same five-week phone lab period to deliver feedback that reinforces best in class customer service.** **<u>Ongoing education</u>** **Experienced CSRs receive updates monthly on policy, legislation or system updates. In most cases, we provide training in an e.Learning format. This lets CSRs complete the training during periods that have the least impact on production.** **As CSRs complete their training, we record the information in our internal online training resource. We track class completion to make sure all CSRs participate in the required training specific to their job function.** **<u>Subcontractor training</u>** **Subcontractor training varies. However, we do require subcontractors to comply with the Aetna Code of Conduct. We also require applicable subcontractor employees to complete our annual Business Conduct and Integrity training.** **Our code of conduct covers the following topics:** • **Conflict of interest** • **Record keeping and use of our property and resources** • **Fraud, dishonesty and criminal conduct** • **Protecting member and other confidential information** • **Business and trade practices** • **Government contracts** • **Employment practices and work environment** • **Securities transactions** • **Interacting with the media, the government or an outside party or organization** • **Intellectual property**	
2.A.9 Describe your plan for ensuring adequate resources to investigate unusual incidents and develop corrective action plans. **Any of our units may identify potential quality of care concerns and report them to the Quality Management (QM) department. Situations may also be identified through:** • **Mail** • **Email** • **Verbal communication (complaints) by external sources**	5 points

- **Members** - **Member's authorized representative** - **Power of attorney** - **Providers** - **Quality improvement organizations** - **External quality review organizations** **We have dedicated computer/data and human resources at the national, regional and local levels sufficient to meet Quality Management (QM) plan objectives and to complete annual and ongoing activities. National QM and behavioral health QM staff work in close partnership to coordinate completion of the required activities and to confirm ample staff is always available.**	
2.A.10 Describe your plan to complete all the duties required for transition at end-of-contract. **We use Microsoft Project to create custom tracking tools for each plan launch. During the implementation meeting, we review your products and services. We also note critical milestone dates, such as the open enrollment period, and produce a detailed implementation management plan.** **The plan identifies:** • **Members of the project team** • **Tasks to be completed** • **Target dates to achieve a successful plan launch** **We monitor the plan throughout implementation to track progress.** **We test all new plans as part of the implementation process. A key tool in this process is the Single Source Document (SSD). We use the document as the basis to build and test the benefit plan. SSD captures major plan changes and serves as a confirmation of the benefits plan.**	5 points
2.A.11 Provide a general end-of-contract transition plan which addresses the key components outlined in the RFP. **Our most successful implementations are the result of our team's strong project management skills and the custom tools we use to manage the process. We develop a custom Implementation Management Plan based on your chosen products, programs and services. We identify tasks, needed resources and key milestone dates to complete a smooth transition.** **Key milestone dates include:** • **Plan set up** • **System test to ensure claim readiness** • **Creation of open enrollment materials** • **Scheduling employee meetings** • **Receipt of eligibility files** • **Production and mailing of ID cards prior to the effective date** **We also use project management tools and an implementation tracking document to track open items to resolution. The implementation manager updates and distributes documents to the implementation team to keep team members on track and informed of the project's progress.**	5 points

2.B Reporting	
2.B.1 Provide examples of all available reports not requested in previous Programs that you feel would be beneficial for managing the Major Service Components of this RFP. **ART (Advanced Reporting Transformation) is our new analytics platform scheduled to begin rolling out in late 2018. The data included in ART comes from our state of the art data environment and is the foundation for a variety of analytic, reporting, trending, predictive modeling and data mining processes that enable us to provide high-value, actionable information to our business partners.** **ART integrates diverse data inputs from multiple product lines including:** • **Medical claims, including behavioral health** • **Pharmacy claims, both routine and specialty** • **Dental claims** • **Vision claims** • **Enrollment and member demographic data** • **Care management programs** • **Provider data** • **Data on products, benefit plans** • **Aetna book of business benchmarks** **After the first release, we will begin integrating additional data inputs such as:** • **Disability claims** • **External industry benchmarks** • **Clinical inputs, such as biometrics, onsite clinics and lab results** • **Wellness programs** • **Health risk assessments** **Other data inputs will be added as we identify additional business needs.** **Our new solution is a dynamic, analytic product that will evolve over time. Continual enhancements increase the value of our offering to our business partners.**	5 points
2.B.2 Provide a detailed description of the process to request ad hoc and/or customized recurring reports. Include an estimated average turn-around time for these types of reports. **EBD will have access to our business consultants who support their information needs. These consultants can help design reports which are run either on demand or at specific requested times. All customers have consulting time included in their service agreement .The prepaid hours available for customized reporting for EBD are 50 hours per year.** **We also offer online reporting through Aetna Health Information Advantage™, our information application software tool created by our Plan Sponsor Insights group. The ideal tool for benefits managers, Aetna Health Information Advantage places valuable information at their fingertips. Aetna Health Information Advantage allows EBD to perform interactive data analysis on topics such as key measures, medical trend and membership.** **We prepare and deliver many ad hoc reports to you within three to five business days.**	5 points

2.B.3	Provide a detailed description of the process to generate reports from currently available portal/web-based applications.	5 points

Aetna Health Information Advantage™ (AHIA) gets EBD the important plan performance information you need, when you need it. It's a rapid and flexible decision support tool that helps you make future benefits and plan decisions more quickly and confidently using focused, experience-driven data.

Aetna Health Information Advantage takes benefits and plan performance to the next level. This web-based decision support tool includes such capabilities as:

- **Detailed modifiable views**
- **System communications**
- **Interactive data analysis**
- **Enhanced visualizations**
- **Preformatted reporting**
- **Ad hoc reporting**

The features of AHIA include:

<u>Dashboard</u>

- **Set user-defined key metrics.**
- **Quickly know when information is out of line.**

<u>Alerts</u>

- **Proactively receive important information.**
- **Stay current with updated system communications.**

<u>Dynamic reporting</u>

- **See results and drill down for answers immediately.**
- **View data by bar graph, table, linear graph, tree map or geography.**
- **Find out how experience compares to others in the industry or against our book of business.**

Information management

- **Print reports or export data for further analysis.**
- **Design, save and reuse user-defined reports.**

<u>On demand help</u>

- **Easily find information using a keyword search.**
- **Get immediate help through built-in training and the use of rollover tool tips.**

<u>Report templates</u>

We offer several preformatted reports that can be run on demand with choices of filters, i.e. account structure, age band and network.

	Available reports include: • **Executive Summary** • **Provider Profile** • **Membership Enrollment** • **Utilization Detail** • **Monthly Claims and Membership** • **Large Claimant** • **Health Profile** • **Impact of Catastrophic Claimants.**	
2.B.4	Describe your company's use of data analytics providing a detailed overview of the analytics tool used and its effectiveness in improving Member health and lowering claims cost. **ART, our new business intelligence tool, is an advanced data analytics and reporting solution that will be available later in 2018. It delivers a flexible, fully integrated application that facilitates analysis and provides reporting across multiple products and services. We collect, organize, standardize and combine the data. Then we apply best-in-class methodologies which include valuable insights regarding costs, utilization, quality and overall plan performance.** **ART leverages our data analysis and predictive modeling capabilities on one platform and provides point-in-time reporting and ever-evolving business intelligence for you and your consultant.** **This powerful technology helps you make more informed decisions with analytic solutions that:** • **Provide value-added analytics: Integrate data from medical and pharmacy claims, care management, disease management and wellness programs, and other sources such as onsite clinics and health risk assessments.** - **Model clinical episodes of care over time** - **Measure, monitor and manage quality of care** - **Understand and respond to both retrospective and prospective risks** - **Compare performance to benchmarks** • **Engage employees: Influence health care and wellness behaviors for increased engagement and improved outcomes.** - **Monitor outcomes of disease and care management** - **Track activities using wearable devices** - **Evaluate trends, risk, care quality and employee health** • **Manage costs: Visualize cost drivers and trends, including health and lost productivity, pharmacy utilization, network leakage and more.** - **Keep up with industry trends** - **Monitor costs and utilization across various product types** - **Manage local outcomes to achieve company goals and objectives**	5 points
2.B.5	Describe your company's reporting, including the threshold criteria, for the following categories: a. Claims by ICD-10 category, as requested b. Age/gender claim reports c. Claims by CPT-4 procedure code, as requested d. Hospital claims data (admissions, number of days) e. ER services	5 points

f. In-Pt/Observation Discharge
g. 30-day re-admission
h. Claims adjudication cycle, including pended claims
i. Network savings reports

Included below is a description of our comprehensive standard reporting package, including the content, format and frequency of each standard report.

Utilization Reports

As mentioned in an earlier response, we're going beyond our current capabilities to offer you an enhanced data and analytics experience. We're reinventing reporting with ART, a powerful new technology that gives you a wide variety of drill-down paths and a "what if" modeling solution. Available in late 2018, we'll be able to respond directly to your top questions by providing dashboards and analytic pathways that are viewable on demand.

Aetna Health Information Advantage™, our current information application software tool created by our Plan Sponsor Insights group, makes performance experience data available in on demand through the Internet.

Aetna Health Information Advantage is the ideal tool for benefits managers, placing valuable information right at their fingertips. Interactive data analysis can be performed on topics such as key measures, components of medical trend, medical, high cost claimants, network savings and membership.
These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis with a two-month claim lag. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, clinical, geographic and provider specific detail.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis, rolling 12 months with a 2-month claim lag. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available monthly, within 30 days following the end of the reporting period.

The Aetna Health Information Advantage software tool is a standard component of our administrative services through which reports can be downloaded into Microsoft Excel for review, analysis and electronic communication. The information is encrypted in so EBD's information remains secure.

The standard preformatted report package provides data on the following:

- **Plan performance (including Aetna pharmacy when our medical product is linked to a pharmacy plan) on key financial and utilization metrics, prior and current with some current Aetna book of business comparisons, such as paid per member and per employee, admissions per 1,000 members, bed days per 1,000 members, average length of stay and office visits per 1,000 members.**

- **Executive Summary providing quick analysis on plan performance by summarizing the key information from the report package.**

- **Medical membership demographics by age bands and gender, prior and current with Aetna book of business comparison and current membership age band buckets by gender with plan paid comparison.**

- **Paid claims for medical catastrophic claimants with user specified dollar threshold, prior and current reporting periods and current trend with and without these catastrophic claimants. There is an additional detail report showing medical catastrophic claimants with a user specified dollar threshold that includes inpatient and ambulatory paid amounts and diagnosis code. We mask these reports to protect against individual identification.**

- **Detail by Major Diagnostic Category (MDC) including three reports: one total report showing facility and professional claims, one inpatient report and one outpatient report. Each report shows the prior and the current period.**

- **Select reports provide a comparison to our product specific book-of-business benchmarks, which are also adjusted for the age and gender of EBD's population.**

- **Provider network experience, including discount savings by inpatient, ambulatory, physician and other for prior and current reporting period.**

- **Medical cost sharing showing COB, deductible, copays, coinsurance, employee-paid portion and employer-plan paid portion.**

- **Trend analysis, utilization and unit cost by medical cost category.**

- **Hospital Profile showing the top 25 hospitals ranked by total medical claims paid amounts.**

- **Health Profile showing top 25 diseases ranked by paid amounts and listing those diseases under the plan that are part of our disease management programs.**

- **Key statistics for Pharmacy by generic, brand single source and brand multi-source if medical plan linked to an Aetna pharmacy plan.**

<u>Accounting Reports</u>

At the end of each contract period, we determine the service fee for the period, including any direct expenses for late service fee payments or claim wires and charges for special services, such as customized reports, new business or printing.

If the service fee calculated at period end is different from the service fee collected throughout the period, reconciliation is included in the accounting package. If the fee is greater, EBD remits the difference. If the fee is less, then we return the difference to you.

We provide the accounting 120 days after the end of the policy period. Reports are available electronically, usually in Microsoft Word format.

The annual accounting will include the following exhibits:

- **Master Services Agreement (MSA) Reconciliation – This shows recorded claims, pending adjustments and the resulting wire transfers. It also compares paid fees to actual fees to develop the MSA balance.**

- **Current and Prior Period Reserve Analysis – This shows the recommended reserve levels, for customers who hold the reserves, by comparing existing reserves to actual contract period run-off claims and new reserves to current run-off to date.**

	Banking Reports **We provide the following monthly banking reports in a Microsoft Excel format. We make the reports available to you through our secure email no later than the 25th of the following month for the prior month's activity.** **Funds Summary Report – This report provides a current month and a year-to-date control-suffix breakdown of claims and the funding applied.** **Funds Request and Receipt Report – This report shows the daily wire transfer requests and receipts for a given month.** **Claim Reports** **Claim Detail reports - We provide you with monthly claim reports, in a Microsoft Excel format 10 business days following the end of the reporting period. The electronic reports summarize claim activity by line of coverage, along with providing detailed claim information for each employee as well as claim totals for employees and dependents by Medicare status.** **Claim reports are delivered to you through secure email.** **The Standard Report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed). We update our data monthly.** **In addition to the product-specific standard reports, we offer a Summary by Product package that provides key information for all medical product lines, pharmacy and dental in one package.**	
2.B.6	Provide a sample copy of the following Financial reports: a. Monthly and year-to-date totals for all claims adjudicated by Plan, including the following components: • Total number of claims • Amount billed • Amount allowed • Accumulators applied (deductible applied) • Amount paid b. Coordination of benefits savings c. Claims payment analysis of payments to providers, separately and combined d. Incurred date lag reporting e. Premiums to claims ration reporting **Please refer to *Sample Claims Report.xls* and *Samples Banking-Funding Summary Report.xls* located in the Additional Requested Attachments section of our proposal response.**	5 points
2.B.7	Provide, in electronic format only, examples of all available reports requested above as part of your company's response to this RFP. **Please refer to *Sample Claims Report.xls*, *Samples Banking-Funding Summary Report.xls, Sample Accounting Package Cover Letter.doc, Sample Accounting Package Report.xls,* and *Sample SI utilization Reports.xls* located in the Additional Requested Attachments section of our proposal response.**	5 points

2.B.8 Provide a list of the **standard** reports you have available as well as the frequency you generate these reports. Provide examples of all reports on the list. **Below is a list of our standard reports and the frequency they are generated:** **Accounting Reports: Annually** **Banking Reports: Monthly** **Claims Reports: Monthly** **Utilization Reports: Monthly reports and on demand access for analysis** **We also provide ad hoc reports on an as-needed basis.** **Please refer to *Sample Claims Report.xls*, *Samples Banking-Funding Summary Report.xls, Sample Accounting Package Cover Letter.doc, Sample Accounting Package Report.xls,* and *Sample SI utilization Reports.xls* located in the Additional Requested Attachments section of our proposal response.**	5 points
2.B.10 Describe your plan for completing the required annual audit. **We will collaborate with EBD and the appropriate contacts and departments throughout our organization to complete the audits required in the Final RFP.**	5 points

2.C Overall Effectiveness	
2.C.1 Describe your company's plan for meeting the Performance Standards in Attachments B, C, D, E and F and for complying with changes to Performance Standards throughout the life of the contract. **We will provide you with final results for the performance guarantees when reporting is available after the end of the respective guarantee period. If necessary, we will provide a "lump sum" refund for any penalties we incurred. Our internal quality results for the unit(s) processing your claims will be used to determine guarantee compliance for any Financial Accuracy, Payment Incidence Accuracy, and/or Total Claim Accuracy Guarantees. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.** **Milliman: Note that only Attachments B and D apply to the work being provided by Milliman.** **Attachment B – Overall Administration Performance Standards – Milliman will assign a team to manage our efforts to ensuring compliance with these standards. We address two of the sections specifically below:** **HIPAA/Compliance - Milliman has mandatory annual training to reinforce robust policies related to proper and lawful handling of sensitive data** **Implementation – Milliman is prepared to participate in regular calls (weekly or bi-weekly) and in-person meetings (monthly) to keep implementation on track.** **Attachment D – Actuarial Services Performance Standards – Milliman will also assign a team to manage our efforts to ensuring compliance with these standards. Our team will take the following steps to ensure compliance:** • **Reports – Create grid to confirm the content and schedule of all reports to be sent, including recurring reports, ad-hoc reports, and newly requested reports. Track progress on reports vs. due dates and send reminders to ensure on time delivery** • **Meetings/Testimony – Create master schedule of all meeting and testimony obligations updates on a frequent basis and confirm that necessary team members have made timely arrangements to attend meetings.**	5 points

- **Primary or Secondary Actuary – Customer Service – Implement system to ensure that contacts from EBD trigger communication alerts to Primary and Secondary Actuaries as well other key team members. In addition, Milliman will create a response process to ensure timely return communication from the Primary or Secondary Actuary.**
- **Consulting and Advisory Services**
  - **Maintenance of Models - Milliman has regular updates on models to align with latest regulatory and industry standards as well as ongoing training and a well-defined quality review process**
  - **Audit Support – Ensure that all audit support requests are logged for timely follow up**

Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations. The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.

We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.

- **Administration**
  - **Actuarial Attestation – Ensure that all requests are logged for timely follow up**
  - **Plan Effectiveness Report – Add to master tracking schedule of recurring reports and implement project management system to ensure timely delivery**

2.C.2 Describe how you will develop an administrative procedure for detecting fraud and abuse. — 5 points

We subscribe to a zero tolerance policy on health care fraud. As a founding member of the National Health Care Antifraud Association (NHCAA), we have been an industry leader in the fight against health care fraud for many years.

Our Special Investigations Unit (SIU), comprised of more than 100 employees, is responsible for our health care fraud, waste and abuse program. The SIU maintains a 24-hour toll-free hotline (1-800-338-6361) for fraud reporting and receives more than 2000 calls per year.

Our Special Investigations Unit (SIU) uses multiple IT Software Anti-fraud Solutions to proactively data mine for fraudulent or abusive billing patterns and to assist us with our investigations. The suite of software products we use enables link analysis, predictive analytics, top down analysis and automated lead generation capabilities. We also use other vendor products including systems from Verscend. To complement our detection solutions the SIU also employs multiple SAS programmers who provide ad hoc analysis and data mining reports to our investigative staff.

The claims system employs automated claim review software to identify and adjust for unbundling of services and duplicate claim billings. We also use this software to identify diagnoses and procedures designated as inappropriate according to our clinical policies.

Our SIU is also made aware of cases of potential fraud through:

- **Industry and law enforcement contacts**
- **State departments of insurance**
- **Medical review boards**
- **Our toll-free fraud hotline**
- **Referrals from claim processors**
- **Email from our public Internet mailbox**
- **From members responding to the toll-free number printed on our EOBs**

When we suspect fraud, we create a case and assign an SIU investigator. When the investigator substantiates an allegation of fraud, or when fraud, waste, or abuse is highly suspected, we place a flag on the provider's file which triggers an edit and either auto denies certain claims, or drops claims from auto adjudication for manual review. We currently have more than 20,000 providers flagged for potential fraud, waste and abuse. In 2017, fraud flags resulted in pre-payment claim denials of $346 million (red flag savings). The SIU has sole authority to place and remove fraud flags in the system.

Customer/employee/member

We have a strong rapport with various law enforcement groups and receive frequent referrals from them. We also have a toll-free hotline that anyone can use. We provide that telephone number on claim forms, health care spending account updates and EOBs.

Internally, we have focused on the identification of potential member fraud by providing fraud training for all employees. The training is available online. We update training material as necessary and track attendance.

There are also Claim Review policies that require audits of claims that help to identify potential member fraud. We are able to place a member notice in the system (much like we do a provider flag) when there is evidence that a member is attempting to deceive or abuse the system.

<u>Claims personnel</u>

We inform processors and other claim personnel about our fraud program. Continued fraud education is a critical deterrent. Our employees are aware of the sophistication of our program and the extreme penalties for such activity.

Our internal controls include the following:

- **Password and procedural limitations within the claims system**
- **Security edits built into the claims system**
- **A series of miscellaneous audits designed to target areas with the potential for abuse (for example, unassigned payments or overrides)**
- **A toll-free compliance alert line which provides employees access 24 hours a day, seven days a week to report known or suspected acts of employee misconduct**

Internal investigations involving employees, agents or vendors are the responsibility of the Investigative Services Unit, located in Hartford, CT.

2.C.3 Describe your internal controls for claims payments and your methods for verifying whether services reimbursed were furnished to Members as billed by Providers.

5 points

Components of our claim processing measurement include an extensive monitoring program that includes the following:

- **Stratified Quality Audits – Using an industry accepted, statistically valid stratified audit methodology, populations of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each stratum. Results are extrapolated over the respective populations based upon the weight of each stratum relative to the given populations. Sampling levels are such that an industry acceptable typical precision level of +2 percent is achieved.**
- **Monthly Processor Rework – Claim rework is tracked, assigned to the responsible claim processor and trended for improvement initiatives. Monthly claim rework is an integral component of an individual claim processor's performance results. In essence, 100 percent of the processor claims are considered in the use of rework as the processor level quality metric. Discretionary, targeted claim audits may be performed as warranted by a claim processor's rework results.**
- **Prepayment Review – We audit all claims equal to or greater than a specified dollar threshold paid on a pre-disbursement basis.**
- **Trainee Audit – Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.**
- **Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of $20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on our policies, Coverage Policy Bulletins (CPB) and in accordance with the facility's contractual arrangements.**
- **Auditor Re-audit – Auditors are subject to a re-audit of their work based on a random sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.**
- **Bank-Cleared Claim Draft Audit – Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.**
- **Corporate Audit – Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.**
- **Medical Bill Audit - We have a comprehensive medical bill audit program in conjunction with external suppliers that includes hospital bill audits; DRG audits for DRG code validation; and targeted contract compliance audits for inpatient and outpatient facility claims.**

  We provide an electronic claim file of paid facility claims greater than $10,000 which the suppliers perform both an automated and manual review of the electronic file to identify claims paid using the "percentage of billed charges" methodology.

Once identified those claims paid with the "percentage of billed charges" methodology are run through their screening process to filter out claims with a low potential for error. After the automated filtering, a registered nurse auditor performs a focused manual screening of remaining claims. If appropriate, an vendor nurse auditor performs a final screening and prioritizes claims for audit. Hospital bill audits occur both off and on-site at the facility.

Claims paid by a methodology other than "percentage of billed charges" and claims where we negotiated a discount through our National Advantage Program are not candidates for audit.

For DRG audits, the DRG assignment and reimbursement are confirmed and any proposed DRG revision and an explanation of the basis of the revision are sent to the provider for acceptance.

Contract compliance audits are performed on targeted claims based on contract compliance criteria, home infusion, durable medical equipment (DME) and renal dialysis coding.

We don't conduct audits to confirm with the claimant that services billed were delivered/charged correctly but we send an Explanation of Benefits (EOB) to the employee for claims received and processed. Our experience indicates that employees will call the claim office when a discrepancy is noted. Billing errors brought to our attention are referred for further review to verify that the billed services were actually rendered. Providers showing a pattern of such errors are automatically red-flagged.

2.C.4 Describe your process for performing preliminary investigations of suspected or confirmed wasted, fraud, or abuse.

5 points

Our automated claim reviews help us identify claim bundling, reasonable and customary reductions and duplicate claims so our processors can take appropriate action. It uses medical diagnosis data in real-time to help us:

- **Curb off-label and potentially unsafe use of prescription drugs**
- **Identify and cut payments for unnecessary services and billing**

We identify savings opportunities by using in excess of 200,000 claim edits that help us cut unnecessary spending.

Stopping fraud before we make a payment

Alerts built into our claims system deny potential fraud before the claim is paid. This sends the claims to our SIU for a deeper level of review to make sure the claim is legitimate. Checking for fraud on the front end helped us save more than $346 million in 2017.

Taking the time to get it right — the first time

Our customer service representatives and claims processors talk to each other, taking you and your employees out of the middle. They have access to the same phone call records, written correspondence and e-mails. They can access the same eligibility data, benefit descriptions, provider files and claims history. Both know what's going on with a claim at any time.

When we suspect fraud, waste or abuse we create a case and assign a Special Investigations Unit (SIU) investigator. When the investigator has substantiated an allegation or when fraud, waste or abuse is highly suspected, a flag is placed on the provider's file, which triggers an edit. This edit either auto denies certain claims and/or drops claims from auto adjudication for manual review. We currently have more than 20,000 providers flagged for possible fraud, waste and abuse. In 2017, SIU flags resulted in pre-payment claim denials of $346 million (red flag savings).

	The SIU has sole authority to place and remove fraud flags in the system. **In addition, when we substantiate allegations or inappropriate billings, SIU investigators will pursue recovery directly with health care providers. In 2017, SIU recoveries totaled approximately $11.2 million.**	
2.C.5	Describe your process for recording, investigating, resolving, and analyzing claim and Member reviews and/or appeals. **We provide a nationally standardized process for resolving member complaints and appeals to enhance our ability to handle complaints and appeals in a consistent and timely fashion.** **Some states have requirements that are different from federal requirements. State requirements supersede only when they are more advantageous to the member (e.g., more aggressive turnaround times for response). Aetna's law department will support the business area in the interpretation of applicable law.** **<u>Complaints</u>** **Our Customer Service Representatives (CSRs) respond to most member inquiries at the point of contact. If the issue cannot be resolved during the call, the CSR forwards the complaint to the Customer Resolution Team (CRT) for handling, and, if needed, to the appropriate business area for investigation and response. Members who are not satisfied with the response may file an oral or written complaint and/or appeal.** **A complaint is defined as any oral or written expression of dissatisfaction/concern, other than an appeal, by a member or a member's authorized representative regarding services provided by Aetna, a network health care professional or a vendor.** **This includes but is not limited to complaints related to:** • **Potential quality of care by a participating health care professional** • **Quality of administrative service provided by a participating health care professional** • **Quality of administrative service provided by Aetna** • **Use of their protected health information** • **A plan benefit, billing, eligibility or contract provision that does not involve a request to review a denied claim or service** **<u>Timing</u>** **The resolution timeframe for complaints is as follows:** • **Complaints – 30 days** • **Expedited complaints – 5 calendar days** **<u>Appeals</u>** **A Level I appeal is defined as a verbal or written request by a member, or a member's authorized representative, requesting a change in an initial determination decision.**	5 points

This includes but is not limited to requests related to the following:

- **Certification of health services (e.g., precertification, concurrent review, emergency services)**
- **Claim payment**
- **Plan interpretation**
- **Benefit determinations**
- **Eligibility**

To start the appeals process, the member or provider/representative acting on behalf of the member submits a verbal or written request asking for a change in the initial determination decision.

Timing

The member or authorized representative has 180 days after receipt of a coverage decision to file an appeal.

A written notice stating the result of the review will be forwarded to the member within the following timeframes:

- **Expedited appeals – 36 hours**
- **Pre-service appeals – 15 hours**
- **Post service appeal – 30 days**

Appeal denial notice

If an appeal is denied, written notice includes:

a. **A statement of the reviewer's understanding of the pertinent facts of the appeal (description of the health care service/claim).**

b. **Evidence or documentation used for the basis of the decision in clear terms.**

c. **An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical circumstances.**

d. **The specific rule, guideline, protocol or other similar criterion that was relied upon in making an adverse determination.**

e. **A statement that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request.**

f. **The specific plan provisions on which an adverse benefit determination is based.**

g. **A list of the titles and qualifications of the individuals participating in the review of the appeal (those individuals involved in the decision making process). Specific names are available upon request.**

h. **A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the member's appeal.**

i. A description of the next review level, if applicable, including time frames and how to file. **j. The following or similar statement (including consumer assistance contact information): "If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA.** **Other resources to help you: Need help understanding this notice or our decision? Call us free of charge at the 1-800 number on your medical ID card. There are also other resources available to help you. Most plans are now subject to health care reform law. Call us or ask your employer if your plan is subject to the law.** **If it is, you can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer. [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information.]"** **k. The availability of external review and how to request it, if applicable.** **l. The following statement:** **"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Plan Administrator or your local U.S. Department of Labor Office."** **If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.** **If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available.** **<u>Tracking</u>** **The Complaints and Appeals Tracking System (CATS) was developed to support our national process. The goals of this system are administrative consistency, centralized data collection, business accountability, a consistent workflow process and generation of standard reports. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.**	
2.C.6 Describe your process for implementing and maintain an electronic system that includes reviews and appeals, investigations, resolutions, and notifications. **We established a national process for handling complaints and appeals from members, providers and customers across all regions and products. This process allows for:** • **Administrative consistency** • **Centralized data collection** • **Business accountability** • **A consistent workflow process** • **Standardized reports**	5 points

We developed the Complaints and Appeals Tracking System (CATS) to support this national process. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.

CATS provides a single system to capture, track, route and resolve all member and provider complaints and appeals. CATS interfaces with the customer service documentation system to capture verbal complaints and appeals. The application is web-based and allows for routing the complaint or appeal and relevant documents between the Customer Resolution Team and the accountable business units for processing.

2.D Call/Customer Service Center(s)

2.D.1 Describe your plan for operating a HIPAA-compliant, toll-free Call Center per the requirements of the RFP, and whether you intend to operate the Call Center for Members and Providers separately or combined.

5 points

Privacy is our priority. We have policies, procedures and technologies to protect member information against inappropriate and unauthorized use and disclosure. We review how we handle confidential information. We adjust our policies, procedures and systems, as necessary, to conform to specific HIPAA requirements on an annual basis. This includes the call centers. Our Privacy Office coordinates such reviews and works closely with Law and Regulatory Affairs.

Under the direction of Aetna's Privacy Office, we maintain policies and procedures that comply with all applicable federal and state laws, including but not limited to the HIPAA Privacy and Security regulations and the Gramm-Leach-Bliley Act (GLBA).

- **We have adopted procedures to provide members, on an individual basis, with:**
  - **Access to their health information**
  - **An accounting of disclosures**
  - **The ability to request changes/corrections to their health information**
- **We provide all new members of fully insured health plans with a "Notice of Privacy Practices" that comply with HIPAA and Notice of Information Practices to satisfy GLBA requirements.**
- **We include a HIPAA-compliant Business Associate Agreement for vendors that use, receive, maintain or disclose protected health information (PHI).**
- **We train all employees on HIPAA's basic requirements. Those employees whose jobs involve routine use or disclosure of PHI receive additional function-specific privacy training.**

Separate member and provider call centers

Members and Providers have separate call centers, Providers and their staff use a unique Provider Contact Center phone number, which is separate from the phone number that members would call. However, if the provider happens to call a member telephone number, we have routing in place to direct the caller to the Provider Contact Center.

2.D.2 Describe your technological capability for auditing and monitoring calls and your process for implementing and utilizing an electronic system to document calls and use the data for reference, tracking, and analysis.

5 points

We use a variety of methods to monitor the quality of our customer service.

Silent Monitoring

Our customer service supervisors monitor telephone conversations to evaluate how well our customer service representatives (CSRs) respond to customers. Our telephone equipment allows supervisors to silently monitor calls without disturbing conversations. A recorded message tells members that their call may be monitored.

Review of Recorded Calls

The formal process of quality review requires a minimum of four calls reviewed per month per CSR by Quality Assurance auditors. During the formal review, the auditors use a standard evaluation tool to measure the following:

- **Business Practices**
- **Proficiency**
- **Documentation**
- **Education**
- **HIPAA**
- **Issue identification**
- **Accuracy and clarity of response**
- **Ownership and resolution of the caller's issue**
- **Completion of follow-up in a timely manner**

This is a random review that is extracted from the recorded calls. Informal monitoring and quality trending discussions take place on a regular basis to allow the supervisory staff to coach the customer service staff on handling difficult or complex situations. We also use the results of the reviews to identify continuous quality improvement and training opportunities; as well as to provide performance feedback to reinforce the value of first call resolution and delivering on our commitments. We have changed our quality program to focus more on coaching the CSRs and on the interaction with our callers.

CSRs that perform written, Internet or email correspondence functions are also subject to a monthly quality letter review assessment, performed by the national local customer service unit quality teams.

Surveys

Our Voice of the Customer Survey program measures how our members rate their experience with Aetna. Members who have authorized us to contact them using an email address are sent an online survey invitation asking them to share their feedback about their recent service experience. Members have seven days to access and complete the survey. After seven days, the link to the survey becomes inactive. Member participation in our survey is voluntary.

After confirming the member's recollection of the service call, the survey will ask members:

- **If their request was addressed during the call.**
- **If this was the first time the member had called about the question or issue.**
- **To rate on a scale of 1 to 10 the satisfaction with the Aetna customer service representative (CSR), with 1 being not satisfied and 10 being extremely satisfied.**
- **To rate on a scale of 1 to 10 the satisfaction with call experience and what contributed to their satisfaction or what could have been done differently.**
- **To rate on a scale of 1 to 10 how likely the member is to recommend Aetna to a friend or colleague.**

- **To rate on a scale of 1 to 10 how valued the member felt as a consumer.**
- **To rate on a scale of 1 to 10 the satisfaction on call experience.**

We use feedback from the Voice of the Customer Survey program to improve the quality of our service.

Telephone Reports

Our service centers produce hourly and daily telephone service reports providing detailed information on telephone usage, including the number of calls answered, average speed of answer and abandonment rate.

Aetna Strategic Desktop (ASD)

We use an online tracking and documentation system called ASD for member and provider contacts including telephone calls, written correspondence and Internet email. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

ASD tracks:

- **Date and time of inquiry (when inquiry is opened and closed)**
- **Method of contact**
- **Source of contact (e.g., member, provider, other)**
- **Name of contact**
- **Representative servicing the inquiry**
- **Reason(s) for the contact**
- **Status of inquiry**
- **Action taken**

Our customer service staff has online access to eligibility data, benefit descriptions, provider files, detailed claim history and other online resources that allow them to resolve many inquiries during the initial contact with the member.

If we are unable to resolve an issue during the initial contact, we will document the outstanding inquiry and direct it to the appropriate area for resolution. Our systems provide the reporting capabilities needed to manage the progress of outstanding inquiries to resolution.

ASD provides the following key values to us and our customer service staff:

- **Member 360-View - This view eliminates the need for the CSR to open multiple screens to see additional products a member has been or is currently enrolled in.**

- **Provider 360-View - ASD provides a customized view of the provider and includes provider specific workflows and reporting capabilities.**

- **Clinical 360-View - Provides clinical data (RX, Pulse Score and Laboratory) and member benefit and eligibility information and provider claim information.**

- **CTI Integration - When a caller (member or provider) opts out of Aetna Voice Advantage® for additional service, the CSR will receive a screen pop that can provide important information about the caller and who they are calling about.**

• **Enhanced Reporting - ASD reports will encompass operational, customer and constituent views and will be accessible through a customized Business Objects interface. The report viewer will be able to filter through numerous options on the pre-formatted reports. There are member and provider specific reports as well as reports that support the ASD business case and CTI technology.** • **Supporting Multiple Business Areas - ASD supports both traditional- and HMO-based products with a single front-end interface. ASD is designed as a flexible and all-encompassing front end to many back-end systems. ASD currently supports all of our business segments, Provider Services Organization, Aetna Behavioral Health and the Patient Management organization.** • **Auto documentation - A key feature of ASD is a quick way for the CSR to document the event by either clicking a checkbox or simply following a specific workflow that will document the task simply by capturing where the CSR went in ASD. This will greatly reduce the need to type manual notes in support of call documentation thus, reducing overall call time and improve reporting capabilities.**	
2.D.3 Describe your plan for demonstrating that all Call Center software, hardware, and staff are available and operational. **Requests for site visits prior to the award of the contract will be considered and may be allowed, with some constraints. All visitor(s) must first sign a Visitor Confidentiality Agreement for Perspective Employees, Students and Others Agreement. We are unable to allow a visitor(s) to view PHI or listen to member calls. Additionally, tours in the site may be conducted in some of our general common areas. Tours in working areas are restricted due to privacy concerns.** **Pre-implementation testing** **One of the most beneficial aspects of our process is the assignment of an implementation manager. The implementation manager is the overall project manager for your transition to Aetna and is accountable for the implementation's success. They accomplish this by working with multiple Aetna teams and your representatives, including your consultants and external vendors. The implementation manager manages all aspects of the transition including, but not limited to:** • **Plan design** • **Employee communications** • **Open enrollment initiatives** • **Eligibility issues** • **ID card issues** • **Contractual issues** **The customer service center tests all new customers' plans prior to the effective date. After you sign off on the plan of benefits, we build the plan into the system and we perform a thorough quality review. We then test the benefits. Once all testing is complete and accurate, we begin to process live claims.**	5 points
2.D.4 Describe your process for handling calls received outside of normal business hours. **For inquiries outside of normal business hours, members have the option of using Aetna Voice Advantage, our self-service telephone system or our member website.** **Callers who exit/opt out of our telephone system after the service center has closed will hear the following message:** **"If your call is regarding an emergency, please contact your primary care physician or seek care immediately. Our business hours are Monday to Friday, 8 a.m. to 6 p.m."**	5 points

2.D.5 Provide an overview of the structure of your call/customer service center(s) including detailed description of call routing for multiple call types.

5 points

Structure of customer service center

We provide customer service through our member services call teams. A call team consists of units or teams of CSRs providing service to a designated group of customers. The teams are dedicated to our Public and Labor Business.

Call managers are responsible for coordinating the team activities that support our customer's benefit plans. The call teams are led by customer service supervisors who report to the call manager.

A call team consists of approximately 20 CSRs and can contain both office-based and home-based staff. Call supervisors have total responsibility and accountability for the prompt and proper response to members' questions and issues.

The telephone system has automatic call distribution and operates by placing the caller into a queue and then routing them to the first available representative.

Call routing

Our toll-free number for member inquiries directs callers to the right service center. Our Automatic Call Distribution (ACD) system then distributes the incoming calls to the next available customer service representative (CSR).

Aetna Voice Advantage, our telephone self-service system, enhances our ability to respond to member service inquiries 24 hours a day, 7 days a week.

The system-automated greeter informs all callers that they have contacted Aetna and that we monitor and record their calls to improve our service.

If we have a matching telephone number on file, we ask the caller to confirm the date of birth; or using natural speech or touch-tone we ask the caller for the following:

- **Aetna ID, or Subscriber's Social Security number if not known**
- **Member date of birth**

Aetna Voice Advantage matches this information against our records and requests that the caller confirm the member's first name. It then provides the caller with specified self-service information such as:

- **Claim payment**
- **Contact information - including claim mailing address, website address and several toll-free numbers**
- **Eligibility and effective date**
- **Benefits support**
- **Support for in/out of network benefits and high performance network referrals**

• **Flexible Spending Account information - Health Care Account, Dependent Care Account and debit card services, if applicable** • **Forms and directories** • **ID card requests** • **Health Savings Account information, if applicable** **During normal business hours, Aetna Voice Advantage also routes callers to the right service center whenever more service assistance is required or requested. Members are able to request to speak to a live CSR at any time during the call by speaking one of the 150+ synonyms for CSR that the system is programmed to recognize. When a member requests to speak to a CSR, their information is already validated and available to the CSR receiving the call.** **We measure telephone response performance through monitoring equipment that produces hourly and daily telephone service reports. The reports include average speed of answer, number of calls answered and abandonment rate. The reports also allow us to monitor responsiveness and to identify additional needs immediately.** **We base staffing schedules on forecasts of potential peaks or valleys in call volume from sophisticated workforce management software products.**	
2.D.6 Describe your process for keeping an electronic record of all concerns received by the Call Center and escalating these concerns to EBD. **We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence and Internet email. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.** **ASD tracks:** • **Date and time of inquiry (when inquiry is opened and closed)** • **Method of contact** • **Source of contact (e.g., member, provider, other)** • **Name of contact** • **Representative servicing the inquiry** • **Reason(s) for the contact** • **Status of inquiry** • **Action taken** **At EBD's request, we can provide a monthly report that details the number of contacts by type of service inquiry. The assigned Plan Sponsor Liaison or Account Executive will provide the report to you after the tenth of each month.**	5 points
2.D.7 Describe your plan for operating the Call Center according to the Performance Standards in the RFP. **Members can access customer service information through a variety of sources including a toll-free telephone number, written correspondence and email. We provide members with a designated toll-free number, printed on their member ID card. EBD will be serviced by our Tampa, Florida service center.**	5 points

Members may request to speak to a live customer service representative (CSR) at any time during the call by speaking one of the more than 150 synonyms for CSR that the system is programmed to recognize. When a member requests to speak to a CSR, their previously validated member information is available to the CSR receiving the call.

We empower Customer Service Representatives (CSRs) to make confident decisions that are in members' best interest. We give them the ideal level of training, system access, resources and online information they need to resolve member issues with the first call. They also look for ways to guide members on how to make the best use of the benefits, tools, and programs available to them.

Our CSRs assist members with inquiries that generally fall into the following categories:

- **Benefits**
  - **Coverage**
  - **Inquiries that address available coverage**
  - **In- and out-of-network benefit levels**
  - **Plan limitations and requirements.**
  - **Guidance for best use of benefits and how to save money**

- **Claims settlement**
  - **How to file a claim**
  - **Claim status**
  - **Explanation of benefits (EOBs)**
  - **Pended or denied claims**

- **Eligibility**
  - **Eligibility requirements**
  - **Enrollment of a new family member**
  - **Coverage continuation**
  - **ID card requests**

- **Network**
  - **How the program works**
  - **How to access care through a PCP**
  - **In- and out-of-network care and benefits**
  - **Provider directory requests**
  - **PCP changes**

- **Patient management**
  - **Precertification**
  - **Referrals**

- **Requests for member information and plan materials**
  - **Replacement of ID cards**
  - **EOBs**
  - **Benefit booklets**
  - **Provider network directories**

	Customer Service representatives have real time access to subject matter experts for complex issues and to act on a member's behalf. For example, they have immediate access to support for appeals, case management and precertification. We also give them the guidance and power to make claims decisions in certain situations to better service members. **We are willing to work with the State of Arkansas to come to a mutually agreeable expectation in regards to the expected performance standard for operating the Call Center.**	

2.D.8	Describe your plan for developing and maintaining a website with separate pages for Member and Providers that is easy to access, user-friendly, and compliant with the required items in the RFP. Describe any available customization. **<u>Member website</u>** **Our secure member website at aetna.com, offers several online resources which include:** • **Benefits information** • **Health education** • **Health assessment tools** • **Cost and quality tools** • **Health care decision support** **Our member website offers secure functionality allowing members to:** • **View eligibility and PCP selections for themselves or covered dependents.** • **Change primary care physician and dentist selections.** • **View eligibility information available on ID cards, such as member ID, group number and coverage effective date.** • **Inquire about the status of a medical, dental and pharmacy claim for themselves or a covered dependent.** • **View details about medical, dental or pharmacy claims such as the amount paid by the plan and the members' responsibility.** • **View benefit balances such as deductible and coinsurance maximums.** • **View their Health History Record, a centralized summary of health information based on claims data for members and covered family members.** • **Download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.** • **Check flexible spending account (FSA) status and detailed payment information.** • **Check health savings account (HSA) status and detailed payment information.** • **View Explanation of Benefit (EOB) statements.** • **Print out Aetna standard forms.** • **Contact Member Services through secure messaging in both English and Spanish.** **Member ID information, registration, claim search and Contact Us features is available on a mobile version of the website, allowing for the functionalities to be available in a more user-friendly format, specific to the mobile device being used.** **Our member website assists members in using their health plan and in making informed health choices by providing access to:** • **Member Payment Estimator (MPE), a tool that helps members save money by making it easy to estimate and compare their out-of-pocket costs for certain health care services. This tool uses the member's specific plan information to provide real-time, personalized out of pocket estimates of what the member could pay if they have the services that day.**	5 points

- **Healthwise® Knowledgebase, a user-friendly decision-support tool designed to encourage informed health decision-making and allow users to better understand their treatment options.**
- **Our online directory of participating providers includes details about providers and facilities as well as links to quality and patient safety information.**
- **Simple Steps To A Healthier Life, a personalized, online health and wellness program that includes a suite of online health coaching programs in addition to a health assessment. The program encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles.**
- **Aetna Navigator Hospital Comparison Tool, a tool that allows users access to evidence-based hospital outcome data and quality and safety information on hospitals in their area.**
- **Estimate the Cost of Care (ECC), a suite of interactive web-based cost tools designed to provide members with cost information they can use to make more informed decisions. Cost information is provided for the most common medical and dental procedures, prescription drugs, office visits, diagnostic test and vaccines and diseases and conditions. The Estimate Drug Costs tool is available for mobile devices.**

<u>Customization</u>

EBD has the opportunity to customize various features of our secure member website. We can add your company logo for no additional charge. We can support a custom online provider directory, for an additional charge.

Customizations:

- **Co-branding - You may add your company logo to our member website home page. Upon request, we will supply a list of technical specifications for adding your logo to the home page and a sample screen shot illustrating logo placement.**
- **Members can search a personalized version of our online provider directory when they use our standard, non-custom provider directory through our member website. This search method provides streamlined access to the network and medical/dental products in which the member enrolled, along with other valuable tools and benefits information. The key is the automatic prefilling of member-specific zip codes and Aetna medical plan and network information - making provider searches easy and more successful. (This option does not support custom networks.)**

<u>Update frequency</u>

Member-specific data is refreshed continually as it becomes available through our core data processes. For example, eligibility changes are generally available within 24 to 48 hours and claims data updates approximately every 4 hours.

General topics, such as health content, are updated through routine review cycles managed by the supporting areas.

2.D.9 Describe your plan for implementing and maintaining secure electronic portals, including personal health records, for Member and for Providers on the website.

5 points

Our secure member website has incorporated the following features to comply with HIPAA privacy rules:

- **Under HIPAA, EOBs may be sent to an employee for all members enrolled under that employee's coverage. Therefore, we have limited the information available through our member website of information that is found on EOBs. This was implemented because the site access is based on the employee, rather than individual members.**

• **If a family member requests that access to his/her information be restricted, or the family member is an adult dependent, that member's information will be filtered out of the member site.** • **Sensitive pharmacy claims for subscribers and dependents over age 14 will display ”private” in place of the drug name. Sensitive medical claims display as “medical services”.**	
2.D.10 Describe your plan for ensuring information on the website is accurate and for ensuring the information is updated in a timely manner. **Our member website accesses data from over 30 core systems to provide current information to members when they access their secure home page. Generally, our member website undergoes quarterly releases for new functionality and enhancements.** **Member-specific data is refreshed continually as it becomes available through our core data processes. For example, eligibility changes are generally available within 24 to 48 hours and claims data updates approximately every 4 hours.** **General topics, such as health content, are updated through routine review cycles managed by the supporting areas. For example:** • **Member Payment Estimator (MPE) makes it easy for members to estimate and compare what they will pay out-of-pocket for certain health care services for themselves or their covered dependents based on their individual medical plans. MPE uses real-time technology to provide members with personalized out-of-pocket estimates of what they could pay for their care if they had the service that day by using members’ specific plan information.** • **Healthwise® Knowledgebase is updated quarterly and the Healthwise Handbook is updated annually.** • **Our online provider directory is refreshed/updated six times a week.** • **Estimate the Cost of Care is updated semi-annually.** • **The Price Transparency Tool accesses our pricing systems real time, and displays the rates that are in effect on any given day.** • **WebMD Health Services obtains data directly from the Centers for Medicare & Medicaid Services (CMS) and updates the data in the Hospital Comparison Tool quarterly. JCAHO and PEP-C (Hospital patient satisfaction results for California hospitals) data is updated annually. Leapfrog survey data is updated monthly.** • **Topics on our main website, aetna.com, are managed through routine cycles. Time-sensitive information, such as Investor Information News, is posted as it becomes available.**	5 points

3 – HEALTH INSURANCE

3.A Claims Administration

3.A.1 Describe how you will develop and maintain an accurate and efficient claims processing system to receive and adjudicate Claims.

5 points

We process claims on a customized version of the Dun & Bradstreet system, ClaimFacts®, that we call Automatic Claim Adjudication System (ACAS). It is a fully computerized, interactive, online, real-time claims payment and accounting system. ACAS is rule-based and allows for improved online availability, increased automatic adjudication and scalability to handle projected claim volume increases.

Our system supports both automated and manual claims processing and contains components for electronic claim intake, workflow management and imaging systems; as well as our plan, member, provider, quality management and utilization management databases.

ACAS processes a full range of health care plans executing a wide range of system controls and edits designed to:

- **Confirm the eligibility of claimants**
- **Confirm adherence to plan provisions**
- **Validate the necessity of treatment**
- **Flag providers rendering inappropriate care**

The system supports automatic adjudication for standard plan designs. While the vast majority of functions within ACAS are fully automated, there are times when claim benefit specialists must make decisions to properly adjudicate a claim. Non-standard plan designs may require the need for additional processor intervention.

ACAS is a sophisticated, efficient and accurate system. When paired with our professional claim, customer service and provider relations staff, the system results in a high level of customer service.

3.A.2 Describe your processes for each of the following:

- claims submission and adjudication, paper and electronic, including receipt of Claims,
- verification of Member and Provider eligibility,
- verification of any needed prior authorization,
- verification of Third Party Liability,
- denial or approval and submission of payment en to detect/correct these discrepancies

5 points

We process claims on a customized version of the Dun & Bradstreet ClaimFacts® system. We call this system Automatic Claim Adjudication System (ACAS). It is a fully computerized, interactive, online, real-time claims payment and accounting system. ACAS is a rule-based system that can handle large volumes. It helps us process and approve more claims without special handling.

ACAS receives, images and processes both automated and manual claims. And it can interface with our plan, member, provider, quality management and utilization management databases.

Our claims system automatically links the following:

- **Member**
- **Plan**
- **Provider**
- **Network**
- **Applicable referral**
- **Fee arrangements**

The system automatically calculates benefits on the basis of the negotiated arrangement or, for non-network providers, according to Nonparticipating Provider Reimbursement policy such as percent of Medicare, state-mandated rate and percent of Fair Health and other guidelines. The system applies copays and coinsurance levels (preferred and nonpreferred) according to plan provisions.

Claim submission

When members use a network provider it's the provider's responsibility to submit the claim on the member's behalf. The member is never responsible for submitting claims for in-network and referred services.

A provider who is not in the network for a particular plan may volunteer to submit the claim for the member. However, it is the member's responsibility to make sure the claim is filed. If the provider does not submit the claim, the member must do so.

Claim format

Electronic claims

Network providers can send claims using any of these methods:

- **Through an Aetna-approved vendor**
- **Using NaviNet® (our secure provider website)**
- **Through our direct-connect website, aetnaedi.com**
- **Through one of many clearinghouses**

We do not auto adjudicate all claims that are submitted electronically; however, we do process them before paper claims.

Paper claims

Providers can download our claim forms from the Provider Services website. Members can access the claim forms from their secure member website. Instructions for completing the form and the address for mailing it are on the form.

Paper claims addressed to Aetna claim P.O. boxes are routed to Conduent (formerly Xerox), our imaging supplier. The image supplier will remove the claims from the envelopes, sort according to processing needs and image all claims. When the supplier scans the claim, a Document Control Number (DCN) is assigned to the claim for tracking and reconciliation purposes.

The image supplier utilizes OCR (optical character recognition) technology where appropriate to capture information off claim forms. Fields that are not captured in OCR are manually keyed offshore into the common claim format, which is required for receipt and processing of electronic claims. During the data keying process, supplier processors will perform certain data validation edits based upon business specifications provided by the Company.

Verification of third party liability **We use The Rawlings Company, an experienced, national vendor of third party recovery services headquartered in Louisville, KY, as our subrogation vendor. We have used the services of Rawlings since 1996.** **Claim recalculation** **Once a claim is adjusted, the original claim transaction is voided in the claims system. If needed, the claims system removes amounts charged, which refers to benefits released (in error) that were applied to a person's remaining annual or lifetime maximum, or used to satisfy an annual or lifetime deductible. The claim is then recalculated and processed correctly to rectify the claim history. Once the correction has been made, the system will reflect the original, incorrect voided transaction and the corrected data.** **When a claim adjustment is needed, it is processed under the original claim number.**	
3.A.3 Describe how you will maintain an automated Claims system according to the requirements in the RFP and offer Providers an electronic Claims portal for automated processing, adjudication, and correction of Claims. **We process claims on a customized version of the Dun & Bradstreet system, ClaimFacts®, that we call Automatic Claim Adjudication System (ACAS). It is a fully computerized, interactive, online, real-time claims payment and accounting system. ACAS is rule-based and allows for improved online availability, increased automatic adjudication and scalability to handle projected claim volume increases.** **Our system supports both automated and manual claims processing and contains components for electronic claim intake, workflow management and imaging systems; as well as our plan, member, provider, quality management and utilization management databases.** **ACAS processes a full range of health care plans executing a wide range of system controls and edits designed to:** • **Confirm the eligibility of claimants** • **Confirm adherence to plan provisions** • **Validate the necessity of treatment** • **Flag providers rendering inappropriate care** **The system supports automatic adjudication for standard plan designs. While the vast majority of functions within ACAS are fully automated, there are times when claim benefit specialists must make decisions to properly adjudicate a claim. Non-standard plan designs may require the need for additional processor intervention.** **ACAS is a sophisticated, efficient and accurate system. When paired with our professional claim, customer service and provider relations staff, the system results in a high level of customer service.** **Once a claim is adjusted, the original claim transaction is voided in the claims system. If needed, the claims system removes amounts charged, which refers to benefits released (in error) that were applied to a person's remaining annual or lifetime maximum, or used to satisfy an annual or lifetime deductible. The claim is then recalculated and processed correctly to rectify the claim history.**	5 points

	Provider portal **Both network and out-of-network physicians and physician groups can submit claims with an online HCFA/CMS 1500 claim form and check claim status on our secure provider website. Providers can also submit claims and check claim status through Post-n-Track® (www.post-n-track.com), our no-cost, direct connect-solution, or our electronic data interchange (EDI) vendors/clearinghouses. We have received CAQH Committee on Operating Rules for Information Exchange (CORE) certification for our claim status transaction support.**	
3.A.4	Describe your plan for completing and maintaining accurate Claim Data for all services. **Our Claim Quality department performs audits daily and compiles accuracy results quarterly and annually. We track performance information, accuracy and turnaround time on internal management reports.**	5 points
3.A.5	State the percentage of claims that generated Member complaints from July 1, 2016 to June 30, 2017. Of those, how many received a written response? **In 2016, we received 72,749 complaints. In 2017, we received 82,833 complaints. We do not track type of complaints separately. However, For 2016 and 2017, the five most common categories for member complaints were:** • **Interactions** • **Benefits** • **Access** • **Enrollment** • **Quality of Care** **Claim processing was the top category for appeals for both years.** **All appeals and complaints receive a written response.**	5 points
3.A.6	Describe how you will identify received claims for services that are not Covered Services for payment and processing. **Our eligibility system interfaces with our claims system. It provides online eligibility information to facilitate accurate claim payments. You provide updated eligibility information to us at least monthly. Our administrative system automatically transmits eligibility data to our claims system within 24 hours of entry.** **The eligibility system maintains eligibility on each family member. This includes but is not limited to:** • **Status** • **Type of coverage** • **Effective date** • **Termination date (if appropriate)** • **Existence of other coverage (primary or secondary)**	5 points

3.A.7 State your company's percentage of claims from July 1, 2016 to June 30, 2017 that were: • Processed within ten (10) business days • Processed within twenty (20) business days • Processed within thirty (30) business days • Percentage of pended claims Formula: Include all claims approved or denied. **We track claims processing within 14 days and 30 days. Our goal is to process 90% of claims in 14 calendar days and 95% in 30 calendar days.** **EBD will be serviced by our Tampa, FL service center. In 2016, the Tampa service center processed 90% of claims in 5.15 days and 95% of claims in 11.52 days. In 2017, the Tampa service center processed 90% of claims in 4.84 days and 95% in 13.55 days.**	5 points
3.A.8 State the percentage of your company's claims from July 1, 2016 to June 30, 2017 which were suspended for any reason. Formula: Total number of suspended claims divided by total number of claims processed from July 1, 2016 to June 30, 2017. **We estimate that we pend less than four percent of claims for additional review or information. With the impact of the First Claim Resolution® process, we anticipate that the percentage of pended claims will continue to decrease.** **First Claim Resolution means that wherever possible, we rapidly resolve a claim the first time we receive it, avoiding the rework, delays and customer dissatisfaction associated with multiple submissions. First Claim Resolution objectives are to process claims accurately the first time, improve customer satisfaction through improved service delivery and focus resources on regional and national capabilities to support First Claim Resolution.**	5 points
3.A.9 State your claims payment accuracy from July 1, 2016 to June 30, 2017. Formula: Total number of correct payments divided by total number of payments from July 1, 2016 to June 30, 2017. **One way we measure claims payment accuracy is by measuring payment incidence accuracy. Payment incidence accuracy is measured by industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by dividing the number of claims paid correctly by the total number of claims audited and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.** **In 2016, the Tampa service center had a payment incidence accuracy of 99.36%. In 2017, the Tampa service center had a payment incidence accuracy of 99.15%.**	5 points

3.A.10 Provide statistics detailing your financial accuracy from July 1, 2016 to June 30, 2017. **We also measure claims payment accuracy by measuring financial accuracy and overall accuracy.** **Financial accuracy is measured using industry accepted stratified audit methodology. The results are determined by calculating the financial accuracy for a subset of claims (a stratum) and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error. They do not offset each other. This includes both manual and auto-adjudicated claims.** **In 2016, the Tampa service center had a financial accuracy of 99.25%. The service center had a 98.48% financial accuracy in 2017.** **Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum is calculated by dividing the number of claims processed correctly by the total number of claims audited, and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.** **In 2016, the Tampa service center had an overall accuracy of 99.02%. The service center had a 98.73% overall accuracy in 2017.**	5 points
3.A.11 Describe your policy on timely filing of claims. How will you accommodate a policy that requires payment within 180 days from date of service, or inpatient service discharge date, for contracted and/or non-contracted providers? **Participating non-hospital providers have 120 days from the date of service to submit a claim for payment unless:** • **Otherwise noted in their contract** • **State law requires otherwise** • **Another exception applies** **Participating hospitals have 365 days from the date of service to submit a claim for payment unless:** • **State law requires otherwise** • **Another exception applies** **Our standard contracts with providers (including physicians, hospitals and other facilities) state that we are not obligated to reimburse claims received outside of the timeframes noted above unless the provider provides notice of extraordinary circumstances causing a delay. Our contracts also state that we consider payment full and final unless the provider notifies us regarding a payment dispute within 180 days of receiving the payment. State laws and provider contractual commitments which grant additional time will supersede the above timeframes.** **In practice, we will accept and process claims submitted by nonparticipating providers or members within two years plus 90 days of the date of service, or in accordance with EBD's plan design and contract/ASC agreement.**	5 points
3.A.12 How often are claims processing workflows audited, including pending claims? **Auditing frequency varies. Components of our claim processing measurement include an extensive monitoring program that includes the following:**	5 points

- **Stratified Quality Audits – Using an industry accepted, statistically valid stratified audit methodology, populations of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each stratum. Results are extrapolated over the respective populations based upon the weight of each stratum relative to the given populations. Sampling levels are such that an industry acceptable typical precision level of +2 percent is achieved.**

- **Monthly Processor Rework – Claim rework is tracked, assigned to the responsible claim processor and trended for improvement initiatives. Monthly claim rework is an integral component of an individual claim processor's performance results. In essence, 100 percent of the processor claims are considered in the use of rework as the processor level quality metric. Discretionary, targeted claim audits may be performed as warranted by a claim processor's rework results.**

- **Prepayment Review – We audit all claims equal to or greater than a specified dollar threshold paid on a pre-disbursement basis.**

- **Trainee Audit – Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.**

- **Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of $20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on our policies, Coverage Policy Bulletins (CPB) and in accordance with the facility's contractual arrangements.**

- **Auditor Re-audit – Auditors are subject to a re-audit of their work based on a random sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.**

- **Bank-Cleared Claim Draft Audit – Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.**

- **Corporate Audit – Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.**

- **Medical Bill Audit - We have a comprehensive medical bill audit program in conjunction with external suppliers that includes hospital bill audits; DRG audits for DRG code validation; and targeted contract compliance audits for inpatient and outpatient facility claims.**

  We provide an electronic claim file of paid facility claims greater than $10,000 which the suppliers perform both an automated and manual review of the electronic file to identify claims paid using the "percentage of billed charges" methodology.

  Once identified those claims paid with the "percentage of billed charges" methodology are run through their screening process to filter out claims with a low potential for error. After the automated filtering, a registered nurse auditor performs a focused manual screening of remaining claims. If appropriate, an vendor nurse auditor performs a final screening and prioritizes claims for audit. Hospital bill audits occur both off and on-site at the facility.

Claims paid by a methodology other than "percentage of billed charges" and claims where we negotiated a discount through our National Advantage Program are not candidates for audit. **For DRG audits, the DRG assignment and reimbursement are confirmed and any proposed DRG revision and an explanation of the basis of the revision are sent to the provider for acceptance.** **Contract compliance audits are performed on targeted claims based on contract compliance criteria, home infusion, durable medical equipment (DME) and renal dialysis coding.** **The medical bill audit program is a standard component of the self-funded agreement with a contingency fees charged and the refund credited to EBD through their wire-lines.** **Quality results are based on the processing unit level and we do not notify the customer of any irregularities discovered. However, we conduct root cause and trend analysis to identify opportunities to continuously improve our service. We assess training needs and conduct training sessions as needed.**	
3.A.13 Provide your performance standards/expectations for each of the following (including the criteria thresholds): a. Payment accuracy b. Financial accuracy c. Overall accuracy Include the annual average for each for 2016 and 2017. **While we strive to process all claims with 100 percent accuracy, our preferred performance guarantee for the following categories is:** **Financial Accuracy: 99%** **Payment Incidence Accuracy: 96%** **Overall Accuracy: 95%** **In 2016, the Tampa service center had a financial accuracy of 99.25%. In 2016, the Tampa service center had a payment incidence accuracy of 99.36%. In 2017, the Tampa service center had a payment incidence accuracy of 99.15%. The service center had a 98.48% financial accuracy in 2017. In 2016, the Tampa service center had an overall accuracy of 99.02%. The service center had a 98.73% overall accuracy in 2017.**	5 points
3.A.14 Identify claim processing locations using a color-coded map for each of the following: • In-network (within Arkansas) • Out-of-network (within Arkansas) • Out-of-area (In-network outside Arkansas) • Out-of-area (Out-of-network, outside Arkansas) **Our Tampa, FL service center will have overall responsibility and accountability of EBD.**	5 points

3.A.15 Explain your criteria for any out-of-network designation of claims within Arkansas.

5 points

National Advantage Program

Our National Advantage™ Program (NAP) offers access to contracted rates for out-of-network services and case-specific rate negotiation with out-of-network providers. NAP also offers reasonable charge allowance review for eligible inpatient and outpatient facility claims through the Facility Charge Review program where NAP contracted rates are not available. NAP also offers Itemized Bill Review for certain large facility claims.

Through several national third-party vendors, NAP offers access to contracted rates for out-of-network claims. These contracted rates can produce average savings, before our NAP fees, of approximately 30 to 35 percent of charges at participating hospitals, facilities and for many physicians' services.

In addition to these third-party vendors, NAP also includes access to significant number of directly contracted rates which can apply for indemnity plan members located in directly contracted network areas. These directly contracted rates can also apply for narrow network plans, for those providers that are in Aetna's broad network, but that are not in the narrow network that applies for a specific plan.

Choice POS II

With our Choice POS II product, we encourage members to select and use a participating PCP for routine treatment, although we do not require PCP referrals. Members may self-refer to any participating provider.

Members receive a PCP benefit level when they visit their selected participating PCP or, when in accordance with the plan design, any participating PCP. Members receive a specialist benefit level when they visit a participating physician, including an unselected participating PCP if the PCP benefit level does not apply. Members may also self-refer to any recognized nonparticipating provider and receive out-of-network benefits.

Aetna Select

With our Aetna Select product, members must select and use a participating PCP for treatment and coordination of care, including referrals to participating specialists and facilities to obtain benefits.

Our members can change their PCPs as often as they like for any reason. When a member changes their PCP, the change is typically effective immediately. We mail a new member ID card shortly thereafter.

Claim form requirements

We do not require claim forms for in-network services. Network providers submit claims on behalf of the member. When the member uses network providers, the claim submission process is paperless from the member's point of view.

For out-of-network or out-of-area services, the member may need to submit claims using our standard claim form if the provider is unable or unwilling to submit the bill to us on the member's behalf.

3.A.16 Explain your criteria for any out-of-network designation of claims outside Arkansas. **NAP offers access to contracted rates for out-of-network services and case-specific rate negotiation with out-of-network providers. Under NAP, we share savings with members, as coinsurance and deductibles are based on actual contracted rates. The fee to EBD for access to NAP (including ad hoc negotiations) is a percentage of savings. We charge a fee when we take a discount and achieve savings.** **As a component of NAP, our Single Case Contracting unit (SCCU) negotiates with nonparticipating providers for a specific service on a prospective or concurrent basis. We refer cases to SCCU at the time of the precertification request by our regional Patient Management departments. Cases must meet the following SCCU criteria in order to qualify for negotiation:** • **The cost of care will equal or exceed $750.00.** • **Aetna is the primary payer.** • **Provider must be nonparticipating or without a contracted rate for the service** • **EBD must be enrolled in NAP for self-funded plans** **Additionally, we will attempt to negotiate ad hoc discounts with non-NAP network providers for certain claims after the claim is submitted for payment. These negotiations will be done either through our Global Claim Services department or, for eligible claims below a defined threshold, a third-party vendor. Claims must be from a provider who is nonparticipating or who does not have a contracted rate for the provided service.**	5 points
3.A.17 Describe your process for tracking claims pended for medical review. Provide the policy/procedure as an electronic document on a flash drive. Number and title the file for easy reference to this question. **We have provided the response to 3.A.17, titled First Claim Resolution (*3.A.17)*, on a flash drive as requested.**	5 points
3.A.18 Describe your process of identifying the unbundling and/or up-coding of rendered services. Explain any proprietary algorithms or policies used. Provide an overview of how this information is applied to the claim adjudication cycle, including how it is reflected on both the Remittance Advice (RA)/Explanation of Benefits (EOB). **We use a customized version of Change Healthcare's ClaimsXten™ software to detect unbundled, upcoded and fragmented provider bills.** **We fully integrated ClaimsXten into our claims processing systems. We use this product to address claims in a broad range of services:** • **Surgical** • **Surgical assistance** • **Medical (office care)** • **Diagnostic services (X-ray and lab)** **ClaimsXten is a robust tool as it contains in excess of one million edits.** **Editing applies to both participating and non-participating providers. The software includes the following types of edits on facility and non-facility providers:** • **Incidental** • **Mutually exclusive** • **Rebundling** • **Frequency** • **Correct coding guidelines**	5 points

ClaimsXten software evaluates a claim containing single or multiple procedure codes (CPT and HCPCS) on one date and automatically adjusts the claim based on the recommendation. In some instances, ClaimsXten auditing occurs across dates of service (for example, when evaluating pre- and post-operative services or new visit frequency). The software further evaluates the claim and recommends the correct procedure coding and multiple surgery percentages. The software also recognizes potential gender and age discrepancies and whether or not an assistant surgeon, co-surgeon or team surgeon is necessary for a procedure.

The software also automates the handling of our Clinical Policy Bulletins across all products, claim processing platforms, and can include customer, benefit plan and state exceptions. Based on the CPT/HCPCS and ICD-10 codes presented on a claim, the tool will automatically allow, deny or pend for review by our clinical claim review staff. Other variables that impact the application of a policy such as patient age or gender can also be automated.

We refer any situations that require a prepayment clinical review or any post-payment appeals to our Clinical Claim Review unit.

Claim status communication

Typically, we communicate with employees and providers about claims status issues using EOBs.

We process and communicate the status of claims as follows:

- **Clean claims - We process the claim according to the plan of benefits, issue a Provider EOB to the provider (if the claim is assigned) or an EOB to the employee (and any unassigned check), detailing how we processed the expense.**

  Our claims system will suppress EOB production in the following situations:

  - **Benefits are assigned and member's liability is zero**
  - **Benefits are assigned and member's liability consists of a copayment only**

- **Incomplete claims - For claims that are missing information (for example, accident details, diagnosis or other coverage payment information) after reviewing all available information included with the claim submission, processors will pend the claim and send an EOB to the provider and/or the member acknowledging receipt of the claim, explaining the reason for the delay and requesting the necessary information.**

  We conduct a follow up with the employee each time they submit the same or a related expense. We conduct follow-ups with providers within approximately 30 days. Generally, after 2 follow ups, we ask the employee for assistance, explaining we are unable to determine benefits because of a lack of information. We will reopen the claim when we receive the requested information.

- **Denied claims - We send employees and providers an EOB explaining the reason for the denial. The EOB describes the appeals process in the event the employee/provider does not agree with our determination.**

Employees can obtain claim information at any time by calling member services or by accessing our secure member website.

3.A.19 Describe the process used to systematically program rules to prevent unbundling and up-coding abuse. How do you monitor to ensure accuracy? **We contractually require network providers to submit clean claims to us for services provided to members. Providers also contractually agree to permit us to rebundle and make other adjustments for inappropriate billing or coding practices when applicable. Providers contractually agree to hold members harmless and never balance bill for covered services.** **Our Claim Quality department performs audits daily and compiles accuracy results quarterly and annually. We track performance information, accuracy and turnaround time on internal management reports.**	5 points
3.A.20 Describe your plans for coordinating benefits to maximize cost avoidance through the utilization of third-party liability (TPL) and subrogation. **COB administration** **Our COB administration starts with the collection and maintenance of accurate information about other coverage. We have a variety of methods for gathering the information including:** • **During enrollment, many of our customers collect information about other coverage and share it with us.** • **During the precertification process, our nurses ask about other coverage.** • **Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.** • **In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.** • **Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature on our secure member website, at aetnanavigator.com.** • **As required by law, we exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.** • **In addition, we participate in COB Smart. COB Smart is a registry of member coverage information. It helps plans and providers correctly identify members who have more than one plan. It helps with order of benefits determination (OBD) when members have more than one plan. All information sent to the registry is protected and secure.** **COB screening** **We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.** **We consider the following as potential indicators of other coverage:** • **Hospital bills submitted as paid** • **Large physician bills submitted as paid** • **Photocopied bills** • **Hospital bills or large physician bills submitted late**	5 points

- **Indication of other party payment on the bill**
- **Auto accidents (potential no-fault insurance)**
- **Workers' compensation**

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we auto deny the claim.

Other coverage information

When we receive other coverage information, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes:

- **Details about the other coverage**
- **Family members the other plan covers**
- **Carrier**
- **Type of coverage (for example, medical only or medical-dental)**
- **Date of the last update**

If we are secondary and the primary carrier's EOB is not attached to the claim, the claim is pended for receipt of the primary carrier's EOB.

Upon receipt of the primary carrier's EOB, claims are processed as follows:

- **For maintenance of benefits (MOB) or non-duplication plans, the COB allowance is our negotiated rate reduced by copays, coinsurance or other applicable plan provisions.**
- **For plans utilizing standard 100% allowable, the COB allowance expense varies based on the 100% allowable model chosen.**

Once we determine the allowable expense, we subtract the primary carrier's payment from it and pay the balance, if any, as long as the balance does not exceed our normal benefit.

Our COB procedure is the same for both in-network and out-of-network.

COB is system-calculated.

Subrogation

We use The Rawlings Company, an experienced, national vendor of third-party recovery services headquartered in Louisville, KY, as our subrogation vendor.

For a self-funded group electing to use Rawlings, arrangements must be made through the account manager for subrogation/reimbursement services. The account manager is responsible for completing applicable forms and providing them to Rawlings. Subrogation/reimbursement language must be included in the group's finalized Summary Plan Description (SPD) before recoveries can be pursued.

We continue to pay the member's eligible expenses during the investigation. Rawlings generally does not involve you in the investigation. If the investigation and recovery efforts warrant, Rawlings will pursue a third party through legal action. If the member has already obtained a recovery, Rawlings may, where appropriate, pursue litigation against the member.
The subrogation service fee of 30 percent is retained upon recovery.

3.A.21 Describe your process for identifying, collecting, and reporting Third Party Liability (TPL).

5 points

The following provides an overview of The Rawlings Company's file identification, investigation and recovery processes:

Identification

- **Using predictive analytics, Rawlings mines paid claims data and member eligibility data using a proprietary set of diagnostic codes to identify trauma-related treatments.**
- **Rawlings proprietary analytics, along with the use of multiple data sources has reduced our need to involve the member in the investigation process.**
- **As a last resort, where information isn't available from other sources, members are mailed up to five inquiry letters that include a brief questionnaire asking about their treatment.**
- **Members have three ways to respond to Rawlings' questionnaire:**
  1. **Member can call a toll-free number answered by experienced analysts.**
  2. **They can return their completed questionnaire in a postage-paid reply envelope.**
  3. **They can visit www.TRGClaimsInfo.com and complete the questionnaire online.**
- **Self-funded customers have an option to enroll in a, "Partnership Program" with Rawlings to receive monthly detailed non-cooperation reports to encourage cooperation among employees and dependents.**
- **Subrogation opportunities may also be brought to our attention when Aetna is asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.**

Investigation

- **Investigations are assigned to analysts organized by client-specific teams supported by team attorneys.**
- **Analysts define a strategy based on every possible source of recovery and place all parties on notice of your claim.**
- **Analysts manage files on their proprietary software. Some of the many features include:**
  - **An automated diary system that allows analysts to record the details of all file activity and share these with other team members collaborating on the file.**
  - **A tickler system that automatically prompts analysts to plan effective follow-up for each file.**
  - **Automated special handling notifications (group restrictions).**
  - **A library of letters and notices approved by Rawlings' legal team.**

Recovery

Subrogation recoveries are remitted from Rawlings to Aetna via a bulk wire and recoveries are credited to an individual customer at the claim level through their wireline account. The customer will see a credit for the gross recovery, a charge for Rawlings fee and a separate charge for any administrative fee charged by Aetna on their claim detail report. Amounts paid but not recovered through subrogation remain charged to your plan.

- **Subrogation recoveries are remitted and processed twice a month.**
- **Reports are provided quarterly.**

Reports

The Rawlings Company offers a standard quarterly report package to you when participating in the program and upon receipt of a report authorization form. The standard reporting includes:

- **Activity Summary – A single page summary of year-to-date activity including:**
  - **Gross recovery amounts**
  - **Number of files opened**
  - **Number of files closed**
  - **Number of initial investigation letters generated**
- **Detailed Report of Recoveries – A report of each recovery processed during the current period.**
- **Detailed Report of Files Closed without Recovery – A report of each closed file with no recovery, including the reason for closure.**
- **Open File Report – A detailed listing of all open files.**
- **Non-Cooperative Report - A detailed report of members who have not responded to at least 3 inquiry letters/questionnaires.**

These reports are available electronically through a secure website for online review if the customer selects the detailed reporting package. There is no additional cost for these reports.

3.A.22 Describe how you will verify during Claims adjudication that the Member was eligible for Services on the date of service.

5 points

We confirm eligibility as the first step in any interaction with a member. This occurs during:

- **Precertification**
- **Other patient management requests**
- **Claims processing**

Our eligibility system interfaces with our claims system. It provides online eligibility information to facilitate accurate claim payments. You provide updated eligibility information to us at least monthly. Our administrative system automatically transmits eligibility data to our claims system within 24 hours of entry.

The eligibility system maintains eligibility on each family member. This includes:

- **Name**
- **Address**
- **Gender**
- **Age**

• **Relationship to employee** • **Social Security number** • **Effective date** • **Termination date (if appropriate)** • **Status** • **Type of coverage** • **Existence of other coverage (primary or secondary)** • **Alternate Payee and Special Handling Information** **If applicable to the plan design, the file also includes the individual's PCP, Ob/Gyn and dentist selections.**	
3.A.23 Explain in detail the workflows for handling incoming correspondence. Include tracking and retrieving. a. Correspondence (letters, emails, and any other form of written correspondence) accompanied by a claim b. Correspondence submitted separately c. Requested medical records to support medical necessity **We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence and Internet email. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.** **We maintain a historical record of contacts online for 18 months and then archive them in accordance with applicable legal requirements, typically for 7 years.** **ASD tracks:** • **Date and time of inquiry (when inquiry is opened and closed)** • **Method of contact** • **Source of contact (e.g., member, provider, other)** • **Name of contact** • **Representative servicing the inquiry** • **Reason(s) for the contact** • **Status of inquiry** • **Action taken** **Our customer service staff has online access to eligibility data, benefit descriptions, provider files, detailed claim history and other online resources that allow them to resolve many inquiries during the initial contact with the member.** **If we are unable to resolve an issue during the initial contact, we will document the outstanding inquiry and direct it to the appropriate area for resolution. Our systems provide the reporting capabilities needed to manage the progress of outstanding inquiries to resolution.** **ASD provides the following key values to us and our customer service staff:** • **Member 360-View - This view eliminates the need for the CSR to open multiple screens to see additional products a member has been or is currently enrolled in.** • **Provider 360-View - ASD provides a customized view of the provider and includes provider specific workflows and reporting capabilities.**	5 points

• **Clinical 360-View - Provides clinical data (RX, Pulse Score and Laboratory) and member benefit and eligibility information and provider claim information.** • **CTI Integration - When a caller (member or provider) opts out of Aetna Voice Advantage® for additional service, the CSR will receive a screen pop that can provide important information about the caller and who they are calling about.** • **Enhanced Reporting - ASD reports will encompass operational, customer and constituent views and will be accessible through a customized Business Objects interface. The report viewer will be able to filter through numerous options on the pre-formatted reports. There are member and provider specific reports as well as reports that support the ASD business case and CTI technology.** • **Supporting Multiple Business Areas - ASD supports both traditional- and HMO-based products with a single front-end interface. ASD is designed as a flexible and all-encompassing front end to many back-end systems. ASD currently supports all of our business segments, Provider Services Organization, Aetna Behavioral Health and the Patient Management organization.** • **Auto documentation - A key feature of ASD is a quick way for the CSR to document the event by either clicking a checkbox or simply following a specific workflow that will document the task simply by capturing where the CSR went in ASD. This will greatly reduce the need to type manual notes in support of call documentation thus, reducing overall call time and improve reporting capabilities.**	
3.A.24 Describe in detail your workflow for responding to Customer Service inquiries, including turnaround time requirements. **Aetna Voice Advantage®, our telephone self-service system, enhances our ability to respond to member service inquiries. The system is available 24 hours a day, 7 days a week. Its automated greeter informs all callers that they have contacted Aetna and that we may record calls to promote quality service.** **Through natural speech or touch-tone, the system requests the caller to state whether they are an Aetna member or provider followed by a request to provide:** • **Reason for their call** • **Aetna ID, or Subscriber's Social Security number if not known** • **Member date of birth** **It then matches the above information against our records and requests that the caller confirm the member's first name.** **The system provides the caller with specific self-service information, such as information on:** • **Claim payment** • **Contact information - including claim mailing address, website address and several toll-free numbers** • **Eligibility and effective date** • **Benefits support** • **Support in and out of network, Aexcel® and referrals** • **Flexible Spending Account information - Health Care Account, Dependent Care Account and debit card services, if applicable**	5 points

- **Forms and directories**
- **ID card requests**
- **Health Savings Account information, if applicable (call is routed to Payflex)**

During normal business hours, Aetna Voice Advantage routes callers to the appropriate service center whenever they need more help.

Live support

Members may request to speak to a live customer service representative (CSR) at any time during the call by speaking one of the more than 150 synonyms for CSR that the system is programmed to recognize. When a member requests to speak to a CSR, their previously validated member information is available to the CSR receiving the call.

We empower Customer Service Representatives (CSRs) to make confident decisions that are in members' best interest. We give them the ideal level of training, system access, resources and online information they need to resolve member issues with the first call. They also look for ways to guide members on how to make the best use of the benefits, tools, and programs available to them.

Our CSRs assist members with inquiries that generally fall into the following categories:

- **Benefits**
  - **Coverage**
  - **Inquiries that address available coverage**
  - **In- and out-of-network benefit levels**
  - **Plan limitations and requirements.**
  - **Guidance for best use of benefits and how to save money**

- **Claims settlement**
  - **How to file a claim**
  - **Claim status**
  - **Explanation of benefits (EOBs)**
  - **Pended or denied claims**
- **Eligibility**
  - **Eligibility requirements**
  - **Enrollment of a new family member**
  - **Coverage continuation**
  - **ID card requests**

- **Network**
  - **How the program works**
  - **How to access care through a PCP**
  - **In- and out-of-network care and benefits**
  - **Provider directory requests**
  - **PCP changes**

- **Patient management**
  - **Precertification**
  - **Referrals**

- **Requests for member information and plan materials**
  - **Replacement of ID cards**
  - **EOBs**
  - **Benefit booklets**
  - **Provider network directories**

Customer Service representatives have real time access to subject matter experts for complex issues and to act on a member's behalf. For example, they have immediate access to support for appeals, case management and precertification. We also give them the guidance and power to make claims decisions in certain situations to better service members.

To meet the needs of the deaf or hard of hearing, the teletypewriter (TTY) feature enables our CSRs to communicate with those members through written communication over telephone lines.

To support foreign language calls, CSRs have access to Voiance Language Services, which offers translation services in over 200 different languages, enabling the CSR to conduct a telephone conversation in practically any language.

<u>Online support</u>

Members may also use our member website to obtain around-the-clock member self-service. Enrolled members can register for a secured, personalized view of their benefits to:

- **Send a written inquiry to Member Services.**
- **Access DocFind, our online provider directory**
- **See integrated claims and plan balances in one view**
- **Look up and change provider selections**
- **Receive personalized health and benefits information**
- **Request member medical ID cards**
- **Review eligibility**
- **View claim status and sort and download claims**
- **View EOBs**
- **Access our Hospital Comparison Tool**

<u>Goals</u>

Here are our goals for answering speed, telephone service factor and call abandonment:

- **Average speed of answer: 30 seconds**

  We define average speed of answer as the amount of time that elapses between the time we receive a call into the telephone system and the time a customer service representative (CSR) responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. We do not include Interactive Voice Response (IVR) system calls in the measurement. In the event there is an outage or when experiencing peak volumes, calls may be transferred to our other call centers.

- **Telephone service factor: 75 percent of all calls answered within 30 seconds**

  Telephone service factor measures the speed in which a CSR answers a call after it has been placed in queue by the auto attendant. This does not include the time the caller spent navigating through any auto attendant menus.

Total service factor includes total calls (answered and abandoned) that are offered to CSR. We do not include IVR system calls in the measurement. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. • **Call abandonment: less than 2.5 percent** **The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the phone skill. In the event there is an outage or when experiencing peak volumes, calls may be transferred to our other call centers.**	
3.A.25 Describe your processes for preventing duplicate payments for the same date of service. **Our claims system automatically identifies duplicate data entries and duplicate claims. It screens against the service date, the type of service, the provider and procedure code. We have set the procedure code screen to scan against the full five digits.** **When the system suspects a possible duplicate, it presents information to the processor, including but not limited to:** • **Provider tax ID number** • **Provider name** • **Full procedure code** • **Type of service** • **Service date** • **Amount charged** • **Amount covered (with explanation for any non-covered amount)** • **Processing activity (paid, denied or pended)** **If desired, the processor can pull up additional information, such as benefit assignment and the provider's address.** **A claim will auto-adjudicate and deny as an exact duplicate claim when it meets specific duplicate claim criteria.**	5 points
3.A.26 Describe in detail your workflow for handling the following: • The evaluation and release of pended claims, including the classification of staff assigned to the process. • Explain how your company will follow-up for subsequent information once a claim is pended. • Explain how your company will prevent duplication of requests to the same individual for the same requested information but for different claims. **We have instituted a strategic initiative, First Claim Resolution®. First Claim Resolution means that wherever possible, we rapidly resolve a claim from the first time it is submitted, avoiding the rework, delays and customer dissatisfaction associated with multiple submissions. The objectives of First Claim Resolution to process claims accurately the first time, improve customer satisfaction through improved service delivery and focus resources on regional and national capabilities to support First Claim Resolution.**	5 points

For claims that are missing information (for example, accident details, diagnosis or other coverage payment information) after reviewing all available information included with the claim submission, processors will pend the claim and send the member an EOB and the provider an EOP, acknowledging receipt of the claim explaining the reason for the delay and requesting the necessary information.

We also pend claims in the following situations:

- **Non-standard or questionable claims**
- **Claims involving coordination of benefits, such as motor vehicle accidents**

We can pay, pend or deny individual expenses within the same transaction.

Once the missing information is returned, we reopen the claim to complete processing. We only pend the expense in question.

To identify and resolve aged claims, our claims system automatically produces a daily report of internally pended claims. Supervisors use this report to monitor the progress of pend situations.

Members can obtain claim status information at any time by calling member services or by accessing our secure member website, at aetnanavigator.com.

We don't provide reports showing the number or status of pending claims.

Our claims process is designed to minimize waste — in both effort and cost — while promoting accuracy. Our built-in features cover every aspect of the claims process, from intake and simple approvals to catching duplicates to fraud prevention. The overall process helps us minimize resources, reduce administrative costs and cut medical spending.

<u>Coordinating benefits with multiple health plans</u>

Before we can even look at a claim for payment, we make sure it's our claim to pay. The Coordination of Benefits (COB) provision places an order on which health plan is responsible for a claim. It ensures that no one is paid twice for the same claim.

When we compare how much we would have paid without COB against how much we paid after COB, we saved:

- **2016 PPO-based and indemnity products**
    - **1.95 percent when coordinated with other commercial plans**
    - **7.73 percent when coordinated with Medicare plans**

<u>Looking for mistakes, duplicates and waste</u>

We use a customized version of Change Healthcare's ClaimsXten™ software that helps us automate claims review, payment, and cut duplicate and incorrectly coded claims. Our "smart edits" evaluate in excess of 200,000 possible areas of concern. For example, a doctor might evaluate a patient before and after surgery, which can occur on different dates. The system recognizes these claims as belonging to the same health event and pays them accordingly.

In addition, our automated claim review recommends the correct procedure coding and checks to see if an assistant surgeon, co-surgeon or team surgeon was necessary for a procedure based on recognized and accepted medical practices.

Detecting and preventing fraud and abuse **When we suspect fraud and abuse, we create a case and assign an SIU investigator. When the investigator has enough evidence to allege that it is indeed fraud and abuse, we place a flag on the provider's file. This triggers an edit that alerts the claim processor to the investigation. Only our SIU can place and remove fraud flags in our system.** **If we've already made a payment that we later learn to be either incorrect billing or outright fraudulent, our SIU investigators work directly with the providers to recover the money.** **The New York State Insurance Frauds Bureau referred to our special investigation unit (SIU) as "the gold standard for SIUs." The unit recovered approximately $11.2 million in fraud payments in 2017 alone. But it's much more than that. The specialists in our SIU also work hard to stop fraud and abuse in its tracks before payment is made. In 2017, their efforts helped us catch more than $346 million in incorrect or fraudulent billing before the payment was made. These are actual figures, not forecasted or assumed amounts.**	
3.A.27 Describe in detail your remittance advice/explanation of benefits process for self-insured plans including delivery method. **We mail member EOBs for the same family, in the same envelope, whenever possible. We mail the EOBs on a consistent day of the week based on the state of residence of the member. We use an every 21-day mailing schedule; however, we may send EOBs out at 7 days or 14 days to comply with any state regulations. EOBs will go out daily, and not age, when there is a member payment or request for additional information from the member. We produce these member EOBs in Erlanger, KY by an off-site print vendor.** **Our claims system will suppress paper EOB production in the following situations:** • **Benefits are assigned and member's liability is zero** • **Benefits are assigned and member's liability consists of a copayment only** **Members can also view all EOBs on our secure member website at aetnanavigator.com, even if the member's liability is zero or copayment only.** **Members can elect to suppress paper EOBs and receive electronic EOBs only. Members that elect paper suppression and/or supply a valid email address on our member website will receive an email notification to their valid email address regarding the availability of the EOB transaction.** **We age and bulk, on a schedule, provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses. We produce these provider EOBs in Bridgeton, MO by an off-site print vendor.**	5 points
3.A.28 Describe your workflow for coordinating a request for a transplant. **The member's PCP or treating specialist doctor starts the member participation process in the National Medical Excellence Program®. The member's doctor must call our unit and pre-authorize the initial transplant evaluation and any subsequent transplant-related service. This allows our transplant case managers, who are registered nurses, to gather all case-specific information. It also begins early interaction to coordinate the member's care with a participating facility that is appropriate for the member's needs.**	5 points

Once we accept a member into the program, we:

- **Assign a nurse transplant manager to provide support**
- **Coordinate care**
- **Act as a member advocate during the member's time of medical crisis**

A full-time medical director oversees all reviews performed by the transplant case manager and personally reviews all questionable cases and potential denials. The transplant case manager develops a plan of care; then works with the member, the family, the attending doctor, the specialist and the facility to coordinate access through doctors who have admitting privileges. This process maximizes the benefits available through their medical plan.

Our transplant case managers direct members to the closest Institutes of Excellence™ (IOE) facility contracted for their specific transplant type. However, members may use any IOE facility contracted for their transplant type to receive in-network benefit levels.

Members also have the option to select a non-contracted or out-of-network facility for their transplant type. However, if they choose to use a facility not in our network, the care is subject to the plan's transplant coverage for out-of-network providers. In addition, there is no allowance for transportation or lodging for out-of-network facilities.

3.B Provider Relations

3.B.1 Describe your company's plan and strategies for monitoring network access throughout the life of the contract, including your plan for taking action with Providers who are determined to be out of compliance.

5 points

Our network strategy is focused on national improvement in our provider discounts, enhancement of our high performance networks and the development of more strategic partnerships with providers that drive delivery system reform (e.g., patient-centered medical homes (PCMHs) and accountable care organizations (ACOs)).

We continue to focus significant resources on the improvement of our hospital, physician and ancillary provider contracts. Some strategies for the near term and beyond include:

- **Aggressive unit price trend targets**
- **Coventry integration, which will continue to improve our discount position nationally**
- **Use centralized national contracting and external consultant resources, supplemented by local market resources as needed, to improve our discount position in targeted markets**
- **Use our ACO strategy to partner with targeted health care delivery systems to build new ACO product offerings which may offer an incremental discount improvement**
- **Focus on the continued expansion of value-based payment models will shift an increasing amount of total spend away from fee-for-service (FFS) to performance based reimbursement, lowering unit price trends and improving discounts**
- **Detailed governance process to continuously monitor discounts and find opportunities to improve**

Providers who are out of compliance **Nationwide, we have terminated less than one percent of network physicians and hospitals due to quality of care concerns, including over and under utilization. One of our organizational strengths has been the ability to develop stable networks through a comprehensive contracting and quality management strategy, as well as by building relationships with providers that promote a positive impact on member care and enhance customer satisfaction.** **When we identify a potential quality of care concern, our regional quality management staff thoroughly investigates the concern and, through the peer review process, brings each case to resolution. If an audit confirms a quality of care concern, we notify the physician in accordance with our peer review process. This may include a request for a corrective action plan or we may terminate that physician's contract. We do not collect aggregate data on the percentage of providers reviewed during these processes or track aggregate results.** **Examples of implemented actions have included medical record reviews/audits, office site visits and termination of participation.**	

3.B.2 Describe your process for maintaining coverage policies, including implementing new policies and updating and/or terminating existing policies. Describe your process in detail for educating both the Provider and Member network. **We will provide EBD with booklet materials and/or amendments to the booklet materials for distribution to the employees. The standard delivery method is a .pdf document through email. We do not produce Summary of Material Modifications (SMMs).** **If there are plan changes in covered services or benefits, we will provide EBD with revised booklet materials and/or amendments to the booklet materials for distribution to the employees upon completion of plan set-up within the standard timelines.** **Our Provider Contact Centers are composed of provider call center staff, which handle all provider inquiries, including contract questions.** **Members can call the Tampa service center by dialing the toll-free number located on the back of the ID card for contract questions. We also distribute information to providers in additional ways. Available on our secure provider website, our Health Care Professional Toolkit provides a comprehensive office manual and reference guide for working with us, including a thorough overview of our policies and procedures. We regularly communicate with providers and their office staff with Aetna OfficeLink updates, our provider newsletter. When a significant change in benefits, policies or procedures occurs, we typically mail a letter of explanation to physician offices, usually 90 days in advance of the effective date.**	5 points
3.B.3 Describe your workflow for determining experimental and investigational status of services. **Our precertification unit reviews requests for experimental and investigational services that are included on our Participating Provider Precertification List.** **We use evidence-based clinical guidelines from nationally recognized authorities along with the terms of the member's benefits plan during the coverage determination process. Medical management staff consults guidelines from the following sources:**	5 points

• **Aetna Clinical Policy Bulletins (CPBs)** • **Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual** • **MCG Health, LLC® (formerly Milliman Care Guidelines®)** • **National Comprehensive Cancer Network (NCCN) guidelines** • **American Society of Addiction Medicine Criteria: Treatment for Addictive, Substance-Related, and Co-Occuring Conditions (ASAM Third Edition), (Chevy Chase, MD: American Society of Addiction Medicine)** • **Aetna Level of Care Assessment Tool (LOCAT©) for mental health admissions** • **Applied Behavior Analysis (ABA) guidelines for the treatment of autism spectrum disorders** **Our medical director can only make denials of a service/procedure based upon medical necessity. We notify the member's providers of all denial determinations in writing. More stringent state requirements may supersede our requirements. The estimated cost of the procedures or a list of alternative treatments is not included.** **For any conditions not on our list, the precertification staff informs the caller that the procedure code requested does not require precertification. Our staff also states that this is not a guarantee of coverage for the type of procedure or service requested. Members and/or providers should contact Member and/or Provider Services, using the number on the member's ID card for any questions about coverage and benefits. They can also request a pre-determination review through Member Services and/or Provider Services.** **We review claims with rare illnesses or treatment plans, as well as those using new technologies or experimental procedures to correctly apply benefits. We regularly update our online reference materials to alert processors to new treatments and technologies. Medical consultants assist in determining benefits on specific claims as needed.**	
3.B.4 Describe your process for reviewing and authorizing all Network Provider contracts. **We maintain data on all contracted providers, and all nonparticipating providers who have filed a claim with the health plan, in our Enterprise Provider Database (EPDB). Our single source for all provider data, the EPDB also holds provider credentialing information and supplies provider demographic and business information to a variety of internal information systems, including our claims systems. We developed the EPDB internally.** **EPDB data is continually updated with new provider information and to align with corporate direction and federal, state and accrediting mandates. Our ongoing EPDB enhancements align with Aetna initiatives and industry developments. We continually monitor and audit EPDB data with established metrics that meet internal and industry standards.** **We perform network contract audits for new contracts and upon contract renewal or modification.**	5 points
3.B.5 Describe your company's plan for ensuring Network Providers are licensed, credentialed, and eligible to render services under applicable federal and state laws, rules, and regulations. **Our Credentialing unit manages the end-to-end credentialing process and ongoing license/sanction monitoring for all participating and nonparticipating providers.**	5 points

	Our credentialing staff is responsible for making sure all provider information is verified and accurately recorded/maintained in order to facilitate member access and minimize corporate risk. **The credentialing staff is composed of analysts, consultants and managers whose scope and mission is to review, evaluate and validate provider data and support extensive research for state, federal and other regulatory compliance. The essential functions include:** • **Evaluation of provider compliance with contract and business requirements** • **Primary source verification of provider data** • **Enhanced data gathering and research on sensitive and complex provider issues** • **Internal and external credentialing training to support credentialing policies and processes** • **Identify and communicate trends, monitor processes and outcomes** • **Research and analysis of state, federal and regulatory compliance** • **Ongoing monitoring of state medical board sanctions, loss of license actions and Office of Inspector General (OIG)/Office of Personnel Management (OPM) reports** **A network medical director or designee supports the exception to maintain compliance with our business participation criteria for the applicable provider type. Our medical directors are physicians who are board certified in a variety of clinical specialties, with significant experience in private medical practice. Qualifications include significant leadership experience in managed care and demonstrated accomplishments in medical care delivery systems, utilization management, quality assurance and peer review.** **The final step in the credentialing and recredentialing process is file review by the regional Credentialing and Performance Committees (CPCs) for professional competence and conduct. Our CPCs are comprised of licensed participating practitioners and meet at least every 45 days.** **More information on our extensive credentialing process is available on our website at www.aetna.com.**	
3.B.6	Describe your process for enrolling currently credentialed Providers in to your Plan during the implementation period. **With more than 650,000 physicians and 5,600 hospitals in our networks, we have one of the largest, fully integrated networks in the country.** **Generally, once we receive all required documentation for credentialing, it takes:** • **120 days minimum to add a physician to our network** • **6 to 9 months to add a community hospital to our network** • **12 months to add an academic hospital to our network** • **120 to 180 days to add a medical group to our network**	5 points
3.B.7	After the initial implementation period, describe your company's plan for recruiting, credentialing, and enrolling providers. **One of our competitive advantages is our uncompromising focus on providing access to care in as many geographic locations as possible. With more than 650,000 physicians and 5,600 hospitals in our networks, we have one of the largest, fully integrated networks in the country. We base our strategy on providing our members with a comprehensive provider network through directly contracted and, depending on the health care plan, indirectly contracted providers. We are generally able to offer network access in most areas of the country. Additionally, we review individual network accessibility to see that members have appropriate access to a full complement of providers. Our inclusive network strategy allows us to offer our members, regardless of product, the most comprehensive network available.**	5 points

Nominate a provider **Members and customers are welcome to nominate a provider for our network. To nominate a provider, members may call or email Member Services and customers may contact their designated account representative. Customer service representatives and account representatives forward the provider nomination information to our Credentialing unit for eligibility and network review. We accept physicians and hospitals into the network if our quality and business criteria are met.**	
3.B.8 Describe your plan for re-credentialing and re-validating Providers, at a minimum of at least everythree (3) years and five (5) years, respectively. **All physicians are credentialed prior to contracting and recredentialed every three years, depending upon individual state requirements. Our re-credentialing turnaround times meet state and other applicable regulations.** **The re-credentialing process gathers information on:** • **The physician's background and ongoing qualifications** • **Reviewing personal conduct history** • **Malpractice history** • **Disciplinary actions** • **Loss or limitations of hospital privileges** • **Active professional liability coverage** • **State licensure** • **Experience to provide quality of care** • **Performance through member complaints** **The re-credentialing process includes but is not limited to the following criteria:** • **Formal application process** • **Primary source verification of license validating status and confirming any limitation, sanction and/or termination of license** • **Primary source verification of malpractice and disciplinary history through the National Practitioner Data Bank (NPDB)** • **Primary source verification of Drug Enforcement Agency through the National Technical Service and/or the Controlled Drug Substance Registration through state agencies to confirm the provider is authorized to distribute pharmaceuticals** • **Primary source verification of Board Certification status, where appropriate, through the American Medical Association, American Board of Medical Specialties, the American Osteopathic Association or the specialty board** • **Primary source verification of Medicare/Medicaid sanctions and/or disbarments through the NPDB and/or the Office of Inspector General and the Office of Personnel Management** • **Confirmation of active professional liability coverage (malpractice insurance)** **We require all participating physicians to successfully complete our re-credentialing process. The percentage of participating physicians recredentialed each year varies by location.**	5 points

3.B.9 Describe how you will maintain a sufficient Network for all Members to have a Primary Care Physician (PCP). In addition, please identify any processes used to identify an auto-assigned PCP. **We continuously monitor existing networks and respond appropriately by addressing membership needs. When deciding to further develop a network, we consider:** • **Geographic location** • **Membership size** • **Physician availability** **The main objectives of network development are quality of service and appropriate provider access. Our network management staff has been successful in meeting the needs of membership growth by actively seeking out quality physicians to provide services. The popularity of our plans reflects our success in developing and maintaining networks.** **We do not auto-assign PCPs.**	5 points
3.B.10 Describe your plans for Provider relations and education. **We believe that open lines of communication and timely interaction are essential to successful long-term relationships with physicians, hospitals and other health care professionals.** **We complete an orientation for new physicians and hospitals joining the network.** **This orientation covers descriptions of:** • **Plan benefits** • **Office administration** • **Referral procedures** • **Patient management** • **Capitated programs** • **Direct access programs** • **Other special programs** **Once in the network, physicians have access to a variety of resources that continuously provide education, assistance and help with problem solving.** **<u>Provider Contact Centers</u>** **Each provider has direct access to our Provider Contact Centers and customer service representatives who are dedicated to their geographic area. Our customer service representative will assist with:** • **Verifying eligibility** • **Utilization review procedures** • **Billing** • **Quality improvement responsibilities** • **Benefits** • **Claims** • **Referral information** • **General problem solving**	5 points

Websites and phone

Our websites and automated phone system help providers get information and contact us. These include:

- **Aetna Voice Advantage®, our automated voice system, and our website, www.aetna.com**
- **Our secure provider website which allows providers to complete real-time transactions and get information on our latest policies and procedures, as well as take continuing medical education courses**

Office guides and newsletter

Our *Health Care Professional Toolkit*, a comprehensive office manual and reference guide, presents providers and their staffs with a thorough overview of our policies, programs, products and procedures along with other essential information. We communicate with providers regularly via our provider newsletter, *Aetna OfficeLink Updates*™. When a significant change in benefits, policies or procedures occurs, we typically mail a letter of explanation to physician offices, usually 90 days in advance of the effective date.

Physician Advisory Board

We work with our participating physicians, their office staffs, hospitals and other providers to simplify administration through meaningful communications and focused education.

3.B.11 Describe your plan for training, deploying, and monitoring Provider relations representatives to visit offices and act as a point of contact for the provider.

5 points

Provider relations staff and training

Provider Contact Center Staff

Our Provider Contact Centers are composed of provider call center staff, which handle all provider inquiries, including contract questions.

We require provider call center staff to have a high school education or GED equivalent. We prefer experience in a production environment and/or customer service experiences in a transaction-based environment, such as a call center or retail location.

Provider call center trainees receive an intense and detailed four-month customer service training experience.

Our training programs begin with benefits and eligibility determinations for a period of six weeks. This training includes:

- **Learning our products and systems**
- **Interpretation of the benefits offered**
- **Determining eligibility of covered employees**

Employees will begin to take live calls for two-weeks, solidifying their new knowledge. Once an employee has demonstrated proficiency and a strong understanding of the benefits and eligibility workflow, they will begin claims theory training. Claim theory training lasts seven weeks and consists of:

- **Learning provider contacts and claim status**
- **Determining claim process outcomes based upon provider contracts, policy and member benefits**
- **Reviewing hands on examples of various claims scenarios**

At the end of claims theory training, all employees remain in a two-week soft landing period in which they are taking live calls, putting their knowledge to use while gaining experience in a training environment that provides opportunity for further clarification and learning.

A variety of resources and ongoing trainings are also available for current employees. Call coaches and team leads are available during the day for immediate assistance. Our Learning and Performance department releases a weekly communication that includes a link to the repository, which houses all policy or procedure changes, newly released trainings, network communications and more. Each week, the staff also participates in training for review of new data and training courses. As trends are noted, the operations staff will request assistance from the Learning and Performance department to develop new and/or reminder instructions (e.g.; communications, formal training) based on the needs identified. Communication and training is an ongoing process.

Network Management

As a primary provider relations resource, our network representatives provide the following services:

- **Develop, maintain and enhance relationships with the physician/provider network**
- **Answer questions**
- **Provide information to providers and office staff regarding our plans and policies**

Network representatives are required to have a bachelor's degree with provider relations and/or managed care experience, plus training in chart review/auditing.

We typically hire provider relations staff from within the company. These employees have some degree of knowledge and experience relating to health care insurance and often network operations.

Training emphasizes knowledge and skill gap assessment and corresponding remedial and supplementary training to fill specific gaps. New hire on boarding plans cover the full range of tasks, training and activities to flexibly guide new provider relations staff through orientation and training. The on boarding plans reference specific time frames for performing the various training and activities. For example, certain tasks and training are recommended for the first days after beginning a new position such as the first week or the first six weeks.

Employees access online training, performance tools and other reference material through the Network Learning Wheel, which is located on an Aetna intranet site dedicated to network staff learning. Each segment of the wheel (contracting, products and programs, systems, and reference tools) displays a list of learning resources specific to the selected category. The on boarding plan recommends when an employee accesses each resource on the wheel.

We schedule classroom training sessions on an as-needed basis.

Routine visits

We do not conduct personal interviews as a requirement for credentialing. However, our provider relations staff visits participating high volume physicians at least twice a year, and other physicians as needed. The frequency varies by market. Our network account managers (NAMs) visit primary care, specialists and other physicians as dictated by requests from physician offices, input from our Provider Contact Centers or as determined by the local market education plan.

During these visits, NAMs update the physician or health care professional on any changes to policy that have occurred since their last visit. This includes referral and claims management policy, member/plan-related information, problem resolution and procedural updates.

Based on the information obtained from office contact and our Provider Contact Center interaction, NAMs re-educate office staff and physicians to improve both physician and member understanding of policies, procedures and programs. If we identify a deficiency, a network representative will work with the office staff to make improvements. For example, if an office is below average regarding appointment wait time, the network representative will work with the office to help identify the cause(s) and offer suggestions for improvement.

Office assessments

We make office site visits to network practitioners if a member complaint is received regarding physical accessibility (including handicapped access), physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered. An office site visit consists of a structured, documented review of a practitioner's office to evaluate the complaint, determine compliance with selected Aetna business participation criteria and Aetna medical record-keeping practice policies, and assess appointment availability. This policy is in accordance with both National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) standards.

3.B.12 Describe your current participation in and plans for participating/educating Providers about value- based programs, e.g. Patient Centered Medical Home; CPC+, etc.

5 points

We are collaborating with health systems and provider offices across the country to create strategic and meaningful relationships. We manage a full range of value-based payment models that include joint ventures, ACOs, patient-centered medical home (PCMH), pay-for-performance and bundled payment models.

We have developed an aggressive roadmap to increase value-based models in our contracts and are working systematically to achieve our goals. Our target for 2018 is to have 60 percent of claim spend going to value-based care, with the expectation that VBC spend will hit 64 percent in 2019. We are committed to having 75 percent of all medical spend in VBC arrangements by 2020.

We are working to drive the degree of change that is necessary, where entire health systems collaborate and innovate, resulting in a higher quality of care and increased patient satisfaction at a lower cost.

Every month we offer live webinars to our network providers and their staff. These live webinars offer the opportunity to ask questions. We encourage our providers and their staff to sign up for our webinars to learn how to use our self-service tools and to work efficiently and effectively with us. For more information and to register go to: aetnawebinars.com We cover how to contact us and identify our products, and we discuss most of the tools and transactions available on our secure provider website.

3.B.13 Describe your process for developing, distributing, updating, and re-distributing the Provider Manual.

5 points

We don't have a provider manual. However, once in the network, physicians have access to a variety of resources that continuously provide education, assistance and help with problem solving. This included the provider contact center,

Provider Contact Centers

Each provider has direct access to our Provider Contact Centers and customer service representatives who are dedicated to their geographic area. Our customer service representative will assist with:

- **Verifying eligibility**
- **Utilization review procedures**
- **Billing**
- **Quality improvement responsibilities**
- **Benefits**
- **Claims**
- **Referral information**
- **General problem solving**

We locate our network account managers (NAMs) in the local markets. They can provide service over the phone or in person, depending on the size of the practice.

Another component of our provider relations organization is our team of medical directors, who are board certified in a variety of clinical specialties, with significant experience in the private practice of medicine. Qualifications include significant leadership experience in managed care and demonstrated accomplishments in:

- **Medical care delivery systems**
- **Utilization management**
- **Quality assurance**
- **Peer review**

These individuals direct and support the administration of our network, while maintaining effective communications with our highly diversified organization. Medical directors may informally communicate clinical policy (practice guidelines) to network providers about care that may be controversial or uncertain in nature.

With our streamlined provider services model, we provide education to our internal employees to enhance their capability to meet the needs of physicians, hospitals and other health care professionals.

Websites and phone

Our websites and automated phone system help providers get information and contact us. These include:

- **Aetna Voice Advantage®, our automated voice system, and our website, www.aetna.com**

- **Our secure provider website which allows providers to complete real-time transactions and get information on our latest policies and procedures, as well as take continuing medical education courses**

Office guides and newsletter **Our *Health Care Professional Toolkit*, a comprehensive office manual and reference guide, presents providers and their staffs with a thorough overview of our policies, programs, products and procedures along with other essential information. We communicate with providers regularly via our provider newsletter, *Aetna OfficeLink Updates*™. When a significant change in benefits, policies or procedures occurs, we typically mail a letter of explanation to physician offices, usually 90 days in advance of the effective date.** **Physician Advisory Board** **We work with our participating physicians, their office staffs, hospitals and other providers to simplify administration through meaningful communications and focused education. In addition, we have established a Physician Advisory Board to provide advice on issues of importance to physicians and make recommendations as appropriate regarding our business practices. We are also meeting with medical societies across the country.**	
3.B.14 Describe how you will ensure your Network is responsive to all linguistic and cultural needs of minority or disabled Members. **We educate both participating and nonparticipating providers about our health plans and offer them real-time member eligibility verification for a specific customer's plan through our secure provider website. We also offer eligibility verification through Aetna EDI Connect℠ at www.AetnaEDI.com and our electronic data interchange (EDI) vendors. We complete an orientation for new physicians and hospitals joining the network. This includes education on EBD's population and needs.** **Customer service representatives at our toll-free provider service centers educate providers about customer-specific plan designs. They have access to current customer information in our Aetna Source Systems and they can provide information and guidance on many issues, including:** • **Verifying eligibility** • **Utilization review procedures** • **Billing** • **Quality improvement responsibilities** • **Benefits** • **Claims** • **Referral information** • **General problem solving** **In the local markets, our network account managers (NAMs) offer further education and service over the phone or in person, depending on the size of the practice.** **We also distribute information to providers in additional ways. Available on our secure provider website, our Health Care Professional Toolkit provides a comprehensive office manual and reference guide for working with us, including a thorough overview of our policies and procedures. We regularly communicate with providers and their office staff with Aetna OfficeLink Updates, our provider newsletter. When a significant change in benefits, policies or procedures occurs, we typically mail a letter of explanation to physician offices, usually 90 days in advance of the effective date.** **We work with our participating physicians, their office staffs, hospitals and other providers to simplify administration through meaningful communications and focused education. In addition, we have established a Physician Advisory Board to provide advice on issues of importance to physicians and make recommendations as appropriate regarding our business practices.**	5 points

Customer input **We welcome customer and member communication. There are no restrictions in our provider contracts that preclude providers from communicating directly with customers, provided they do not disclose patient-specific confidential information.** **We include customer input in our communications to providers to help promote quality of care. We also encourage open communication between providers and our** **We do not currently offer cultural competency training to providers.**	
3.B.15 Describe your reimbursement method for the below services. a. Inpatient hospital facility medical/surgical admission b. Inpatient hospital facility maternity admission c. Outpatient hospital facility emergency room d. Outpatient hospital facility surgery e. Ambulatory surgical center f. Other outpatient hospital services g. Primary care physician h. Specialist i. Independent lab (indicate the independent lab organization utilized in Arkansas) **a-e)** **Hospitals** **We have a variety of financial arrangements with hospitals. Reimbursement structures may include a combination of per diems, case rates, percentage of charges or other payment methodologies for services covered by the health plan. We base the majority of our negotiated hospital agreements on per diems for inpatient care and fee schedules, where appropriate, for outpatient services. In addition, there are instances (e.g., open-heart surgery and transplants) where we negotiate specific case rates. Fee structures for outpatient care include case rates, fee schedules and percentage of charge arrangements. Our standard hospital contracts provide for the lesser of the eligible billed charge or the contracted amount to be paid.** **Our goal is to negotiate rates with individual hospitals to achieve average savings of at least 30 percent compared to the cost of hospital services in the community, although specific savings levels vary by contract and market.** **f)** **Ancillary Services** **We use a variety of reimbursement arrangements to compensate ancillary providers. We typically compensate participating ancillary providers on a contracted fee-for-service basis.** **Network ancillary services include:** • **Lab** • **Durable medical equipment** • **Home health care** • **Hospice** • **Radiology**	5 points

• **Physical therapy** • **Medical transport (including air ambulance)** • **Podiatry (in most of our networks)** • **Chiropractic services (in most of our networks)** **When ancillary services such as lab work or X-rays are provided in an inpatient setting, these fees will be included in the per diem or case rate payment to a hospital.** **g-h)** **<u>Physicians</u>** **We pay physicians, including PCPs and specialists, on a negotiated fee schedule. The fee schedule compensates physicians at the lesser of their usual charge or the negotiated fee. Each of our networks has a unique fee structure. We base our fees on market factors and the federal government's Resource Based Relative Value Scale (RBRVS) methodology with adjustments made at the local level. We adjust fees geographically and they may also vary among providers in the same geographical area as determined by market considerations.** **i)** **<u>Laboratory/Radiology Services</u>** **We have a national laboratory contract with Quest Diagnostics, as well as local contracts with medical laboratories and radiology services through independent facilities and network hospitals. We also contract with clinical and specialty laboratories and radiology networks. The particular type of arrangement depends on the local environment. We typically contract each provider on a negotiated fee-for-service basis.**	
3.B.16 What is your provider turnover for both voluntary/involuntary for 2015, 2016, and 2017? **The following are the voluntary and involuntary provider turnover percentages in Arkansas for 2015-2017:** **<u>Voluntary</u>** **2015: 2.20%** **2016: 2.36%** **2017: 1.91%** **<u>Involuntary</u>** **2015: 1.63%** **2016: 2.39%** **2017: 2.01%**	5 points
3.B.17 Describe the criteria you use for determining adequate network coverage for primary/general and specialty care. **We continuously monitor existing networks and respond appropriately by addressing membership needs. When deciding to further develop a network, we consider:** • **Geographic location** • **Membership size** • **Physician availability**	5 points

The main objectives of network development are quality of service and appropriate provider access. Our dedicated network management staff has been successful in meeting the needs of membership growth by actively seeking out quality physicians to provide services. The popularity of our plans reflects our success in developing and maintaining networks.	
3.B.18 Describe your network participation with statewide ambulance service providers (land/air/water), detailing which are considered in-network, and the payment arrangements with out-of-network providers. **We cover ambulance charges considered to be an emergency at the in-network level regardless if the facility or provider is in-network.** **Our standard hospital arrangements typically reimburse outpatient emergency care according to the applicable emergency room negotiated rate. Where possible, we negotiate a case rate for emergency room care. The case rate can be one blended rate for all provided services during a member's visit, or there can be distinct case rates for varying levels of emergency care.**	5 points
3.B.19 Describe how you update and distribute network and service area information to Members, employers and providers. **For the most up-to-date network information, members, EBD, and providers can go onto DocFind, our online provider directory. EBD's account team will also communicate any significant network changes to you in a timely manner.**	5 points
3.B.20 What are your provider contracting policies regarding provisions to pay the lesser of the billed charges than the contracted rate? **We reimburse participating physicians, including PCPs and specialists, based on a fee schedule. The fee schedule compensates physicians at the lesser of their usual charge or the negotiated fee, which is a fee-for-service payment based on CPT codes or other industry standard coding.**	5 points

3.B.21 What are your provider contracting policies regarding separate fee schedules for self-insured businesses versus fully insured businesses? Explain how the separate fee schedules might differ. **Our standard provider contract provisions, including rates, generally apply equally to fully insured and self-funded plans of the same type. In many situations, state regulations may dictate payment methods. Additionally, we may pay some providers a different rate based on administrative servicing requirements.**	5 points
3.B.22 Do you have any intermediary or leased network arrangements for any facilities and/or providers referenced in your responses to this RFP? If yes, describe all associated reimbursement models. Provide a copy of the lease arrangement. If none, describe reimbursement models for directly contracted facilities and/or providers referenced in your response to this RFP. **We do not have any leased network arrangements in the Arkansas network.** **Reimbursement models** **Providers**	5 points

We reimburse participating physicians, including PCPs and specialists, based on a fee schedule. The fee schedule compensates physicians at the lesser of their usual charge or the negotiated fee, which is a fee-for-service payment based on CPT codes or other industry standard coding. **We base fees on market factors and the federal government's Resource Based Relative Value Scale (RBRVS) methodology with adjustments made at the local level. We develop fee schedules separately for each service area, and fee schedules may also vary among providers in the same geographical area as determined by market considerations.** **<u>Hospitals</u>** **We have a variety of financial arrangements with hospitals. Reimbursement structures may include a combination of per diems, case rates, percentage of charges or other payment methodologies for services covered by the health plan. Our standard hospital contracts provide for the lesser of the eligible billed charge or the contracted amount to be paid.** **Our contracting strategy focuses on negotiating contracts that remove variable cost drivers and provide appropriate reimbursement structures that are market competitive. This approach supports our overall goal of superior medical cost trends and predictability, in addition to utilization review conditions to assist our members in obtaining affordable, quality health care.**	
3.B.23 Describe your provider contracting policies that would increase provider reimbursement on a case-by-case basis. **We are actively transitioning to a number of provider payment strategies that align provider financial incentives for collaboration, clinical integration and efficiencies, and reduced health care costs. These payment methodologies, called value-based contracting, represent a shift away from the traditional payment model, which rewards providers for the volume of services they perform rather than the quality and outcomes of care. Value-based contracting now encompasses more than 40 percent of spend and is growing at an accelerating rate. We have committed to a goal of 75 percent in value-based payment arrangements by 2020.** **In value-based contracting, we work strategically with participating providers on a payment model that incrementally increases risk, with the ultimate goal of providers assuming financial responsibility for the quality and outcomes of care they provide. As a direct result of our ability to be flexible, not all value-based contracting payment models are the same. Value-based contracting models include:** • **Accountable care organizations (ACOs)** • **Patient-centered medical homes (PCMHs)** • **Pay for performance** • **Bundled payments** **In our traditional provider agreements, we most commonly reimburse providers based on negotiated fee-for-service schedules, which do not incorporate risk arrangements (i.e., risk pools, risk sharing, withholds) or put a provider at risk.**	5 points
3.B.24 Provide a blank copy of all provider/facility contracts that will be used during the life of the contract, including special programs such as: value-based programs, accountable care organization and global payment arrangements. **Please refer to *Provider Agreement.doc* and *Hospital Agreeement.doc* located in the Additional Requested Attachments section of our proposal response.**	5 points

3.C Network Coverage	
3.C.1 List in-network hospitals in Arkansas and provide a map showing the hospitals coverage area. **These have been provided in the Additional Requested Attachments section.**	5 points
3.C.2 Describe your in-network and out-of-network processes for out-of-state access. **Aetna Select plan** **An eligible spouse/dependent child living out-of-area where another of our networks is located may choose a PCP from the network in their location. For the most up-to-date information on participating providers, members can access DocFind®, our Internet provider directory. DocFind is located at www.aetnanavigator.com or www.aetna.com. Members can also request paper directories on an annual basis. The plan would be administered based on the plan design of the employee's home network. Benefits will be reimbursed at the preferred level of benefits only, and only when in-network. Treatment must be provided or coordinated through the member's PCP.** **Where there is no local network, the spouse/child can choose a PCP from the employee's home network. Should the spouse/child need to seek care, the PCP should be contacted to discuss a referral to a local provider. The plan would be administered based on the plan design of the home network.** **It is expected that covered dependents away at school will seek medical care through the student health services associated with the school, college or university. When the required care is beyond the scope of the student health services, the PCP should be contacted to review the necessity for immediate care. If the PCP determines that care cannot be delayed, the PCP selected from the home network will request referral certification for the student to obtain care locally.** **In the case of an emergency, the member may seek medical care at the nearest emergency facility. Coverage is provided for emergency services, regardless of the facility's participating status. The member will not be responsible for amounts above the plan cost share that may be billed by an out-of-network provider.** **Choice POS II plan** **We recognize that there are instances where dependents may live outside of the employee's home network. In order to receive the preferred level of reimbursement, the dependent must select a participating network provider. Dependents that live in a network service area other than the employees can select that network as their primary network and receive the preferred level of reimbursement for in-network care based on the plan design of the employee's network. Dependents who do not live in another Aetna network must return to the employee's network to receive the preferred level of benefits. For the most up-to-date information on participating providers, members can access DocFind®, our Internet provider directory, or call the toll-free number listed on their ID card. DocFind is located at www.aetnanavigator.com or www.aetna.com.** **We reimburse all covered services for routine care received out-of-network at the non-preferred benefit level.** **In the case of an emergency, the member may seek medical care at the nearest emergency facility. We provide coverage for emergency services, regardless of the facility's participating status. Some plans may hold the member harmless from balanced billed charges, while others may allow balance billing. Members should consult their plan documents to determine any out of pocket costs if care is received by an out-of-network provider.**	5 points

3.C.3	Complete Attachment L – Network Coverage a. Indicate the number of primary care physicians, specialists, and hospitals in your network that would be made available for the Plan(s). b. Complete a similar chart for: 1. Outpatient surgical centers 2. Outpatient imaging centers 3. Urgent care facilities 4. Convenience care facilities 5. Physician assistants 6. Nurse practitioners 7. Alternative care providers c. List hospitals in contiguous service areas. **Confirmed. We have completed Attachment L-Network Coverage.**	5 points
3.C.4	During the period of 2015 – 2017 list the percentage of active providers by specialty without any claims activity. **We do not track this.**	5 points

3.C.5	Describe the process for determining provider responsibility vs Member liability for failure to follow Medical Management requirements (i.e. pre-certification, prior authorization, and specialty referrals) within your provider network contracting. Describe the process for communicating this information to the network community. Describe the process for communicating this information to the Member community. Describe the process for monitoring network leakage. **Aetna Select** **Our plan designs can have varying levels of penalties for noncompliance with utilization management activities. The penalties depend on your plan design.** **Network doctors must start precertification for the member. The plan may penalize them if they fail to comply. If the PCP or a network specialist through referral by the PCP provides the care, the PCP is responsible for obtaining the precertification. Our plans don't penalize the member when the doctor fails to precertify.** **The claims system determines and applies any penalty amounts within the plan design.** **Choice POS II** **Our plan designs can have varying levels of penalties for noncompliance with utilization management activities. The penalties depend on your plan design.** **Network doctors must start precertification for the member. The plan may penalize them if they fail to comply. Our plans don't penalize the member when the doctor fails to precertify.** **When a member uses a doctor outside the network, or the member's plan does not include a network option, the member is responsible for precertification. If the member does not precertify a service, a penalty may apply to eligible charges.**	5 points

Members should check their member certificate/SPD for:

- **Services that require precertification**
- **Information about the benefit reduction that might result from not seeking precertification**

The claims system determines and applies any penalty amounts within the plan design.

Network community

To the extent required by the member's plan, our standard contract language requires participating physicians to refer members only to participating providers.

In addition, we contractually instruct physicians to refer members with out-of-network benefits to participating providers to the fullest extent possible.

Our standard contractual arrangements designate physicians and hospitals as independent contractors, who are solely responsible for their actions. These parties contractually acknowledge that all member care and related decisions are the responsibility of the physician or of the hospital and its medical staff, as applicable. They also acknowledge that our policies do not dictate or control their clinical decisions with respect to member care.

Member community

Once benefits have been finalized, we electronically send the documents to you. If requested and for an additional cost, documents can be printed and bulk shipped to you for distribution to employees.

Network leakage

We encourage participating physicians to use participating providers (i.e. specialists, labs, hospitals); however, our patient management department may authorize treatment from an out-of-network provider if the treatment and/or services are not available in network or if the services received are for a transition-of-care period. If a participating PCP refers a member to a nonparticipating provider and receives authorization for that provider, the member receives coverage at the in-network benefit level.

If there is no authorization, we cover services in accordance with the health plan's out-of-network benefit level, if applicable. If there is no authorization and the plan does not have an out-of-network benefit level, there is no coverage. Members are responsible for determining the participating status of providers.

A participating provider can obtain out-of-network authorization by contacting our patient management area on behalf of the member. If the plan design includes out-of-network benefits and the member self-refers to an out-of-network provider, the member is responsible for obtaining authorization for coverage at the in-network benefit level.

Alternatively, if a physician suggests a nonparticipating provider, the member may work with their physician to identify a participating provider. Members can determine whether a provider participates in our network or locate a participating provider by accessing DocFind®, our online provider directory at www.aetna.com, or by calling member services.

Members receive the in-network benefit level when they access participating providers in accordance with their plan design, which may require obtaining a referral.

Compliance

Our network management staff monitors provider compliance with contractual requirements. When necessary, our staff may either directly educate the provider or provide supplemental educational materials. If we find a provider to be materially noncompliant with the administrative terms of the provider contract, such as inappropriate balance bill.

3.C.6 Describe your wrap-around provider contracts that allow discounts for out-of-network benefits. Detail under what conditions the use of these providers would be treated as in-network.

5 points

Our National Advantage™ Program (NAP) offers access to contracted rates for out-of-network services and case-specific rate negotiation with out-of-network providers. NAP also offers reasonable charge allowance review for eligible inpatient and outpatient facility claims through the Facility Charge Review program where NAP contracted rates are not available. NAP also offers Itemized Bill Review for certain large facility claims.

National Advantage Program

Through several national third-party vendors, NAP offers access to contracted rates for out-of-network claims. These contracted rates can produce average savings, before our NAP fees, of approximately 30 to 35 percent of charges at participating hospitals, facilities and for many physicians' services.

In addition to these third-party vendors, NAP also includes access to significant number of directly contracted rates which can apply for indemnity plan members located in directly contracted network areas. These directly contracted rates can also apply for narrow network plans, for those providers that are in Aetna's broad network, but that are not in the narrow network that applies for a specific plan.

If a medically necessary service is not available in network or through a third-party vendor, we attempt to negotiate a discount for eligible claims if EBD's plan includes NAP.

Under NAP, we share savings with members, as coinsurance and deductibles are based on actual contracted rates. The fee to EBD for access to NAP (including ad hoc negotiations) is a percentage of savings. We charge a fee when we take a discount and achieve savings.

As a component of NAP, our Single Case Contracting unit (SCCU) negotiates with nonparticipating providers for a specific service on a prospective or concurrent basis. We refer cases to SCCU at the time of the precertification request by our regional Patient Management departments. Cases must meet the following SCCU criteria in order to qualify for negotiation:

- **The cost of care will equal or exceed $750.00.**
- **Aetna is the primary payer.**
- **Provider must be nonparticipating or without a contracted rate for the service**
- **EBD must be enrolled in NAP for self-funded plans**

Additionally, we will attempt to negotiate ad hoc discounts with non-NAP network providers for certain claims after the claim is submitted for payment. These negotiations will be done either through our Global Claim Services department or, for eligible claims below a defined threshold, a third-party vendor. Claims must be from a provider who is nonparticipating or who does not have a contracted rate for the provided service.

The following claim situations may not be eligible for NAP: • **Claims involving Medicare when we are the secondary payer** • **Claims involving coordination of benefits (COB) when we are the secondary payer** • **Claims that have already been paid directly by the member** **There could also be other situations where a NAP discount may not apply.** **A listing of participating NAP hospitals, facilities and physicians can be found on DocFind®, our online provider directory.**	
3.C.7 Describe the advantages of your company's provider network regarding pricing and Member access within Arkansas and nationwide. **With more than 650,000 physicians in our national network and over 9,600 physician in Arkansas , we have one of the largest, fully integrated networks in the country. We drive competitive discounts and overall network costs and quality through many innovative initiatives, including provider transparency and steering consumers to the right physicians and care with strong results. Our network initiatives produce savings that go well beyond discount improvements.** **<u>Transparency</u>** **We introduced price transparency in 2005, well ahead of our competitors. Our transparency initiatives are an integral part of our overall strategy to lower health care costs while preserving quality. We educate both members and providers that there are more cost-effective, high-quality options available and help by:** • **Building networks of high-performing, high-efficiency providers** • **Leading members to those providers** • **Giving members the tools to check prices and quality before they receive care** • **Showing physicians alternative facilities where the same outpatient tests and procedures can be done at lower rates** **Our premier transparency tool is the Member Payment Estimator (MPE), which allows members to estimate out-of-pocket costs for over 700 services. The tool allows members to compare costs for up to ten providers or facilities at a time and provides real-time estimates based on the member's actual plan design, our provider contracts and claims adjustment system. It also factors in all applicable deductibles, coinsurance, copayments and plan limits. To highlight the cost savings of getting care within the network, the tool also lets members compare costs between a network and out-of-network physician.** **MPE provides average member savings of $612 on allowed expenses and $170 on out-of-pocket costs.**	5 points
3.C.8 When coordinating benefits among other Payers, describe your policy for determining both co-insurance/patient responsibility when a fee schedule exceeds this contract's allowable rates. **Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.**	5 points

COB administration

Our COB administration starts with the collection and maintenance of accurate information about other coverage. We have a variety of methods for gathering the information including:

- **During enrollment, many of our customers collect information about other coverage and share it with us.**
- **During the precertification process, our nurses ask about other coverage.**
- **Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.**
- **In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.**
- **Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature on our secure member website, at aetnanavigator.com.**
- **As required by law, we exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.**
- **In addition, we participate in COB Smart. COB Smart is a registry of member coverage information. It helps plans and providers correctly identify members who have more than one plan. It helps with order of benefits determination (OBD) when members have more than one plan. All information sent to the registry is protected and secure.**

<u>COB screening</u>

We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

We consider the following as potential indicators of other coverage:

- **Hospital bills submitted as paid**
- **Large physician bills submitted as paid**
- **Photocopied bills**
- **Hospital bills or large physician bills submitted late**
- **Indication of other party payment on the bill**
- **Auto accidents (potential no-fault insurance)**
- **Workers' compensation**

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we auto deny the claim.

<u>Other coverage information</u>

When we receive other coverage information, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary.

	The notice includes: • **Details about the other coverage** • **Family members the other plan covers** • **Carrier** • **Type of coverage (for example, medical only or medical-dental)** • **Date of the last update** **If we are secondary and the primary carrier's EOB is not attached to the claim, the claim is pended for receipt of the primary carrier's EOB.** **Upon receipt of the primary carrier's EOB, claims are processed as follows:** • **For maintenance of benefits (MOB) or non-duplication plans, the COB allowance is our negotiated rate reduced by copays, coinsurance or other applicable plan provisions.** • **For plans utilizing standard 100% allowable, the COB allowance expense varies based on the 100% allowable model chosen.** **Once we determine the allowable expense, we subtract the primary carrier's payment from it and pay the balance, if any, as long as the balance does not exceed our normal benefit.** **Our COB procedure is the same for both in-network and out-of-network.**	
3.C.9	What is your policy for allowing in-network providers to balance bill Members? **Network providers contractually agree to hold members harmless. We prohibit them from balance billing for covered services.** **Our standard provider contracts contain hold harmless provisions that do not allow providers to seek reimbursement from our members for covered services outside of applicable copayments, coinsurance or deductibles, in accordance with the plan design. This includes, but is not limited to, in the event of payment failure, delay, denial or reduction by us, Aetna insolvency, provider insolvency, or breach of the provider contract.** **Our standard provider contracts state that the medical provider may bill the member only in the following circumstances.** • **Applicable copayments, coinsurance or deductibles were not collected when the covered services were rendered** • **A self-funded customer becomes insolvent or otherwise fails to pay the provider in accordance with applicable federal law or regulation, provided that the provider has first exhausted all reasonable efforts to obtain payment from the customer** • **The member's plan provides and/or we confirm that specific services are not covered, the member was advised in writing prior to the services being rendered that the specific services may not be covered services, and the member agreed in writing to pay for such services after being so advised.**	5 points

3.C.10 Per RFP item 3.12.B, should the State decide to build a proprietary network, outline the requirements for the development, implementation and maintenance. **We have the ability to create custom network arrangements for various customer network needs. We support custom networks for all types of providers, including physicians, ancillary providers and hospitals. We can exclude specific participating providers from the custom network.** **We can set up a separate benefit level for the providers in the custom network. To administer these arrangements, we create a unique system identifier that includes all of the providers that EBD designates as part of their network.** **We can administer specific contracted rates for providers, if required, within the custom network. We load the provider data into our systems, as well as any specific provider reimbursement/contracted rates, to facilitate auto-adjudication of claims.** **Depending on the size and complexity of the network, additional fees may apply. Our team works with EBD to understand your goals and assist in building the custom fee schedule according to your specifications.** **We'll provide resources to support EBD's custom network. This includes a designated network manager who assists in the implementation and serves as a liaison for ongoing maintenance and all questions related to the network.**	5 points
3.C.11 Provide a list of in-network facilities that do not have a DRG arrangements for all services rendered. **Our facility contracts are paid with various methodologies that include case rate/per diem, percent of billed charges with protective clauses and DRG. We have provided a full hospital listing within this proposal.**	5 points
3.C.12 Identify items that would trigger an increase/decrease on agreed upon fee schedules such as group participation/size. List triggers and related changes to the agreed upon fee schedules. **Our standard process is to load provider contracts, including rates, into our claims payment system prior to the contract effective date, which is when the provider's participation begins and the negotiated rates go into effect. We update fee schedules according to contractual or regulatory obligations. If an alternate rating system is created specifically for one contract, it is updated at the time of contract renewal.**	5 points
3.C.13 Provide an overview of your transplant network. Including information on the specific transplant types, location of facilities and transplants performed at each facility and network status of each facility. **Aetna Institutes™ facilities are publicly recognized, high quality, high value health care facilities. Our goals are to:** • **Recognize facilities with distinguished performance for health services that are critical to members.** • **Engage consumers by providing them with information to help make informed choices about facilities with distinguished performance.** • **Provide members access to high quality, cost-effective care.** **Major components of Aetna Institutes**	5 points

Institutes of Quality® (IOQ) **This is our name for health care facilities that offer clinical services to members for prevalent health conditions. IOQs include bariatric surgery, cardiac care, and orthopedic surgery.** **Institutes of Excellence™ (IOE)** **This is our name for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers nationally coordinate a member's clinical care for these cases. IOEs include transplant care, pediatric congenital heart surgery, and infertility. Transplant care includes:** - **Heart** - **Lung** - **Heart/Lung** - **Simultaneous pancreas kidney (SPK)** - **Pancreas** - **Kidney** - **Liver** - **Intestine** - **Bone marrow/stem cell** **We identify IOE and IOQ facilities in DocFind, our online provider directory. In-network and out-of-network determination can be located here. DocFind can be accessed by going to www.aetna.com or www.aetnanavigator.com.**	
3.C.14 Outline the various fee schedules your company utilizes for at risk business vs. standard ASO arrangements. **Aetna's Market Fee Schedules (AMFS) are used to compensate specialist physicians and ancillaries for services they provide to members on a fee-for-service basis. AMFS also compensates PCPs for billable services outside the primary cap. RBRVS is the basis for developing AMFS, but it does not represent the final AMFS. AMFS is considered standard and is the only schedule the Aetna system recognizes as a default schedule.**	5 points
3.C.15 Describe your company's program and processes in place to systematically evaluate participating providers for: • Cost • Utilization • Cooperation with administration • Member services satisfaction **We use CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. Quality improvement is implemented through a cross-functional team approach, as evidenced by multidisciplinary committees.** **We use quality reports to monitor, communicate and compare key quality indicators. In addition, we develop relationships with various professional entities and provider organizations and may include feedback on structure and implementation of their QM program activities or work collaboratively on quality improvement projects.**	5 points

Quality Management program scope **The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM Program includes, but is not limited to, the following:** • **Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care** • **Development of written policies and procedures reflecting current standards of clinical practice** • **Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines** • **Monitoring of medical, behavioral health, case and disease management programs** • **Achievement and maintenance of regulatory and accreditation compliance** • **Evaluation of accessibility and availability of network providers** • **Evaluation of network adequacy** • **Establishing standards for, and auditing medical record and behavioral health record documentation** • **Monitoring for over and underutilization of services (Medicare)** • **Performing credentialing and re-credentialing activities** • **Oversight of delegated activities** • **Evaluation of member and practitioner satisfaction** • **Supporting initiatives to address racial and ethnic disparities in health care** • **Following these guidelines in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost, or quality only, but never cost data alone (except in unique situations where there are not standardized measures of quality and/or there is insufficient data)** **Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual basis.** **Member services satisfaction** **We measure overall member satisfaction using our telephone-based Aetna Performance Tracking Member Satisfaction Survey. The survey is conducted continually throughout the year using a random sample of 6,300 members. Survey topics include member satisfaction with claims processing, member services and the health plan in general. The survey focuses on the following target areas:** • **Satisfaction with member services** • **Overall satisfaction with the health plan** • **Satisfaction with Aetna's network** • **Satisfaction with the EOB** • **Satisfaction with our claims process** • **Satisfaction with the enrollment process** **Our 2017 overall member satisfaction was 89 percent.**	
3.C.16 Describe your company's objectives regarding provider relations, including training, and the structure in place to support these objectives. **We believe that open lines of communication and timely interaction are essential to successful long-term relationships with physicians, hospitals and other health care professionals.**	5 points

We complete an orientation for new physicians and hospitals joining the network. This orientation covers descriptions of:

- **Plan benefits**
- **Office administration**
- **Referral procedures**
- **Patient management**
- **Capitated programs**
- **Direct access programs**
- **Other special programs**

Once in the network, physicians have access to a variety of resources that continuously provide education, assistance and help with problem solving.

Provider Contact Centers

Each provider has direct access to our Provider Contact Centers and customer service representatives who are dedicated to their geographic area. Our customer service representative will assist with:

- **Verifying eligibility**
- **Utilization review procedures**
- **Billing**
- **Quality improvement responsibilities**
- **Benefits**
- **Claims**
- **Referral information**
- **General problem solving**

We locate our network account managers (NAMs) in the local markets. They can provide service over the phone or in person, depending on the size of the practice.

Another component of our provider relations organization is our team of medical directors, who are board certified in a variety of clinical specialties, with significant experience in the private practice of medicine. Qualifications include significant leadership experience in managed care and demonstrated accomplishments in:

- **Medical care delivery systems**
- **Utilization management**
- **Quality assurance**
- **Peer review**

These individuals direct and support the administration of our network, while maintaining effective communications with our highly diversified organization. Medical directors may informally communicate clinical policy (practice guidelines) to network providers about care that may be controversial or uncertain in nature.

With our streamlined provider services model, we provide education to our internal employees to enhance their capability to meet the needs of physicians, hospitals and other health care professionals.

Websites and phone

Our websites and automated phone system help providers get information and contact us. These include:

- **Aetna Voice Advantage®, our automated voice system, and our website, www.aetna.com**
- **Our secure provider website which allows providers to complete real-time transactions and get information on our latest policies and procedures, as well as take continuing medical education courses**

Office guides and newsletter

Our *Health Care Professional Toolkit*, a comprehensive office manual and reference guide, presents providers and their staffs with a thorough overview of our policies, programs, products and procedures along with other essential information. We communicate with providers regularly via our provider newsletter, *Aetna OfficeLink Updates™*. When a significant change in benefits, policies or procedures occurs, we typically mail a letter of explanation to physician offices, usually 90 days in advance of the effective date.

Physician Advisory Board

We work with our participating physicians, their office staffs, hospitals and other providers to simplify administration through meaningful communications and focused education. In addition, we have established a Physician Advisory Board to provide advice on issues of importance to physicians and make recommendations as appropriate regarding our business practices. We are also meeting with medical societies across the country.

Staff and training

Provider Contact Center Staff

Our Provider Contact Centers are composed of provider call center staff, which handle all provider inquiries, including contract questions.

We require provider call center staff to have a high school education or GED equivalent. We prefer experience in a production environment and/or customer service experiences in a transaction-based environment, such as a call center or retail location.

Provider call center trainees receive an intense and detailed four-month customer service training experience.

Our training programs begin with benefits and eligibility determinations for a period of six weeks. This training includes:

- **Learning our products and systems**
- **Interpretation of the benefits offered**
- **Determining eligibility of covered employees**

Employees will begin to take live calls for two-weeks, solidifying their new knowledge. Once an employee has demonstrated proficiency and a strong understanding of the benefits and eligibility workflow, they will begin claims theory training. Claim theory training lasts seven weeks and consists of:

- **Learning provider contacts and claim status**
- **Determining claim process outcomes based upon provider contracts, policy and member benefits**
- **Reviewing hands on examples of various claims scenarios**

At the end of claims theory training, all employees remain in a two-week soft landing period in which they are taking live calls, putting their knowledge to use while gaining experience in a training environment that provides opportunity for further clarification and learning.

A variety of resources and ongoing trainings are also available for current employees. Call coaches and team leads are available during the day for immediate assistance. Our Learning and Performance department releases a weekly communication that includes a link to the repository, which houses all policy or procedure changes, newly released trainings, network communications and more. Each week, the staff also participates in training for review of new data and training courses. As trends are noted, the operations staff will request assistance from the Learning and Performance department to develop new and/or reminder instructions (e.g.; communications, formal training) based on the needs identified. Communication and training is an ongoing process.

<u>Network Management</u>

As a primary provider relations resource, our network representatives provide the following services:

- **Develop, maintain and enhance relationships with the physician/provider network**
- **Answer questions**
- **Provide information to providers and office staff regarding our plans and policies**

Network representatives are required to have a bachelor's degree with provider relations and/or managed care experience, plus training in chart review/auditing.

We typically hire provider relations staff from within the company. These employees have some degree of knowledge and experience relating to health care insurance and often network operations.

Training emphasizes knowledge and skill gap assessment and corresponding remedial and supplementary training to fill specific gaps. New hire on boarding plans cover the full range of tasks, training and activities to flexibly guide new provider relations staff through orientation and training. The on boarding plans reference specific time frames for performing the various training and activities. For example, certain tasks and training are recommended for the first days after beginning a new position such as the first week or the first six weeks.

Employees access online training, performance tools and other reference material through the Network Learning Wheel, which is located on an Aetna intranet site dedicated to network staff learning. Each segment of the wheel (contracting, products and programs, systems, and reference tools) displays a list of learning resources specific to the selected category. The on boarding plan recommends when an employee accesses each resource on the wheel.

We schedule classroom training sessions on an as-needed basis.

3.D Quality Assurance/Management

3.D.1 Describe your plan for developing and implementing a quality assurance and improvement program.

5 points

Our Quality Management (QM) program is designed to promote and maintain quality assessment and improvement; effective, efficient and comprehensive provider/practitioner selection and retention processes through credentialing and re-credentialing; achievement, maintenance, and compliance with external accreditation and regulatory standards; a complaint and appeal process for members and practitioners; and review activities involving quality of care events.

Specific goals include:

- **Promote the principles and spirit of continuous quality improvement (CQI)**
- **Measure and monitor previously identified issues, evaluate the QM program and improve performance in key aspects of quality and safety of clinical care, including behavioral health, and quality of service for all of our constituents (e.g., members, customers, and participating providers/practitioners)**
- **Address racial and ethnic disparities in health care that could negatively impact quality health care**
- **Institute company-wide initiatives to improve the safety of members and our communities and foster communications about the programs**
- **Implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population across the continuum of care**
- **Develop a comprehensive, meaningful and soundly executed QM strategy**
- **Increase the knowledge/skill base of staff and to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program**
- **Operate the QM program in compliance with and responsive to applicable requirements of customers, federal and state regulators, and appropriate accrediting bodies**
- **Maintain effective, efficient and comprehensive provider/practitioner selection and retention processes through credentialing and re-credentialing activities**
- **Encourage the development and use of services and activities that support public health goals**

<u>Quality Management process</u>

We use CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. Quality improvement is implemented through a cross-functional team approach, as evidenced by multidisciplinary committees.

We use quality reports to monitor, communicate and compare key quality indicators. In addition, we develop relationships with various professional entities and provider organizations and may include feedback on structure and implementation of their QM program activities or work collaboratively on quality improvement projects.

<u>Quality Management program scope</u>

The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM

Program includes, but is not limited to, the following:

- **Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care**
- **Development of written policies and procedures reflecting current standards of clinical practice**
- **Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines**
- **Monitoring of medical, behavioral health, case and disease management programs**
- **Achievement and maintenance of regulatory and accreditation compliance**
- **Evaluation of accessibility and availability of network providers**
- **Evaluation of network adequacy**
- **Establishing standards for, and auditing medical record and behavioral health record documentation**
- **Monitoring for over and underutilization of services (Medicare)**
- **Performing credentialing and re-credentialing activities**
- **Oversight of delegated activities**
- **Evaluation of member and practitioner satisfaction**
- **Supporting initiatives to address racial and ethnic disparities in health care**
- **Following these guidelines in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost, or quality only, but never cost data alone (except in unique situations where there are not standardized measures of quality and/or there is insufficient data)**

Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual basis.

<u>Quality Management program resources</u>

We have dedicated computer/data and human resources at the national, regional and local levels sufficient to meet QM plan objectives and to complete annual and ongoing activities. National QM and behavioral health QM staff work in close partnership to coordinate completion of the required activities.

Medical Directors, QM, and other medical and professional staff from across the organization monitor, facilitate and support the QM program and initiatives focused on improving quality of care and service. NQM and behavioral health staff work collaboratively to implement QM program activities. This includes facilitating quality improvement efforts through clinical improvement workgroups, development of QM tools and templates and the development of national service and clinical indicators.

NQM coordinates development and review of national QM policies with input from NQM, Behavioral Health QM and other departmental representatives as needed. They provide support for and monitoring of activities for consistent implementation of processes impacting QM program goals and provide support relative to accreditation strategies. NQM coordinates administration of the Physician Practice Site Survey and CAHPS® (registered trademark of the Agency for Healthcare Research and Quality (AHRQ)). Review of survey results, analysis and the development of improvement plans are conducted by the NQM staff. Behavioral health conducts its own annual behavioral health experience survey and analysis.

National and behavioral health QM staffs are involved in the implementation of the QM program. NQM and behavioral health staff work collaboratively to ensure that QM program goals are met. Joint participation in regularly scheduled work groups and the Behavioral Health Quality Oversight Committee results in the sharing of information and is a critical component of this collaborative integrated strategy.

Other Aetna functional areas, including but not limited to the following, also support the QM program at all levels:

- **Network and Provider Services**
- **Utilization, Case and Disease Management**
- **National Medical Policy and Operations**
- **Complaints, Grievances and Appeals**
- **Member Communications**
- **Customer Service**
- **Pharmacy**
- **Compliance**
- **Legal**
- **Information Technology**

Additional national committees and work groups support the QM program, and some exchange information and reports with the regional committees.

3.D.2 Describe how you will look for opportunities for quality improvement and implement corrective action.

5 points

We use continuous quality improvement (CQI) techniques and tools on an ongoing basis to improve the quality and safety of clinical care and service delivered to members. These techniques and tools help us to support and monitor the consistent implementation of processes that affect our Quality Management (QM) program goals, as well as support our accreditation strategies.

We use quality reports to monitor, communicate and compare key indicators, such as for the following purposes:

- **Monitoring health, case and disease management programs**
- **Evaluating the accessibility and availability of network providers**
- **Evaluating member and physician satisfaction**
- **Developing, implementing and monitoring patient safety initiatives**

In addition, our annual QM program evaluation provides a comprehensive summary of completed and ongoing quality improvement activities performed under the scope of our QM program and identifies opportunities for improvement.

Corrective action

QM staff investigates and evaluates the facts surrounding the event. They also facilitate the review and follow-up action, if indicated, by the appropriate committee.

Between re-credentialing cycles, the appropriate QM committee considers issues related to potential quality of care concerns or other issues that adversely affect or could adversely affect the health or welfare of a member.

Sanction process

Physicians

We verify and obtain disciplinary or adverse action outcome information during credentialing and re-credentialing through sources such as state licensing boards and the National Practitioner Databank, which meets NCQA credentials criteria requirements as a verification source for sanctions or limitations on licensures.

We also monitor provider disciplinary actions between credentialing cycles by reviewing state board reports, Office of Inspector General sanction reports and the government-wide List of Parties Excluded from Federal procurement and non-procurement programs (i.e., the Office of Personnel Management Debarment reports). We review these reports as frequently as they are made available to capture any adverse activity that could potentially result in a non-renewal.

Facilities

We monitor facility disciplinary actions between credentialing cycles by reviewing Office of Inspector General sanction reports and Office of Personnel Management Debarment reports. We review these reports as frequently as they are made available to capture any adverse activity that could potentially result in a non-renewal.

3.D.3 Describe your process for developing advisory committees, ensuring and facilitating their regular meetings, and your plan for evaluating and incorporating feedback from these committees.

5 points

We implement quality improvement through a cross-functional team approach as demonstrated by our multidisciplinary committees. Our quality committees include the National Quality Oversight committee (NQOC) that is empowered to oversee and address quality improvement activities and the National Quality Advisory Committee (NQAC), which sets direction for clinical quality improvement initiatives. We use quality reports to monitor, communicate and compare key indicators and quality improvement initiatives.

National Quality Oversight committee

The National Quality Oversight committee (NQOC) manages quality improvement activities and processes. The committee provides oversight of Quality Management (QM) policy and activities, review of quality measurements and indicators, quality-of-care concerns/complaints, and quality improvement studies and initiatives.

The NQOC is a multidisciplinary group composed of representatives from key business areas.

The NQOC meets at least 10 times per year.

National Quality Advisory committee

The National Quality Advisory committee (NQAC) reviews and provides feedback on clinical quality improvement initiatives. It also reviews and makes recommendations on quality improvement studies and surveys, clinical indicators, member and provider initiatives, provider communications, and QM program documents. The NQAC provides feedback on clinical criteria, medical clinical practice and preventive services guidelines and integrated medical and behavioral health programs.

The NQAC is comprised of a medical director and representatives from a range of participating practitioners in specialties that include primary care and high-volume specialists, as well as a behavioral health practitioner. Other specialty practitioners may be included as necessary for clinical input. The NQAC meets at least five times a year.

Behavioral Health Quality committees

The Behavioral Health (BH) Quality committees provide guidance and direction to the BH staff and senior management who are accountable for behavioral health administrative, clinical and quality issues, and utilization management activities. The BH Quality committees provide an environment for collaborative initiatives and facilitate the integration of behavioral health with primary medical services. It is comprised of BH department heads, representatives from BH and national QM representatives. The BH Quality committee meets at least 10 times a year.

Behavioral Health Quality Advisory committee

The Behavioral Health Quality Advisory committee (BH QAC) manages and provides direction on behavioral health clinical quality improvement initiatives and provides input into the QM program. The BH QAC provides feedback on BH clinical practice and preventive services guidelines, preferred drug lists, and integrated medical and behavioral health programs. The BH QAC is comprised of the behavioral health medical director and six to eight participating behavioral health practitioners. The BH QAC meets at least twice a year.

Aetna Pharmacy Management Quality Oversight committee

The Aetna Pharmacy Management Quality Oversight Committee (APM QOC) is an internal pharmacy committee delegated authority by the Pharmacy Senior Management Team to provide guidance and direction on Pharmacy administrative, clinical and quality issues. APM QOC membership is comprised of cross-functional representation within APM and from other Aetna functional areas. The APM QOC meets at least six times per year.

3.D.4 Explain how individual providers are monitored. Describe the quality standards you use. Include samples of performance data supplied to network providers and a description of measures.

5 points

We monitor the quality of care rendered by network practitioners in many ways and at multiple levels. These include:

- **Monitoring individual practitioner quality**
- **Aggregating data (at the plan, regional or national level)**
- **Measuring performance across networks**

Ensuring a high-quality network

The credentialing/re-credentialing process evaluates the qualifications of individual practitioners who participate with us.

- **Credentialing – We credential each provider before they join the network.**
- **Re-credentialing – We re-credential providers on a three-year cycle, as required by regulatory agencies and accrediting organizations.**
- **Ongoing monitoring – Between re-credentialing cycles, a peer review committee may consider specific issues related to member complaints, potential quality of care concerns or other issues of professional competence and conduct that adversely affect or could adversely affect the member's health or welfare.**

In addition, we have several programs for measuring and rewarding individual practitioner performance. These include our performance networks, value-based contracting programs, identifying patient-specific opportunities for improved care and clinical review.

Performance networks

For our performance networks, we evaluate and designate providers based on certain measures of quality and efficiency. Certain markets have designated hospitals and designated specialists, while other markets have designated specialists only. And some markets feature accountable care organizations (ACOs).

- **Physician measures include, but are not limited to:**
  - **Treatments proven to show positive results, according to industry standards**
  - **Lower hospital readmission rates**
  - **Fewer reported complications**
  - **Technology use**
  - **Industry certification**
- **Hospital measures include, but are not limited to:**
  - **Adverse events**
  - **Average length of stay**
  - **30-day hospital readmissions**
  - **Centers for Medicare & Medicaid Services (CMS) process-of-care weighted index**
  - **Institutes of Quality® designation**
  - **Leapfrog scores**

Each ACO program is different. Some arrangements purely assess self-improvement, while others use a combination of self-improvement and comparison to national benchmarks. However, all metrics address clinical quality, costs and efficiency. We provide ongoing analytical and care management consulting to ACOs in order to support continuous improvement in quality and financial outcomes.

Value-based contracting

In value-based contracting arrangements, we reward providers based on the value they deliver, usually through effective population health management and their focus on health outcomes for their patient base as a whole. We measure performance based on improved quality of care, positive/improved health outcomes, and competitive and efficient total medical costs on a sustainable basis.

Value-based contracting models include:

- **Accountable care organizations**
- **Patient-centered medical homes**
- **Bundled payment arrangements**
- **Pay for performance (hospital and physician)**

We collaborate with each unique practice or health system to set the right targets on the right clinical and quality measures. Across the spectrum of models and deals, some assess self-improvement, while others use a combination of self-improvement and comparison to national benchmarks. All metrics address clinical quality, costs and efficiency.

MedQuery®

The MedQuery® program, which is powered by the CareEngine®, identifies opportunities for improved care and delivers patient-specific, evidence-based treatment guidelines to physicians.

The CareEngine applies clinical algorithms to identify potential errors or omissions in care. As opportunities for improved care are identified, they are stratified and assigned a severity level. The member-specific opportunities are then communicated to the appropriate treating physician according to evidence-based medical research.

MedQuery empowers physicians to optimize care and avoid adverse events, thereby improving clinical quality, patient safety and financial outcomes. The data that fuel this program includes medical and pharmacy claims, lab results and member demographics.

Selected Members' Clinical Information List

Our Plan Sponsor Insights group developed the Selected Members' Clinical Information List to provide PCPs with actionable information for reviewing members' treatment and compliance with treatment.

Based on widely accepted standards of treatment and administrative data available within the past 12 months, the list profiles patients in a practice who have asthma, diabetes and cardiac disease and who may benefit from an adjustment to their therapy or a review for medication compliance. The list also identifies members with potential drug interactions or evidence of six or more prescriptions dispensed simultaneously that may affect their health.

PCPs can access the list, which is updated monthly, on our secure provider website.

Clinical policies

We have developed a combined proactive and retroactive approach to identify emerging medical technologies and changing indications for existing medical technologies. Our Clinical Policy unit evaluates and renders an opinion on the experimental and investigational status and medical necessity of a medical technology that we consider for coverage under our medical benefit plans. These assessments are published on an ongoing basis as Clinical Policy Bulletins (CPBs), and are available to practitioners, members and consumers on our website, www.aetna.com. We use the CPBs in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members.

Utilization review

Our utilization management staff uses evidence-based clinical guidelines from nationally recognized authorities along with state mandates and the terms of the member's benefit plan to guide decisions for precertification, concurrent review, discharge planning and retrospective review. We review outpatient procedures using the same criteria or guidelines as inpatient procedures. The relevant guidelines used in making coverage decisions are available to our members and their treating practitioners upon request.

Our behavioral health staff use Aetna's Level of Care Assessment Tool (LOCAT) and the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM), in making coverage decisions about the medically necessary level of care for behavioral health services. For treatment provided in Texas, the Texas Alcohol and Drug Addiction Criteria is used in place of ASAM.

The guidelines are designed to assist health care providers utilize benefits more effectively while providing effective treatment that reflects widely accepted medical practices focused on the best health outcomes. Used as tools, they associate targeted time frames for medical activity and define expected levels of functionality and clinical status throughout the course of treatment and recovery. Licensed and experienced clinicians and professionals make decisions based on the guidelines as well as the individual needs of the member.

Network level quality

We systematically monitor clinical care and service activities that are applicable to a large portion of the membership. Our annual HEDIS® (registered trademark of NCQA) data collection activities assess plan performance on several clinical performance measures, with data reported in aggregate by market. Results are compared to NCQA benchmarks, previous performance and health plan goals to identify opportunities for quality improvement programs. We have established national quality improvement work groups focused on improving our HEDIS rates. These work groups focus on specific barriers identified through demographic and morbidity analysis of our members.

External accreditation

We are committed to Health Plan as well as Managed Behavioral Healthcare Organization accreditation by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to continuous quality improvement, meeting customer expectations and establishing a competitive advantage among HMOs and PPOs. HEDIS® (registered trademark of NCQA) and CAHPS® (registered trademark of the Agency for Healthcare Research and Quality (AHRQ)) reports are produced annually and submitted to NCQA for public reporting and accountability.

Performance data and measures

We do not track patient satisfaction with individual providers. Our Aetna Performance Tracking Member Satisfaction Survey is designed to measure overall satisfaction with our health plan; however, this survey also measures satisfaction with our network. We have provided a sample copy of our survey, though this is not shared with providers.

Based on 2017 year-end Aetna Performance Tracking Member Satisfaction Survey results, 93 percent of members indicated they were satisfied with our network.

	We use a top 3 box satisfaction methodology for the Aetna Performance Tracking Member Survey, which measures overall member satisfaction with Aetna. The top 3 box satisfaction methodology has been a standard in the industry for calculating book-of-business results. This methodology presents five satisfaction answer options (completely satisfied, very satisfied, somewhat satisfied, not too satisfied and not at all satisfied) to a survey question and reports the percent of members selecting one of the top 3 (completely satisfied, very satisfied or somewhat satisfied). **We make office site visits to network practitioners if a member complaint is received regarding physical accessibility (including handicapped access), physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered.**	
3.D.5	State the frequency and method in which the performance of individual physicians and facilities are evaluated in the following areas: a. Inpatient/outpatient utilization (e.g. global, condition or site-specific). b. Appropriateness of care (e.g. inpatient critical path audits, HEDIS, Accountable Care Organizations). c. Customer/patient service (e.g. site visits or member surveys). d. Referral patterns (e.g. PCP tracking of specialty care referrals, use of specific therapies). e. Administrative compliance (e.g. documented irregularities in procedure). f. Over-utilization of testing/diagnostic services. **We continuously evaluate provider performance as part of our quality management process. Our claim databases allow network managers and local medical directors to analyze trends in provider utilization (both over and under-utilization), with the intent of educating to improve performance, and locate opportunities for improving our delivery of medical services. We combine utilization and unit-cost metrics of performance with clinical effectiveness measures of performance.**	5 points
3.D.6	State the frequency and method in which providers receive feedback on their performance (e.g. formal profiling, provider relations visit, Medical Director Discussion) **We believe that measuring performance and sharing the results with providers can help providers deliver better clinical services to our members. Our goal is to provide access to quality care that is consistent with established standards.** **As part of our quality management process, our network managers and local medical directors use our claim databases to analyze trends in provider utilization, with the intent of educating to improve performance, and locate opportunities for improving our delivery of medical services. Our Plan Sponsor Insights group utilizes Symmetry Health Data Systems' Episode Treatment Groups software to stratify providers by efficiency, and also identifies and tracks adverse events, as well as assesses quality, in the inpatient setting with the Inpatient Performance Measurement System.** **We provide patient-specific feedback to providers with our MedQuery® program and our Selected Members' Clinical Information List. Physicians can use this information to support their discussions with members. Frequency varies.** **We also reward performance with payments based on recognized clinical effectiveness and efficiency measures through our value-based contracting initiatives.**	5 points

3.D.7 Describe how you address issues with providers who do not meet your quality standards, including:

a. Type of communication to providers of quality standards for which are they being held accountable.
b. Specific steps followed to rectify a provider quality problem.
c. Description of programs available for assisting providers in improving effectiveness and efficiency.
d. How do you address instances where providers fail to perform at an acceptable level? If providers are removed from the network, explain how members, EBD, and employers are notified.

5 points

We monitor the quality of care rendered by network practitioners in many ways and at multiple levels. These include:

- **Monitoring individual practitioner quality**
- **Aggregating data (at the plan, regional or national level)**
- **Measuring performance across networks**

Any of our units may identify potential quality of care concerns and report them to the Quality Management (QM) department. Situations may also be identified through:

- **Mail**
- **Email**
- **Verbal communication (complaints) by external sources**
  - **Members**
  - **Member's authorized representative**
  - **Power of attorney**
  - **Providers**
  - **Quality improvement organizations**
  - **External quality review organizations**

Quality of care concerns include unexpected outcome/adverse events, surgery-related events, delay of care/service, mental health/substance abuse concerns, and member-reported events.

Examples of situations that may be considered for review:

- **Member expressed concern about quality of care**
- **Practitioner expressed concern about previous medical management**
- **Questionable medical or behavioral health management identified during case review for utilization management, disease management, or other clinical review**
- **Allegation concerning inappropriate conduct on the part of a practitioner**

QM staff investigates and evaluates the facts surrounding the event. They also facilitate the review and follow-up action, if indicated, by the appropriate committee.

Between re-credentialing cycles, the appropriate QM committee considers issues related to potential quality of care concerns or other issues that adversely affect or could adversely affect the health or welfare of a member.

Sanction process

Physicians

We verify and obtain disciplinary or adverse action outcome information during credentialing and recredentialing through sources such as state licensing boards and the National Practitioner Databank, which meets NCQA credentials criteria requirements as a verification source for sanctions or limitations on licensures.

We also monitor provider disciplinary actions between credentialing cycles by reviewing state board reports, Office of Inspector General sanction reports and the government-wide List of Parties Excluded from Federal procurement and non-procurement programs (i.e., the Office of Personnel Management Debarment reports). We review these reports as frequently as they are made available to capture any adverse activity that could potentially result in a non-renewal.

Facilities

We monitor facility disciplinary actions between credentialing cycles by reviewing Office of Inspector General sanction reports and Office of Personnel Management Debarment reports. We review these reports as frequently as they are made available to capture any adverse activity that could potentially result in a non-renewal.

MedQuery

The MedQuery® program, which is powered by the CareEngine®, identifies opportunities for improved care and delivers patient-specific, evidence-based treatment guidelines to physicians.

The CareEngine applies clinical algorithms to identify potential errors or omissions in care. As opportunities for improved care are identified, they are stratified and assigned a severity level. The member-specific opportunities are then communicated to the appropriate treating physician according to evidence-based medical research.

MedQuery empowers physicians to optimize care and avoid adverse events, thereby improving clinical quality, patient safety and financial outcomes. The data that fuel this program includes medical and pharmacy claims, lab results and member demographics.

Notification

Member notification

When we know a provider is leaving our network, an automated system typically generates member notices 30 days prior to the provider's termination date, or in accordance with applicable regulations. If the provider is a PCP, we send letters to all members assigned to the PCP. We also send letters to members who have not selected a PCP, but have had at least 1 visit with the PCP during the previous 12 months.

If the provider is a specialist, hospital, facility, ancillary or other medical health care provider (as defined by state mandates), we send letters to all members who have had at least 2 visits within the past 12 months, in accordance with NCQA standards. The process may vary based on state specific criteria. We also send retraction notices if a provider is reinstated, which is automatically generated the night the termination is removed from the system.

	Where allowed by applicable state law, our standard provider contracts allow both parties to terminate without cause, typically with a 120-day notice for physicians, a 90-day notice for physician groups of less than 5, and a 120 to 180-day notice for hospitals. Both parties also may terminate for default or breach, typically with a 60-day notice. All participating providers are required to continue care until treatment is completed or we are able to make appropriate arrangements to have another provider render the service. **<u>Customer notification</u>** **EBD's account team will communicate any significant network changes to you in a timely manner.** **Our standard policy is to notify you at least 30 days prior to any significant network changes, such as hospital or large physician group terminations.** **We use a network update process to notify our internal account representatives of these changes. These communications provide the account teams with the important details and a customizable customer email, which the account teams can use to alert EBD to the network change.**	
3.D.8	State the percentage of physicians who are credentialed prior to contracting (including physicians with leased health plans). **100%. All physicians are credentialed prior to contracting and recredentialed every three years, depending upon individual state requirements. Every provider in our network must meet our participation criteria.**	5 points
3.D.8	Describe any formal, written credentialing/re-credentialing standards for general medical and surgical hospitals. If applicable, provide a copy. **We require hospitals to be in good standing with state and federal regulatory bodies and to have been reviewed and approved by The Joint Commission (TJC), the American Osteopathic Association (AOA), Det Norske Veritas Healthcare, Inc. (DNVHC) or an accrediting entity deemed appropriate by Aetna policy. These accrediting bodies perform detailed reviews of hospitals including on-site visits, and require demonstration of quality improvement activities. If a hospital is not accredited, we require an on-site quality assessment; however, if we find that the Centers for Medicare and Medicaid Services (CMS)/state survey includes review of substantially the same scope of our review for hospitals, the CMS/state survey may be substituted for an on-site quality assessment.** **We contractually require hospitals to maintain comprehensive general and professional liability insurance or self-insurance in adequate amounts and to provide documentary evidence of such coverage upon request. Hospitals must notify us of any material change of licensure or accreditation status, or any changes to their general or professional liability coverage. We also contractually obligate hospitals to participate in our quality management and patient management activities.** **Between formal recredentialing cycles, we routinely monitor the Office of Personnel Management/Office of Inspector General reports to capture any adverse activity that could potentially result in a non-renewal. We review these reports as frequently as they are made available and have processes in place to communicate the information to the appropriate department for action.**	5 points

	We confirm every three years that the hospital continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body. **Our formal, written credentialing/re-credentialing policies are proprietary; therefore, they are not available for distribution outside of Aetna.**	
3.D.10	State the percentage of facilities which are reviewed prior to contracting or renewal (including facilities in leased health plans) for an initial on-site visit at a prospective physician's office; provide a copy of your office survey form. **Our standard hospital contracts require participating hospitals to represent and warrant their accreditation by The Joint Commission, the American Osteopathic Association (AOA), Det Norske Veritas Healthcare, Inc. (DNVHC) or an accrediting entity deemed appropriate by Aetna policy. These accrediting bodies perform detailed reviews of hospitals, including on-site visits, and require demonstration of quality improvement activities.** **We make office site visits to network practitioners if a member complaint is received regarding physical accessibility (including handicapped access), physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered. An office site visit consists of a structured, documented review of a practitioner's office to evaluate the complaint, determine compliance with selected Aetna business participation criteria and Aetna medical record-keeping practice policies, and assess appointment availability. This policy is in accordance with both National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) standards.**	5 points
3.D.11	How often is a provider's office visited for the purpose of credentialing/re- credentialing/verification of quality practice? **We do not conduct personal interviews as a requirement for credentialing/re-credentialing.** **We make office site visits to network practitioners if a member complaint is received regarding physical accessibility (including handicapped access), physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered. An office site visit consists of a structured, documented review of a practitioner's office to evaluate the complaint, determine compliance with selected Aetna business participation criteria and Aetna medical record-keeping practice policies, and assess appointment availability. This policy is in accordance with both National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) standards.** **When complaints are identified and determined by Quality Management to be appropriate, Network Management staff will conduct a site visit at the office within 60 days of the report to assess and institute actions to improve the office. If we receive subsequent complaints regarding an office that has previously resolved a complaint, we will conduct a new site visit within 60 days of the report.** **We evaluate the effectiveness of corrective actions at least every six months until deficiencies are resolved. A practitioner's office must fully comply with our office assessment criteria (which include a review of medical record documentation), as stated in the provider agreement and participation criteria.** **We adhere to more stringent state-specific requirements, as applicable.**	5 points

	Contracting visits **Network managers may meet with providers face-to-face during contract negotiations, which generally take place between the time a provider submits an application and credentialing.**	
3.D.12	Regarding facility contracting: a. List the criteria which are used to select hospitals and other health care facilities. b. List the hospitals participating in your network which are not accredited by JCAHO. c. State the liability coverage that the participating hospitals are required to carry. d. Describe how the hospitals are monitored for cost efficiency and quality of care on an ongoing basis. e. State the frequency in which this review is conducted. f. List any hospitals that have been terminated or dropped. g. State the number of nationwide hospitals with which you directly contract. h. List any treatment options that cannot be provided by your hospital network. State the length of time in which your negotiated hospital rates are guaranteed, if any. **a)** **In addition to meeting our participation criteria (e.g. accreditation, licensure, liability insurance), hospitals must agree to the following terms to be included in the network:** • **Negotiated compensation arrangements** • **Other contractual terms, including agreeing to cooperate with our medical management programs** • **To file claims on behalf of their patients** • **Not to balance bill for any amount in excess of negotiated rates for covered services** **b)** **Our standard hospital contracts require participating hospitals to represent and warrant their accreditation by The Joint Commission, the American Osteopathic Association (AOA), Det Norske Veritas Healthcare, Inc. (DNVHC) or an accrediting entity deemed appropriate by Aetna policy. We don't track JCAHO separately.** **c)** **For professional liability insurance, hospital requirements generally range from $1 million per claim/$3 million annual aggregate. Professional liability for non-hospital facilities (e.g., skilled nursing facilities, surgery centers, urgent care centers) is generally $1 million/$1 million.** **d)** **We monitor the quality of care rendered by network practitioners in many ways and at multiple levels. These include:** • **Monitoring individual practitioner quality** • **Aggregating data (at the plan, regional or national level)** • **Measuring performance across networks**	5 points

We monitor potential quality of care concerns and identify them for review and intervention. Also, Our Plan Sponsor Insights group identifies and tracks adverse events, as well as assesses quality, with the Inpatient Performance Measurement System.

Quality of care concerns for physicians and facilities

Quality of care concerns include unexpected outcome/adverse events, surgery-related events, delay of care/service, mental health/substance abuse concerns, and member-reported events.

Potential quality of care concerns may be identified by any functional unit, and are reported to the appropriate Quality Management (QM) department. Situations may also be identified by external sources, through mail, email or verbal communication (complaints) including: members, providers, practitioners, Quality Improvement Organizations (QIOs) or External Quality Review Organizations (EQROs).

Inpatient Performance Measurement System

Aetna Informatics® has created the Inpatient Performance Measurement System (IPMS), which compares hospital and provider performance in the inpatient setting to case-mix adjusted averages. IPMS is our system to apply clinical logic to adjust for the severity of illness within the hospitalized population and to provide indicators to evaluate performance associated with adverse events and length of stay.

We track adverse events through population-based trending analysis, as well as on an individual patient level. Through proactive analysis, for instance, we have found hospitals with high nosocomial (hospital-acquired) infection rates. We were able to bring these high rates to the hospitals' attention, and they reduced the infection rate through programmatic efforts.

Quality monitoring across networks

Members can access evidence-based hospital outcomes data on more than 6,000 hospitals nationwide by using the Aetna Navigator® Hospital Comparison Tool on our member website. This web-based, decision-support tool provides members with information to help them select a hospital for their inpatient medical care for certain procedures, conditions and diagnoses. The tool provides comparisons on specific medical and surgical diagnoses and procedures based on four measures: number of patients treated per year, mortality rates, complication rates and lengths of stay. We license the Aetna Navigator Hospital Comparison Tool from WebMD Health Services.

e)

Because we have different forms of reviews. Reviews are performed on an ongoing basis. Between formal re-credentialing cycles, we routinely monitor the Office of Personnel Management/Office of Inspector General reports to capture any adverse activity that could potentially result in a non-renewal. We review these reports as frequently as they are made available and have processes in place to communicate the information to the appropriate department for action.

We confirm every three years that the hospital continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

f)

The Aetna network in Arkansas is very stable and there have been no major terminations in the last several years.

Aetna has a dual responsibility to our customers. The first is to provide our members with access to a comprehensive, high quality network of providers and services. The second is to help contain rising health care costs, which in part is dependent on competitive provider contracts.

We remain committed to increasing the quality and efficiency of health care while decreasing costs. An increasing number of hospitals are demanding substantially higher reimbursement rates – far ahead of general inflation and comparable hospital rates in the market – as well as new clauses that put additional financial burdens on Aetna and our customers.

Aetna has a comprehensive, national network process in place, which includes resilient contracting strategies with our providers. As a result, some negotiations may lead to terminations of providers within our network. However, we have been executing this strategy for some time, and have had very limited reduction to our overall network.

At this time, we do not expect our networks to materially change and remain committed to proactively communicating with our customers regarding any changes that may take place on an ongoing basis. Aetna uses the Network Update process to keep plan sponsors, like the State of Arkansas, informed on a timely basis of significant network changes that may take place throughout the course of the year.

g)

We directly contract with 90 percent of our provider network. In certain instances, generally for smaller towns and rural areas, we do lease networks. If we do not have a directly contracted network in an area, we may use rental network vendors that administer provider networks on our behalf. These networks are based on our contract standards and principles.

h)

We administer benefits according to EBD's benefits plan.

<u>Length of negotiated hospital rates</u>

The initial terms of our provider contracts vary based on negotiations, but are generally for a period of one year or more. Many of our contracts are longer-term agreements, typically multi-year deals. After the initial term, the contracts usually automatically renew for additional terms of one year each until either party initiates discussions to renegotiate the terms and the renegotiations are completed.

At this time, we do not expect the composition of our networks to materially change. Aetna's network strategy is focused on the development and enhancement of strategic network initiatives and products (e.g. tiered networks) and the development of more strategic partnerships with providers that drive delivery system reform (e.g. Accountable Care Organizations).

3.D.13	Specify what HEDIS and/or ACO data you currently capture and/or report, identifying the data that is submitted to each. Submit copies of HEDIS and/or ACO reports for the last reporting period. **We are committed to continuous improvement and collaboration with the medical community, customers and members to facilitate access to quality and cost-effective health care. Improving quality through adherence to evidence-based medicine is the fundamental principle that guides Aetna's clinical work.**	5 points

	As such, we submit HEDIS® (registered trademark of NCQA) data to the National Committee for Quality Assurance (NCQA) on an annual basis for our commercial and Medicare HMO/PPO products. HEDIS rates are produced in accordance with NCQA specifications. **HEDIS commercial HMO and PPO report cards are available to customers, physicians, members and the public at www.aetna.com. We can also meet with EBD to discuss possibly providing customer-specific HEDIS reports. To maintain confidentiality, we present the data in summary form that does not identify specific facilities, practitioners or members.** **Please refer to the HEDIS Report (3.D.13) located in the Additional Requested Attachments section of our proposal response**.	
3.D.14	Using the following formula, state your member satisfaction level over the last year. **Formula:** "Overall satisfaction level" from member survey or total or "satisfied" / "very satisfied" responses divided by total responses (exclude neutral responses). **Based on 2017 year-end Aetna Performance Tracking Member Satisfaction Survey results, 89 percent of members indicated they were satisfied with our network.**	5 points
3.D.15	Using the following formula, state your physician satisfaction level over the last year. **Formula**: "overall satisfaction level" from provider survey or total of "satisfied" / "very satisfied" responses divided by total responses (exclude neutral responses). **Our Physician and Office Manager Surveys are designed to measure physician and office manager satisfaction with the health plan and to explore our performance on specific interactions. Our recent online physician and office manager surveys were conducted from April 25, 2016 to May 13, 2016. A total of 279 physician surveys were completed in 2016. Survey results indicated 78 percent of physicians are satisfied with us.**	5 points
3.D.16	Describe how the actual satisfaction results compare to your target performance goals for members and for providers. **Our goal is to maintain a positive overall satisfaction rating of at least 80 percent. We have consistently exceeded that goal.** **Our 2017 year-end Aetna Performance Tracking Member Satisfaction Survey results indicated an overall annual member satisfaction rate of 93 percent.**	5 points
3.D.17	Explain what quality information is provided to members via different communication avenues: web page, mailing, on-site meetings, etc. **Member website** **Aetna Navigator, our secure member website at aetna.com, offers several online resources which include:** • **Benefits information** • **Health education** • **Health assessment tools** • **Cost and quality tools** • **Health care decision support**	5 points

Our member website assists members in using their health plan and in making informed health choices by quality information by providing access to:

- **Member Payment Estimator (MPE), a tool that helps members save money by making it easy to estimate and compare their out-of-pocket costs for certain health care services. This tool uses the member's specific plan information to provide real-time, personalized out of pocket estimates of what the member could pay if they have the services that day.**

- **Healthwise® Knowledgebase, a user-friendly decision-support tool designed to encourage informed health decision-making and allow users to better understand their treatment options.**

- **Our online directory of participating providers includes details about providers and facilities as well as links to quality and patient safety information.**

- **Simple Steps To A Healthier Life, a personalized, online health and wellness program that includes a suite of online health coaching programs in addition to a health assessment. The program encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles.**

- **Aetna Navigator Hospital Comparison Tool, a tool that allows users access to evidence-based hospital outcome data and quality and safety information on hospitals in their area.**

- **Estimate the Cost of Care (ECC), a suite of interactive web-based cost tools designed to provide members with cost information they can use to make more informed decisions. Cost information is provided for the most common medical and dental procedures, prescription drugs, office visits, diagnostic test and vaccines and diseases and conditions. The Estimate Drug Costs tool is available for mobile devices.**

<u>Aetna Mobile App</u>

Our free app provides on-the-go capabilities and lets employees and their families care for their health easily and simply, from anywhere. Members can access our most popular mobile web features from the app, including:

- **Member Payment Estimator**
  -Member can get real-time estimates for out-of-pocket medical expenses based on their plan.

- **Search for a doctor, dentist, hospital or urgent care facility**
  -Based on current location, members can find participating providers in our online directory that includes details about providers and facilities as well as links to quality and patient safety information.

- **View a map of the office location**
  -Get turn-by-turn directions with built-in global positioning system (GPS)

- **Call the doctor's office with the tap of a finger**
  -Transfer the doctor's contact information right to their address books

	• **Claims View** **-Members can click on Claims View to quickly see the status of their recent claims. With one more click, members can get a detailed view of each claim, or search specifically for additional claims by member name or date.** • **Personal Health Record (PHR)** **-Members with a PHR know how helpful it is for storing and organizing all of the important information they need to manage their health. Now members can easily view sections of their PHR – like Activities and Alerts, Emergency Information, Medications and Tests and Procedures – when they're on the go.** • **Check coverage and benefits** **-Members can view their plan's deductible and coinsurance information, including limits, amounts applied to date and balances.** • **ID card information** **-Members can view their medical and dental ID card information directly from their smartphone.** • **Urgent Care Finder** **-Members can find urgent care centers and walk-in clinics without even logging in – at home or at work, while traveling for vacation or business. A map provides turn-by-turn directions.** **To use the Aetna mobile app, members use the same secure member site user name and password. If they aren't yet registered for the secure member website they can register on the mobile app.** **<u>Email</u>** **We send html emails promoting our online tools and resources.** **<u>Onsite meetings</u>** **Your account management team is available for onsite meetings with you and your members. We are happy to further discuss this with EBD to determine frequency and specific quality information meeting topics.**	
3.D.18	Detail your tracking and reporting of "never events". **We require hospitals to notify us of any never events. We report "never events" and "serious reportable events" (SREs) to customers upon request. We rely on facilities to report all such events to us. We also evaluate events identified by our staff, members or providers through mail or verbal communication, by our utilization management programs, or by an external organization (e.g., state organizations that publicly report incidents).**	5 points
3.D.19	Provide a copy, in electronic format ONLY, of the data dictionary for all fields that are operational and will be directly used to support EBD in any system proposed. This data dictionary **must** include the length of the field and a specific description of the data stored in each field. **Please refer to *Data Dictionary.doc* located in the Additional Requested Attachments section of our proposal response.**	5 points

3.E Medicare Population Coverage		
3.E.1	Describe your process for coordination of benefits between your proposed Health Insurance Program and CMS. Identify the manual vs. automated/electronically processed elements within the process. **Medicare Advantage plans do not coordinate benefits with CMS. Medicare Advantage does not have to coordinate because these plans replace traditional Medicare.**	5 points
3.E.2	Describe any special services and or discount programs that you offer, which are not required for the RFP, for the Medicare population of our membership (i.e. Silver Sneakers, discounts at participating retailers, etc.). **Aetna is pleased to offer a fitness benefit with our Medicare Advantage medical plans as a buy up. Aetna has contracted with a national fitness vendor, Tivity Health, to offer the SilverSneakers® program for retirees. The program offers a monthly membership at any one of thousands of participating fitness clubs and facilities nationwide. Plan members that do not live close to an in-network facility or who prefer to exercise at home may take advantage of a home fitness kit.** **<u>SilverSneakers®</u>** **Aetna is contracting with Tivity Health to offer the SilverSneakers fitness program. This program will offer a monthly membership at any one of thousands of participating fitness clubs and facilities nationwide. SilverSneakers offers the following great features that let members improve and sustain their health:** • **A fitness membership gives members access to all basic amenities such as fitness equipment, pools and walking tracks, plus SilverSneakers group exercise classes and fun social activities at more than 13,000 SilverSneakers locations nationwide. Members can use any location any time they would like.** • **SilverSneakers FLEX™ offers classes including tai chi, yoga, dance and walking groups at neighborhood locations such as parks, recreation centers and adult-living communities. Members can take part in FLEX classes and still go to SilverSneakers fitness locations.** • **SilverSneakers® Steps is a personalized fitness program for members who can't get to a SilverSneakers location. With Steps, members may select one of four kits that best fits their lifestyle and fitness level – stress relief, strength, walking or yoga.** • **Online resources are available to enhance the fitness experience. The SilverSneakers member website silversneakers.com, includes a fitness location tool, healthy meal plans and recipes, and the SilverSneakers blog with fitness tips and advice plus interesting articles.** **We can also offer the following buy up program options with our Medicare Advantage plans.** **<u>Food benefit</u>** **Aetna offers a meal benefit through our relationship with GA Foods. GA Foods is a producer of highly nutritious, frozen, shelf stable and fresh meals for specialized populations. They have 7 production facilities and produce over 75,000 meals daily.**	5 points

Aetna offers this meal benefit in line with CMS guidance. The benefit is offered only for a short time, immediately following surgery or an inpatient hospital admission. The goal is to help members transition from an inpatient setting back to home and their community. We also want to improve health, lower readmission rates and support well-being and independent living.

GA Foods has certified chefs and registered dietitians on staff. All meals meet guidelines from:

- **The American Diabetes Association**
- **The American Heart Association**
- **Dietary Reference Intake (DRI) recommendations from the Institute of Medicine of The National Academies of Sciences, Engineering, and Medicine**

Custom meals are available for customers who may require a change in eating habits:

- **Diabetic**
- **Puree foods**
- **Kosher**

Teladoc

Teladoc® has over 700 U.S. board-certified, state-licensed health care professionals, including family practitioners, Primary Care Physicians (PCP's) and doctors, as well as dermatologists, and therapists. Members can reach Teladoc online, by phone or mobile app. Members can choose their method for their "visit" – video, or phone - to resolve many common and routine medical issues. Here's how it works:

- **The member will be contacted by a Teladoc doctor within an average of 16 minutes once requested.**
- **Teladoc guarantees that the member will be contacted within one hour.**
- **Members can have only one consult per day but there is no time limit when they are talking to the doctor so they can take as much time as they need.**
- **Teladoc providers cannot order diagnostic testing. Members will be referred to their primary care provider if that level of care is needed.**
- **Telephone consults are available 24 hours a day, 7 days a week, 365 days per year**
- **Video consults are available every day during the hours of 7 a.m. – 9 p.m. in all U.S. Time Zones***

This remote health care can be used to treat many common health issues. Teladoc doctors can diagnose many health issues like cold and flu, allergies, ear infection, rash and skin problems and so much more! Here is a small sample of the general health issues they treated in the last year:

Stomach Pain/Cramps	**Constipation**	**Laryngitis**
Abscess	**Cough**	**Pink eye**
Acid Reflux	**Croup**	**Poison Ivy/Oak**
Allergies	**Diarrhea**	**Rash**
Animal/Insect bite	**Eye Infection/Irritation**	**Respiratory infection**
Arthritis	**Feeling Dizzy**	**Sinusitis**
Asthma	**Fever**	**Skin Injury**
Backache	**Flu**	**Sore throat**
Blood Pressure issues	**Gas**	**Sprains & Strains**
Bronchitis	**Gout**	**Strep**
Bowel/Digestive issues	**Headache/Migraine**	**Tonsillitis**
Skin Infection	**Herpes**	**Vaginal/menstrual issues**
Cold	**Joint Pain/Swelling**	**Yeast infection**

	Transportation benefit **We want to make sure that our members can make it to and from their doctors or hospital appointments without always having to rely on family or friends. Knowing that they have don't have to worry about how they will get to their appointments helps give them peace of mind so they can concentrate on their health and stay on their treatment plans.** **This is why we offer an optional, non-emergency transportation benefit that you can purchase. The benefit gives rides to members, through the best method, including wheelchair accessible vans.** **The standard benefit includes twenty-four (24) one-way trips per year. These trips can be used for travel to and from their doctors or hospitals for any services that are covered under their Aetna Medicare Advantage plan. There is no cost to members for these trips.** **The number of one-way trips and pricing for this benefit can be variable depending on the national distribution of your retirees. Your account management team can give you all the information and choices for this valuable member benefit.** **Vision, Hearing and Dental Benefit Choices (Riders)** **Other benefits (riders) such as vision and hearing aid reimbursements can be added to any Aetna Medicare Advantage HMO and PPO medical plans at an added cost. Dental plans are available for PPO medical plans only. These benefit riders can only be offered on a fully insured basis.** **Neither vision nor hearing riders can be added to stand-alone Aetna Medicare Rx® Prescription Drug Plan (PDP) coverage.**	
3.E.3	Describe your process for coordinating benefits with Medicare Primary claims for services rendered outside Arkansas and/or outside of your established network. **When a member uses an out-of-network or out-of-area provider, the member may need to send claims using our standard claim form. In this case, the member would need to get an itemized bill from the provider of service and send it along with a completed standard claim form. Standard claim forms can be accessed on Aetna Navigator.** **Aetna offers Medicare Advantage (MA) plans to retirees throughout the 50 states, Washington, DC, and the Territories of Puerto Rico, Guam and the US Virgin Islands* through use of a CMS service area waiver.** **This waiver lets plan sponsors offer the MA plan to all of their retirees, no matter where they live, as long as the majority (at least 51 percent) of retirees enrolled in the Aetna Medicare plans live in a network-based service area of the plan.** **To meet these waiver requirements, Aetna offers the Aetna Medicare℠ Plan (PPO) with Extended Service Area (ESA). These MA PPO plans offer all the benefits and features of our Aetna Medicare℠ Plan (PPO) and offer the same cost sharing for both in-network and out-of-network benefits.** **Retirees who live in the ESA service area have the freedom to use any provider that is eligible to take Medicare payment and willing to accept the member. The member cost sharing will be the same if they use In-network or out-of-network providers.**	5 points

We help retirees in the ESA find providers in non-network-based service areas, encourage providers to use the plan's Medical Management Program and work with providers interested in joining the network.

***Coverage in the US Territories is limited to medical coverage. Aetna does not offer Medicare prescription drug coverage outside the United States.**

4 – ACTUARIAL SERVICES

4.A Actuarial Experience

4.A.1 Provide an overview of your data analysis capabilities in 750 words or less. — 5 points

Milliman is a market leader in data analysis using our propriety software called the Health Cost Guidelines Grouper™ ("HCG Grouper"). The HCG Grouper utilizes historical medical and pharmacy claims and enrollment data to map the data into more than sixty detailed benefit service categories. This level of detail allows Milliman to analyze and benchmark utilization and cost for our clients. Milliman's HCG Grouper is licensed by many leading health plans, provider organizations and large employers.

Other Milliman products used for data analysis include:

- **Milliman Advanced Risk Adjusters™ ("MARA"): This proprietary software generates member-level risk scores that are used to develop risk-adjust allowed costs. MARA concurrent risk scores provide a point of comparison between the risk of cohorts and a method for normalization in benchmark comparisons.**

- **MedInsight GlobalRVUs: Assigns relative value units ("RVU"s) to for all health services, which allows aggregation of unit costs and utilization efficiency for healthcare services across provider types. This software provides a method normalizing subsets of data that vary by mix of providers and services.**

- **Benchmarking: Milliman performs analysis for benchmarking with respect to Utilization and Unit Cost. Utilization benchmarking focuses on categories that are likely to be actionable; a comparison is done of cost model results for utilization per 1,000 to the range of risk-adjusted employer performance at the service category level. Unit Cost benchmarking focuses on comparing cost model results for average allowed charges to the range of employer performance in total using average allowed charges per Milliman's Global RVU.**

In addition to the products listed above, Milliman offers other data analysis capabilities including that relating to total cost of care (Allowed Per Member Per Month), preference-sensitive conditions, waste calculations, avoidable admissions related to chronic conditions, care gaps, and evaluation of care management programs. Analyses relating to the items listed are provided within reports, like those listed in the response to E.2.2 above.

4.A.2 Describe your company's experience in performing actuarial valuations of health care plans, including retiree and public plans with at least 100,000 members. — 5 points

Milliman has offices located throughout the country that provide actuarial consulting services to retiree health care plans. The following list provides a sample of clients where we provide these

	actuarial services: • **Los Angeles County Employees Retirement Association (LACERA)** • **UAW Retiree Medical Trust – GM** • **UAW Retiree Medical Trust – Ford** • **UAW Retiree medical Trust – Chrysler** • **1199 National Benefit Fund**	
4.A.3	Describe your company's process for interfacing with a client, including the role of your company's actuary and/or consultant. **The lead Milliman consultant for the program will be responsible for the following:** • **Serve as primary point of contact for EBD staff** • **Oversee and supervise all analyses, reports, and other work products** • **Communicate Milliman results to EBD staff, Board, and legislative staff** • **Attend all on-site meetings in Little Rock** ***In other words, the lead consultant embraces a very close, ongoing relationship to the client. Most contact with EBD staff and others will be directly with the lead consultant, with other Milliman staff included who will be involved in the detail work.***	5 points
4.A.4	Outline your company's process for sharing information with EBD that pertains to Internal Revenue Code Sections. **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations.** **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.**	5 points
4.A.5	Outline your company's process for sharing information with EBD that pertains to ADA. **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed**	5 points

	legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations. **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.**	
4.A.6	Outline your company's process for sharing information with EBD that pertains to HIPAA. **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations.** **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.**	5 points
4.A.7	Outline your company's process for sharing information with EBD that pertains to other regulatory issues or laws. **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations.** **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.**	5 points

4.A.8	Describe how you currently update your accounts on regulatory changes. Provide a recent example (i.e. annual FSA deposit thresholds). **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations.** **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.** **Milliman also monitors regulatory changes and will model the financial impact of regulatory changes where applicable**	5 points
4.A.9	Describe the workflow used by your company to notify clients of important industry updates including but not limited to the following: • State requirements including pending legislation and/or regulations • Federal requirements including pending legislation and/or regulations • Revisions to accounting standards affecting actuarial calculations or health care reporting **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations.** **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.** **Aetna or their designated subcontractor will copy Milliman on its legislative announcements and Milliman will assess and estimate potential financial impacts, if any.**	5 points

4.A.10 Describe the workflow used by your company to educate clients on industry specific information such as: • Methods of achieving various benefit objectives • Methods of proposing changes to the Plan (i.e. adding/deleting covered services, etc.) **Milliman's workflow for items such as achieving various benefit objectives or proposing plan changes includes the following steps:** **1) Milliman will lead an initial meeting with the Plan to understand the Plan's objectives and priorities. As applicable, we will include key Plan representatives in the meeting so that Milliman understands both the HR and financial goals.** **2) After understanding the Plan's objective, Milliman will present to the Plan some potential scenarios and options to consider. This may be developed in a "brainstorming" format with the Plan, or it may be a take-away for Milliman to complete after our initial meeting.** **3) Milliman will model the changes and summarize financial implications and HR considerations related to each change. In many instances, Milliman will model multiple scenarios so that the Plan can understand the impact of multiple options.** **4) Milliman will meet with the Plan (either by phone or in person) to discuss the findings of their modeling and to determine if any additional modeling is needed.** **5) For every deliverable that Milliman gives to the Plan, we adhere to a rigorous Peer Review process. Milliman requires multiple levels of internal review prior to sending results to clients. Each project will be reviewed by a minimum of two to three levels of actuaries/consultants before it is released externally.**	5 points
4.A.11 Describe who prepares presentation materials (i.e. actuary, consultant, etc.). **We will engage all team members in preparing presentation materials for the Plan. An analyst will often be involved in preparing a first draft of materials, but in all cases, the primary actuary and/or consultant for the Plan will have ownership of the final deliverable.** **As discussed above, Milliman requires multiple levels of internal review for all deliverables, and all presentation material will be reviewed by a minimum of two to three actuaries and/or consultants prior to release.**	5 points
4.A.12 Describe how you will facilitate the provision of legal opinions regarding proposed changes to the Plans, including but not limited to: • Covered services • Exclusions/limitations • Eligibility rules/guidelines • Premiums **Aetna's State Government Affairs and Federal Government Affairs units monitor proposed legislation and regulations and lobby to influence and shape our regulatory**	5 points

environment. For laws and regulations that have been enacted, our Legislative Analysis and Implementation Team (LAIT) receives information about newly enacted regulations from a contracted vendor that specializes in legislative and regulatory tracking. The LAIT also receives information from regulators, such as the state insurance departments and trade associations. **The LAIT communicates this information to impacted business areas and coordinates any necessary compliance activities to verify that our products, operations and business practices are compliant. Customers may be advised of regulatory or legislative developments and their impact on our services through their account management team.** **We do not provide compliance advice to customers relating to laws or regulations that apply directly to them as employers or sponsors of health benefit plans.**	
4.A.13 Describe quality control policies and procedures for your company. **Milliman has a strong ethic of peer review that is employed in any project that is undertaken. This process requires a secondary review of the work performed, reports prepared, and overall project management. The reviewer is selected as someone familiar with the project but who has not performed significant work on the specific project, and is designated by Milliman as an individual who has sufficient work experience to perform reviews. This allows for a qualified, impartial review and the opportunity for additional insights.** **The review is structured to identify any issues with the calculations in the work product, outstanding issues not addressed by the primary consultant and the information is presented in a logical and complete manner. The review process also helps to maintain the high quality of the work product that meets Milliman's standards. This process adds an additional level of security for our clients.**	5 points
4.B Methodology	
4.B.1 Detail your approach and methodology for analyzing claims experience as it relates to multiple Plans. **Claims analysis is an ever-constant part of the work that Milliman performs for its self-insured clients. At the start of a new client relationship, we meet to discuss analysis needs and timing. We take steps to ensure the Milliman team has access to the data it will need to complete the requested claims analysis.** **Examples of claims analysis, as it relates to experience for a client's different Plans, include:** • **Ongoing Monitoring of Plan Performance: A comparison of actual claim costs by plan compared to budgeted costs. More details related to Plan Monitoring is outlined in 4.3.B.** • **Actual Plan Cost Compared to Actuarial Values: A comparison of actual costs by Plan compared to the Actuarial Values ("AV") of each Plan. Due to antiselection, the gap between actual Plan cost is usually much wider than the gap between the Plans' AVs. The actual cost differences and AV differences should be reviewed annually, in relation to the rate relationships that are in place for the Plans.** • **Utilization and Unit Cost: Summary of Plan utilization and unit cost by service category. Differences by plan can serve as a springboard for strategy discussion. For example, abnormally high utilization for a certain service category or Plan may indicate that the Plan design should be reviewed in that area.**	5 points

• **High Cost Claimant Experience: Summary of high cost claimant experience by Plan** • **Trend Analysis: A chart of actual medical and prescription drug trends by plan over a recent time period** **The above list is not an all-inclusive list. Each client has unique needs in this area, so we work with our clients to determine the types of claims analysis that is most beneficial to the group.**	
4.B.2 Detail your approach and methodology for identifying and producing necessary reports. **Each client has its own particular needs in terms of reporting. We work closely with each of the key stakeholders to establish custom reporting packages based on overall needs and requirements. Some of the reporting packages we provide to our clients include (but are not limited to):** • **Monitoring Reports:** Provide an overview of how the Plan is performing and expected to perform for the remainder of the year. The monitoring reports are typically updated on a monthly basis and split by benefit type. Depending upon the client's needs, these may be split into further cohorts such as regions, business units, etc. • **Executive Dashboards:** Provide visual interpretations of the Plan's current performance and expected overall annual budget. The dashboard illustrates key cost drivers, such as demographic changes, plan changes, utilization / behavior changes, high cost claims, etc. • **Cost Models:** Detailed claims and utilization analysis. This report summarizes utilization and unit cost by service category. The report is used to identify key cost drivers by comparing against our data sources (over 40M lives) based on service categories, regions, and plan elections. Based on findings from this report we can provide recommendations on which vendors to partner with to help mitigate / reduce cost in these areas. • **Trend Analysis:** Conduct a 3, 6, 12 and 24 month trend analysis to determine both short term and long term trends. Identify if particular service categories, regions or plans are trending higher than norms. • **Contribution Analysis:** Help key stakeholders understand the impact of program and benefit changes on its employees from a payroll perspective. • **Employee Impact Report:** Help key stakeholders understand the impact of program and benefit changes on its employees due to plan design or program changes. • **IBNR:** Tool used for estimating unpaid claim liabilities for healthcare plans. It supports several varieties of lag development and trending methods. • **OPEB:** Milliman performs calculations in accordance with GASB guidance and current actuarial standards of practice. Key computations include the OPEB liability, the annual required contribution, and projected future benefit payments.	5 points

	• **Waste Calculator:** Help key stakeholders leverage value-based principles by identifying wasteful services as defined by national initiatives, including the U.S. Preventive Services Task Force.	
4.B.3	Detail your approach and methodology for monitoring the performance of the Plans. ***Milliman reviews and monitors the Plan's experience regularly. At the onset of the engagement, we work closely with our client's human resource team and finance team to establish overall objectives of the monitoring reports. We will then work with the client's data warehouses and vendors to secure the required data in a timely manner to meet objectives and timing of the monitoring reporting. Typically we conduct two different monitoring reports.*** • **Overall plan performance (recommended monthly): The overall plan performance report provides an overview of how the Plan is tracking relative to the annual budget, and it reforecasts the expected cost for the remainder of the year based on updated claims experience. The cost projections are broken down based on client needs (typically by benefit type).** • **Variance Analysis (recommended quarterly): The variance analysis provide explanations to HR, Finance and the Executive team on why there are deviations from actual claims experience to the budget. Some of the items included in a variance analysis include, but not limited to:** o **High cost claimants** o **Utilization vs. Per Unit Cost trends** ▪ **Impact by plan** ▪ **Impact by region** ▪ **Impact by service type** o **Demographic changes (change in family size, age, gender)** o **Plan election (migration between plans)** **Reports are designed based on the needs of our clients. We typically set up multiple reporting interfaces depending upon the audience for the reports. Our executive monitoring reports are typically very visual in nature and highlight key findings; these reports are easily interpreted by finance and the executive team. We also provide a more detailed report that dives into the detailed analysis to help HR determine appropriate action plans to identify key cost drivers and explore cost mitigation techniques.**	5 points
4.B.4	Detail your approach and methodology for calculating incurred but not reported (IBNR). **The Milliman reserve model is a robust, flexible tool used for estimating unpaid claim liabilities for healthcare plans. It was developed collaboratively by staff at Milliman's Health Practice. It supports several varieties of lag development and trending methods, and combinations thereof. Milliman utilizes a number of methods for calculating claim reserves which includes:** • **Completion Factor Method: Factors are developed based on incurred/paid values and patterns from prior months. This is the most widely used method; however, it generally requires at least 24 months of claims by paid and incurred month.** • **Loss Ratio Method: Based on collected premium and a target loss ratio to estimate target**	5 points

	incurred claims for a given time period. The paid claims are then subtracted from the incurred claims to determine the claim reserve. • **Pure Premium Method: Uses a target claim cost per employee per month ("PEPM") or per member per month ("PMPM") estimate along with the estimated average number of months of incurred claims represented by the claim reserve.** **Milliman employs a best practice approach for setting client-specific claims reserves, which includes forty-eight months of historical claims data for medical (by product), dental, and pharmacy claims, separately. If the data is sufficiently credible, we split the medical claims into major service categories (i.e. inpatient facility, outpatient facility, and professional), as the lag can vary considerably by claim type. For the more recent months, we use a combination of pricing trends, seasonality patterns and actuarial judgment to develop pure premiums. We may use a combination of the methods above when setting the IBNR for the most recent months.** **Estimates for other issues outside the claim lags would need to be factored into our IBNR calculations prior to entry into a financial statement or reported to the client. For example, explicit adjustments can be made for large claims, since if claim lag grids are gross of reinsurance, our estimates would be derived without any credit being taken for expected reinsurance recoveries.** **We recommend that clients add an explicit margin to our estimates. The margin is intended to account for any uncertainty in our estimates. The smaller the membership, the greater the need for margin and the higher the margins need to be. In general, companies use margins in the 5% to 15% range depending on the membership and their desired confidence level.** **The best estimate claim reserves are intended to be values that have about equal probability of being higher or lower than the values that ultimately emerge.**	
4.B.5	Detail your approach and methodology for calculating other post employee benefits (OPEB) Liability. **The GASB 45 analysis accomplishes the following objectives:** • **Data Collection: Milliman gathers requested information from our client related to other post-employment benefits ("OPEB"s) offered to retirees. This includes the actuarial valuation report from the prior actuary so that we may assess the reasonability of the baseline assumptions and valuation results. Upon the review of the prior valuation, we will discuss any proposed changes in advance of completing the current analysis.** • **Valuation: Milliman performs calculations in accordance with GASB guidance and current actuarial standards of practice. Key computations include the OPEB liability, the annual required contribution, and projected future benefit payments.** • **Sensitivity Analysis: Milliman provides a sensitivity analysis to demonstrate the impact of variation in the assumed discount rate and other key assumptions. This information is valuable in identifying the key drivers of expected cost of associated with providing OPEBs to retirees.** • **Presentation of Results: Milliman provides valuation results and discusses important issues with client.** • **Financial Statement Preparation: Milliman assists client auditors, as necessary, to review the GASB 45 section of the financial statement to assure that the disclosed information is consistent with our valuation results.** **Strategy and Implementation** **Based on conclusions drawn from the valuation, Milliman discusses next steps with the client. Next steps typically include analysis of strategies to explore prior to the effective date of disclosing**	5 points

	GASB information in employer financial statements. Key considerations may include: • **The effect of potential plan design changes on GASB cost** • **The impact of changes in employee cost-sharing provisions** • **Whether advance funding of benefits in a trust is appropriate** **Ongoing Reporting** **After completion of the valuation and any additional analysis, Milliman is well-positioned to provide OPEB valuations on an ongoing basis as required under GASB. The steps involved in performing ongoing valuations will be similar to the steps described above for the initial valuation performed by Milliman, except where a more simplified approach may be used for interim valuations.**	
4.B.6	Detail your approach and methodology for auditing network/provider contracts and network adequacy. **Milliman performs contract audits for our clients to evaluate the accuracy of medical, prescription drug, dental and vision claim payments. Using our proprietary Claim Audit Intelligence tool and industry experience, Milliman provides the due diligence necessary to identify any inconsistencies in the client's contract terms and how the claims are actually paid. Milliman's review includes an automated audit of 100% of claims, which tests for over 50 potential issues. We also can perform a detailed manual audit of potentially problematic claims identified in the automated audit, as well as a detailed manual audit of additional claims samples through all phases of the adjudication process,** **Our comprehensive audit includes the analysis of:** • **Potential billing errors or anomalies** • **Duplicate claims and services** • **Outlier charges** • **Overpayments** • **Bill splitting and upcoding** • **Accuracy of accumulations, such as deductible & out-of-pocket** • **Data integrity between claims processing system and accumulators** • **Potential subrogation claim** • **Hospital specialty drugs** • **High frequency DME & ambulance** • **Stop-loss Maximums** • **Eligibility issues** • **Fraud and abuse** • **COB recovery opportunities** **Milliman delivers a report to the client with the claims in question, which includes the relative number and value of claims that may have been adjudicated incorrectly. Milliman can also discuss claims in question with the applicable TPA and carrier on behalf of the client.**	5 points
4.B.7	Detail your approach and methodology for risk assessment and ongoing risk management. **We take risk assessment and management very seriously at Milliman. We have established Quality & Risk Management Guidelines that all consultants must follow. The Guidelines include the following key components:** • **Business & risk evaluation: Identify and assess project risk levels and how Milliman's work may impact our clients and our reputation.**	5 points

• **Work process standards: Maintain well-organized work files and documentation that allow others to review and/or replicate the work performed. Our deliverables include the appropriate caveats, considerations and assumptions so our clients understand the risk before placing final reliance on results.** • **Peer review standards and requirements: Milliman requires multiple levels of internal review prior to sending results to clients. We assess the level of risk at the beginning of the project. Based on the determination, the project may be reviewed by up to three levels of actuaries/consultants before it is released externally.** • **Continuing education: Milliman provides employees a variety of continuing education opportunities to stay abreast of the current health care topics and developments. All credentialed actuaries are required to meet the annual standards as set forth by the American Academy of Actuaries to continue in an actuarial role within Milliman.**	
4.B.8 Detail your approach, methodology and strategy for Plan(s) design. **Milliman starts with assessing current plan performance, plan design, and utilization/care management programs compared to external benchmarks and to best practices. Once we complete this preliminary analysis, we facilitate a series of discussions to develop a 3 to 5 year Plan strategy, of which Plan Design strategy is just one component.** **Milliman's approach to Plan Design includes the following:** • **Understand targets set by HR and Finance for net plan trend over the next several years.** • **Understand targets set by the employer for plan value and total employee cost share over the next several years.** • **Discuss themes for general direction with the understanding that the final strategy may have elements of all of these models:** o **Consumerism Model: Examples include the use of high deductible and/or high coinsurance to promote wise use of the health plan by plan beneficiaries.** o **Tight Utilization Management Model: Examples include the use of pre-certification for services that tend to be overutilized (e.g., high-tech radiology, elective surgeries).** o **Wellness Models: Examples include programs to promote employee and family health.** o **Monitor Plan Eligibility: Examples include plan dependent eligibility audits and restricting/eliminating spousal coverage.** • **Discuss specific tactics from the themes above to understand preference and build the outline of a strategy.**	5 points

	• **Model the financial impact associated with any Plan Design changes under consideration. Milliman has a variety of tools and access to an extensive amount of data that helps us estimate this impact as accurately as possible.** • **Review strategy and revise based on feedback.**	
4.B.9	Detail your approach, methodology and strategy for premium evaluation and determining premiums. **Milliman has extensive experience developing premium equivalents for self-insured groups. As a first step in the annual rate development process, we typically project plan costs and develop premium equivalents for the upcoming plan year under a baseline scenario (i.e. assuming no plan changes). These baseline results provide the client with an understanding of the expected rate increase prior to plan changes and serve as a starting point for strategy discussions. We then work with our client to understand financial requirements and member issues so that we can offer solutions that are specific to the client's needs. These solutions include modeling plan design changes, adjusting member contribution levels, and proposing programs that incent members to use the plan wisely and take actions to improve health.** **We typically use the following methodology in developing active and COBRA premium equivalents:** • **Receive paid claims and employee months by month separately for medical and prescription drug coverage for a recent 12 month time period.** • **Subtract expected high cost claims over a group's specific stop-loss threshold (if applicable).** • **Convert paid claims to claim costs per employee per month ("PEPM") by dividing paid claims by exposure for the experience period, using a two-month setback for medical coverage.** • **Trend the claim costs PEPM from the midpoint of the experience period to the midpoint of the rating period to determine projected claims, using industry average or client-specific expected trend rates.** • **Apply benefit adjustments to reflect plan design changes that are not yet realized in the claims experience, if applicable.** • **Estimate the cost impact of any expected migration between plans (particularly when significant plan changes are made and/or a plan option is added or removed).** • **Apply expected savings associated with a medical network change or a change in PBM contracting, if applicable.** • **Apply a factor to reflect significant demographic changes (e.g. change in family size, change in age/gender mix), if applicable.** • **The resulting claim cost PEPM projection may not be fully credible for smaller populations. In this case, the proceeding items are repeated for a second 12 month time period. The resulting claim cost projections for the two different experience periods are blended, usually giving more weight to the more recent time period. For very small groups, a third experience period or alternate data source (such as a manual rate) may need to be blended, for credibility purposes.**	5 points

• **Add projected specific and aggregate stop loss premiums, converted to a PEPM basis, if applicable.** • **Add projected PEPM administrative expenses, converted to a PEPM basis.** • ***Estimate the premium equivalency PEPM for each benefit plan based on the current premium relativities adjusted for benefit changes.*** • **Convert the premium equivalency PEPM to premium equivalents by family tier.** • **Add 2% to the premium equivalents to develop COBRA premium equivalents.**	
4.B.10 Describe any other services that you offer, which are not required for the RFP, but are relative to the scope of work. **In addition to those services requested in the RFP (and described elsewhere in our proposal response), Milliman offers the following services:** • **Network discount comparisons** • **RFP Evaluation** • **ACA impact modeling** • **Support related to mergers and acquisitions** • **Large claims analysis** • **Support for ancillary and voluntary products, including life, disability, dental, and vision** **Renewal support, including fully-insured and self-insured products**	5 points

5 – MEDICAL MANAGEMENT (MM)	
5.A General Services	
5.A.1 Describe how you will determine a person requesting assistance or prior authorization is eligible for the requested service. **Our Intake Specialists determine whether the caller (physician or other licensed provider, designated office personnel, facility, member or designated representative) has verified benefits and eligibility of the covered person; check for previous recommendations which might be relevant to the current request, and verify that the provider and/or facility requested is a participating network member. Our intake and clinical staff have access to member eligibility data within our Nurse/coach online workflow platform, ActiveAdvice, in order to confirm the member's eligibility. For eligibility updates (add/change/delete) we currently receive daily update files for the EBD to ensure eligibility is always up-to-date.**	5 points
5.A.2 Describe your process for rendering a decision of pre-authorization requests in a timely manner. **With regard to certification decisions,** REDACTED REDACTED **. This includes Medical Director reviews. ActiveHealth's utilization review process abides by the individual State and Federal laws governing utilization management and uses the URAC and ERISA Standards as a baseline for performance and quality measures.** **Process** **ActiveHealth's URAC-accredited Utilization Management program provides evaluation of the appropriateness, medical need, and efficacy of health care services, procedures, and facilities according to established** REDACTED **clinical guidelines. ActiveHealth's utilization management services encompass discharge planning, concurrent planning, pre-certification, clinical case appeals, concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient. ActiveHealth staff provides pre-certification, pre-notification and medical necessity reviews in house.** **ActiveHealth reviews all Inpatient Admissions as well as all Outpatient Procedures on our recommended outpatient pre-certification list (or client's customized list) for medical necessity.** **For both inpatient and outpatient pre-certification, ActiveHealth's clinical review process begins with a telephone call coming into our dedicated medical management call center or via facsimile from any of the following: physician or other licensed provider, designated office personnel, facility, member or designated representative. Intake Specialists determine whether the caller has verified benefits and eligibility of the covered person; check for previous recommendations which might be relevant to the current request, and verify that the provider and/or facility requested are a participating network member. They then enter all pertinent member, provider/facility information, diagnosis and procedure codes into our clinical platform.** REDACTED REDACTED **ActiveHealth's staff is then able to combine this information with the plan design detail within our system to inform members and providers that the requested facility or physician is not included in the network, explain potential penalties, and redirect them to in-network resources, if possible.** REDACTED REDACTED	5 points

	The call or fax is then routed to the first available Utilization Management nurse for clinical review of medical necessity. Once the information is received, the nurse documents the appropriate diagnosis and procedure codes and requested length of stay (for inpatient admissions) and reviews the request against evidence based guidelines REDACTED REDACTED **to make the authorization decision.** **For inpatient admissions, once we authorize the admission, the nurse will assign the appropriate length of stay** REDACTED **based on the goal, length of stay or grouper results from the input of the diagnosis and procedure codes.** **Our nurse will also assign the date for the next review (being the day before the first non-covered day) according to the last date of the approved length of stay.** **Generally, in any questionable situation, the nurse refers a case to a Medical Director or a physician specialist to determine its appropriateness and the level of care.** REDACTED REDACTED **For both inpatient admissions and outpatient procedures, based on the decision rendered, automated letters will generate and be mailed to the provider, member and facility reflecting the decision, diagnosis, procedures and date of service. Peer-to-peer review is offered to 100 percent of cases where a denial decision is being made based on available utilization management information. ActiveHealth attempts to contact all treating physicians when the medical director is not able to approve the case after a referral from utilization management staff. The initial referral rate to physician advisors is** REDACTED	
5.A.3	Describe your process for complying with Arkansas Act 815 of 2017 ensuring continuation of Covered Services when a newly enrolled Participant has a prior authorization or when Participant is completing services commenced before enrolling in the Plan. **ActiveHealth Management, in our role as private review agent we would partner with the State to ensure there is appropriate continuity of care for the member. The State would need to determine if they will accept the prior authorization in order to approve payment. If a new authorization is required, ActiveHealth Management would provide authorization once we have confirmation of eligibility with an EBD plan. For example, the State may want ActiveHealth to enter an administrative approval for a service that was authorized by a previous carrier. We would partner with the state to be sure there is a smooth transition for the member.**	5 points
5.A.4	Describe your plan for Provider submission of pre-authorization requests. **Our clinical review process begins with a telephone call coming into our dedicated medical management call center or via facsimile from the physician or other licensed provider, or designated office personnel. Intake Specialists determine whether the caller has verified benefits and eligibility of the covered person; check for previous recommendations which might be relevant to the current request, and verify that the provider and/or facility requested are a participating network provider. They then enter all pertinent member, provider/facility information, diagnosis and procedure codes into our clinical platform.** **During pre-certification review, our care managers are automatically notified if the provider is in or out of network by electronic flags within the system. ActiveHealth's staff is then able to combine this information with the plan design detail within our system to inform members and providers that the requested facility or physician is not included in the network,**	5 points

	explain potential penalties, and redirect them to in-network resources, if possible. REDACTED **The call or fax is then routed to the first available Utilization Management nurse for clinical review of medical necessity. Once the information is received, the nurse documents the appropriate diagnosis and procedure codes and requested length of stay (for inpatient admissions) and reviews the request against evidence based guidelines** REDACTED REDACTED **to make the authorization decision.** **For inpatient admissions, once we authorize the admission, the nurse will assign the appropriate length of stay** REDACTED **based on the goal, length of stay or grouper results from the input of the diagnosis and procedure codes.** **Our nurse will also assign the date for the next review (being the day before the first non-covered day) according to the last date of the approved length of stay. Generally, in any questionable situation, the nurse can refer a case to a Medical Director or a physician specialist to determine its appropriateness and the level of care.** **For both inpatient admissions and outpatient procedures, based on the decision rendered, automated letters will generate and be mailed to the provider, member and facility reflecting the decision, diagnosis, procedures and date of service.** **Peer-to-peer review is offered to 100 percent of cases where a denial decision is being made based on available utilization management information. ActiveHealth attempts to contact all treating physicians when the medical director is not able to approve the case after a referral from utilization management staff.**	
5.A.5	Describe your plan for implementing and maintaining an electronic log of all Adverse Benefit Decisions. REDACTED REDACTED **Additionally, we comply with the state of Arkansas regulation of publishing Arkansas state resident utilization statistics quarterly on our website.**	5 points
5.A.6	Describe any patient advocacy services (i.e. community resources such as Alcoholics Anonymous, Care Link, Meals on Wheels, etc.) coordinated by your organization. **In our Medical Management programs, we view one of our primary roles as patient advocate. During coaching sessions with members, our clinicians guide members to available resources,** REDACTED REDACTED REDACTED **The member's primary Nurse or Health Coach can then refer members to community health resources as appropriate. In addition, ActiveHealth would work with the State's Medical Carrier(s) within their benefit structure to assist in any needs for the family during a member's stay at a facility or hospital.**	5 points

(Example- Assisting the member's family in arranging for travel and other needs.) REDACTED	
5.A.7 Describe your plan for making a determination of Medical Necessity on a case-by-case basis for services requiring preauthorization. **ActiveHealth's URAC-accredited Utilization Management program provides evaluation of the appropriateness, medical need and efficiency of health care services, procedures, and facilities according to clinical guidelines. Based on a hierarchical approach, the nurse would utilize the appropriate guideline selected in order of** REDACTED REDACTED **We review the patient's clinical data using clinical criteria which guidelines,** REDACTED **, to deliver a standardized opinion on the medical necessity of a procedure or treatment for a specific member's clinical situation. The Medical Director is involved in this determination if there is any question of the requested treatment meeting the criteria for medical necessity.** **Generally, in any questionable situation, our Medical Director or a physician specialist will determine its appropriateness and the level of care. Verification of available benefits is the first step followed by requests for clinical documentation from all involved providers and health professionals for the recent past (generally less than two years) related to the type of procedure. Once documentation is received, the nurse reviews the materials in conjunction with our clinical guidelines to determine if medical necessity can be established.** **Peer-to-peer review is offered to 100 percent of cases where a denial decision is being made based on available utilization management information. We attempt to contact all treating physicians when the medical director is not able to approve the case after a referral from utilization management (UM) staff.**	5 points
5.A.8 Provide an overview of programs your company has in place today that incorporate the Centers of Excellence strategy for specialty services and procedures. **As a Care Management organization, we have experience working with our customer's health plan and network Centers of Excellence resources for specialty services and procedures. The specific resources for each of our customers can vary based on each organization's network design. For** REDACTED **necessary. In addition to working with the health plan/network to access those services, we will provide information to the member/family about any family support available during the member's treatment that is available within the scope of the benefit structure (e.g. member's family may have travel benefits).** **As a Care Management organization, we work with health plan and network resources to connect members to Centers of Excellence available through the customer's network(s) and we educate members on the resources available through the benefit plan design.** REDACTED REDACTED	5 points

5.A.9 Describe your company's strategy for population management as it would apply to the Services offered in this RFP. Identify three (3) areas your company would target and the processes you would implement to address them. 5 points

We are passionate about improving the quality of care, lowering costs and transforming lives. Our mission aligns with EBD's overall goal of assuring your members obtain the best care possible, thereby enabling them to be healthier and more productive, which would lead to a reduction in claims and lower cost to the plan and member.

We cannot accomplish this mission alone. To help transform the healthcare system, ActiveHealth nurtures strong, collaborative relationships with our clients, such as EBD, and their employees and dependents. We believe collaborative relationships influence and motivate people on a truly personal and emotional level. As a result, we foster lasting relationships that lead to sustainable behavior change, healthier decisions and better outcomes.

REDACTED

Solutions to Meet Your Current and Long-Term Needs

Across the country, we are recognized by our clients for our exceptional clinical resources and technology systems. Our work has propelled ActiveHealth to the top of industry surveys measuring innovation and capabilities and earned awards for best practices in quality care as well as cost savings.

REDACTED

ActiveHealth offers implementation, data, shared systems, and work-flow and integration services for our State government, including EBD. Only ActiveHealth offers solutions that address needs across the full spectrum of care, coupled with patented and unsurpassed resources and expertise that will help you successfully navigate your evolving population health and wellness needs.

Technology alone won't help inspire the EBD employees to take action regarding their health, or improve the effectiveness of their physician relationships. REDACTED

REDACTED

REDACTED **Our solutions offer more complete, health improvement opportunities than other industry competitors. This means we cannot only continue our partnership, but offer increased responsive value over time as health care delivery changes with market and government initiatives.**

REDACTED

REDACTED

5.A.10	Describe your workflow for predictive modeling including if performed for specific Participant and/or all Participants?	5 points

REDACTED

5.A.11	Describe your workflow for risk stratification including if performed for a specific Participant and/or all Participants.	5 points

REDACTED

REDACTED **Please see our response to Question 5.A.10, which describes our predictive model, including stratification and identification, in greater detail.**	
5.A.12 Describe your process for utilizing biometric screening and health risk assessments for improving overall population health for Participants. **We currently receive direct feeds from EBD's current biometric vendor, Catapult, in a format that allows us to share that data with** REDACTED REDACTED REDACTED **. This database is the foundation of the member's health record. Our Data Ingest Group imports all our data feeds and has a rigorous quality assurance. ActiveHealth ingests our clients' biometric screenings and Health Assessment results data as part of our population health management approach.** **After biometric data is cleaned and formatted, it is included in our aggregated member medical records along with medical and pharmacy claims data, lab and test results, Health Assessment and other data sources. ActiveHealth receives data values from biometric screenings as well as eligibility files, medical claims, pharmacy data, lab data, and other self-reported information on a predetermined basis (typically daily, weekly or monthly). Each of these data sources are integrated into our data vault and CareEngine algorithms are applied to identify errors or gaps in care, as well as potential high risk members to whom we would reach out and offer lifestyle and chronic condition support.** **When ActiveHealth's proprietary Health Assessment is used, after the member completes the Health Assessment, immediate feedback in the form of an electronic Health Report is presented to the member. The report summarizes the results of the Health Assessment and provides information to educate and spur action. If the biometric screening has already taken place prior to the member completing the Health Assessment, the biometric screening results will have already been pre-populated into their Health Assessment and PHR and will be reflected within the member's electronic Health Report. Conversely, if the member's biometric screening results are fed into our data vault subsequent to their Health Assessment completion, they will update the member's electronic Health Report. The member would need to log into MyActiveHealth, our member engagement platform to access their updated Health Report.**	5 points
5.A.13 Describe your process for medication reconciliations including any minimum/maximum criteria per case. **Our Disease Management program includes interventions that focus on educating members about the importance of maintaining compliance with their treatment plan, including their medications. As we receive pharmacy data from a prescription benefit manager (PBM), we review all medications, both prescription and over-the-counter with the goal of ensuring the member is taking the medication as prescribed, understanding the purpose of the medication and the potential side effects.**	5 points

We also assess compliance and help the member to overcome any barriers to compliance. We encourage members to talk to their physicians about any medication issues and we will consult with our medical directors if there are issues that require further discussion. An outcome of a discussion with our medical director can include outreach to the member's treating physician for further discussion about medications, compliance issues, and side effects or other issues.

Our CareEngine system aggregates pharmacy claims with medical claims and lab/test results, then compares each members profile against thousands of evidence based rules to uncover over REDACTED **pharmaceutical gaps in care, such as stop/modify drug gaps in care. Pharmaceutical-related Care Considerations fall into three broad categories: add or titrate a therapeutic agent, withdraw or change a therapeutic agent, screen or Monitor a clinical scenario. The add or titrate a therapeutic agent Care Considerations monitor actual compliance with therapeutic regimens through measurement of medical possession ratio. When lack of compliance is identified an alert or Care Consideration is generated and messaged to the provider of care and the patient.**

Additionally for those patients who are engaged by one of our condition management nurses, medication reconciliation takes place with every engagement, including cataloging of over the counter, nutraceutical, and prescription medication use. Medications that the nurse enters into the nurse workflow platform are fed into the system and are added to the patient's electronic record and can trigger subsequent analytics. Nurses use CareEngine information to assess initial and ongoing behaviors surrounding medication adherence to provide education to members when gaps are detected. Care Considerations are stratified by three levels of clinical severity. Based on the clinical urgency of the issue, a Care Consideration notification letter may be sent electronically, by fax or mailed to the provider. A toll-free number is provided should the provider's office wish to speak directly with an ActiveHealth clinician. ActiveHealth will arrange to have a clinician or a medical director (upon request) call the provider back.

Our clinical algorithms address a broad range of clinical topics but primarily analyze individuals' records for potential errors of commission, (e.g., drug contraindications) and errors of omission (e.g., recommended therapeutics or tests). Some medication related examples of clinical issues that our CareEngine interventions address include the:

- **Absence of angiotensin-converting enzyme inhibitor therapy in patients with both diabetes and hypertension**
- **Absence of angiotensin-converting enzyme inhibitor therapy in patients with congestive heart failure and in those who meet the Heart Outcomes Prevention Evaluation (HOPE) trial criteria**
- **Use of St. John's Wort and Cyclosporine**
- **Absence of statin therapy in patients with ischemic heart disease or who are high risk for a cardiovascular event**
- **Absence of anticoagulation in patients with atrial fibrillation and structural heart disease or a history of stroke**
- **Absence of documented laboratory monitoring in patients taking warfarin, anti-diabetic agents, and other medications that require specific laboratory tests**
- **Absence of breast, colorectal and cervical cancer screening**
- **Screening for abdominal aortic aneurysm in elderly male smokers**

For several clients we have rolled out a value-based insurance design (VBID) solution based on a member's personal profile and evidence-based sources. The program enables design of a formulary and co-pay structure that provides those individual members who derive the most clinical benefit from specific drugs with the most financial incentive to use those drugs. This program motivates members to take their required drugs and ensures contraindicated drugs are not inadvertently administered.

5.A.14 Describe your plan for designing, producing, and distributing outreach and education materials to Participants that are appropriate to Participants' ages, languages, cultures, and reading levels.	5 points

In terms of culture, language, and other unique requirements of our clients' populations, all ActiveHealth staff assigned to each client account is fully trained in the client's programs, culture and unique requirements. Training includes an overview of the client's programs, both ActiveHealth and those provided by the client's other vendors, an overview of the business, overall benefits strategy and general cultural challenges. During the implementation phase, we work directly with the client to assure case-specific training issues are addressed.

Across our book of business we work with many types of members across different income, ethnic, educational and literacy levels. Additionally, we work with employees and their dependents in many different types of positions including executives, managers, factory workers, union members, and others. For members with low income or if income is a barrier to compliance with their treatment plan, we strategize with them on low cost ways to implement a recommendation and become compliant with their treatment plan. For example, there are low cost ways to adhere to a specific diet and nutritional plan; generics versus brand name medications can also help lower costs, as well as obtaining prescription fills at discount retailers such as Wal-Mart. We will also call the treating provider's office to strategize about other options, such as samples, if compliance remains a problem.

Nurses have tools to support engagement sessions with culturally diverse members such as the "Food Pyramid for Various Cultural Groups" (e.g., Breads, Fruits, Vegetables, Protein, Milk), such as African American, Asian, Native American and Hispanic.

Once the member engages with a nurse, the engagement process is structured to build rapport with members, and become the member's trusted advisor. Our nurses, who are trained in coaching, health literacy and cultural competency, work with members to motivate them to define realistic goals and begin to take culturally appropriate action steps to reach those goals.

We recognize that health literacy is a challenge for some of our members and that all of our members, even those with high literacy levels, can benefit from clear, simple communications. We incorporate the principles of "plain language" into our member communications. All of our member reminders and program materials are written in English and in Spanish and we design culturally sensitive educational brochures in English and Spanish. We also provide an 800 number on all of our reminders that a member can use to call one of our nurses. Through our care management system, our nurses have online access to all reminders mailed to each member in the program and can read the reminder to the member over the phone, or connect the member to a translator. Additionally, we also have TTD capabilities for hearing impaired members.

REDACTED

5.A.15 What applications and processes are utilized to populate articles and materials customized for a specific Participant? Include methods of distributing information to Participants (i.e. dashboard). **The member's primary nurse will encourage the member to engage in** REDACTED **activities in between appointments and can also email health education materials that address their condition and lifestyle risks to their email address or to their home.** REDACTED **Members will also be directed by their Nurse care manager or health coach to a wealth of health information on the MyActiveHealth member engagement platform.** **Through the platform we also message Health Actions to members to help them find ways to improve their individual health, and we share these Health Actions with their doctors and our health coaches. Our personalized Health Actions are based on data analyzed by CareEngine, which is at the core of our member engagement platform. Not only does CareEngine take in all medical, pharmacy and lab claims, but it also takes in member demographics and self-reported information and keeps track of our members' digital footprints as they engage with our online tools/resources. As an example, members who have been identified for program engagement, will receive different messaging when a Health Actions is generated, helping them engage in a more sustained activity such as digital coaching or working direction with a coach. Noting and analyzing this data supports and differentiates our program as we know what our members are interested in, and embedded incentive design encourages action by members.** **Lastly, designed around 'teachable moments' such as after a biometric screening or HbA1c testing, Health Events are messages generated to members enrolled in our coaching programs whenever they have had a change in their health status that can relate to opportunities to improve health behaviors. These messages generate very high engagement, and are intended to get members connected with appropriate program services to work on specific areas of health improvement.**	5 points
5.A.16 Describe the process for applying Evidence Based Medicine (EBM) into your Medical Management workflow. **All of our programs are centered on evidence-based guidelines.** REDACTED REDACTED	5 points

REDACTED

REDACTED **When Care Considerations have been generated, clinicians can communicate highly specific care improvement recommendations to patients and treating physicians. From a data science perspective the recommendations are technically a form of advanced prescriptive analytics, and this helps augment the treating clinician judgment and reinforce the provider-patient relationship.**

All of our programs are evidence-based and incorporate the industry's latest technologies, communication strategies and behavioral change principles. ActiveHealth has continued to develop as an integral part of the health care delivery system by supporting physicians, nurses and patients through state-of-the-art evidence based health information tools and medical management services. We utilize evidence-based medical guidelines to develop our clinical decision support rules and in our identification and scoring algorithms as well as in the clinical content that we use in the coaching process. Evidence-based guidelines are also used to establish target metrics or outcomes for the issue in question.

Examples of evidence based guideline sources for the various topics are listed below.

REDACTED

Clinicians in a wide range of specialties have, as their primary roles, the continual review of first-line North American and European journals, specialty society guidelines and FDA communications to identify additions and changes in evidence-based recommendations. We require at least a large, randomized controlled study to support the definition of a health improvement opportunity. Additionally, a multi-specialty panel of physicians on the faculty of Harvard Medical School reviews all of our Care Considerations.

ActiveHealth's evidence-based practice guidelines have helped improve population health and reduce healthcare costs with targeted interventions and personalized engagement solutions.

5.A.17 Describe your plan for reaching out to Participants to ensure each Participant has the information needed to receive Medically Necessary Covered Services.

5 points

In terms of our Case Management program, the member's Case Manager works with the treating physicians and other providers of care that are part of the member's care team, to develop goals, milestones and interventions that make up and support the member's plan of care. Resources required to implement and support the plan of care are also identified. ActiveHealth's Case Manager, in partnership with the treating physician and the member, monitor the care plan and work jointly with the care provider in making recommendations or modifications to the plan.

Case management interventions include, but are not limited to:

REDACTED

Lifestyle and Chronic Condition Coaching

Within our lifestyle and chronic condition coaching program, based on the member's responses to questions that are within the assessments conducted by our Nurses and Coaches with the member, REDACTED care plan is generated for each member, which includes recommendations supporting individual RED goal setting, interventions, and ongoing follow-up. The assessment tools also enable the primary nurse to provide member education and communication specific to the member's condition(s) and potential opportunities to improve their care.

Levels of monitoring and tracking are highly-specific to each member based on their individual preferences, clinical and lifestyle needs and plan of care. Engaged members are monitored by the REDACTED their health coach who will assess the member's progress during follow-up interactions.

REDACTED

The member's health coach assesses the member's progress during follow-up interactions. Depending on the member's preferred method of contact, we will follow up with the member to assess status of goals, completion of assigned homework, achievement of clinical targets related to the member's conditions or lifestyle issues, barriers to treatment adherence and progress towards graduation. During each health coach / member engagement session, the members' health coach will assess the member's compliance with the treatment plan and their progress by determining if: the member has completed their homework assignments; the member can verbalize understanding their targets; the member is taking their medication; and the member has met their healthcare goals. If the patient is non-compliant, the nurse identifies the barriers to compliance and coaches the patient on ways to overcome the barriers.

Should the member need to seek care or treatment, the Nurse will facilitate access to appropriate level of care.

Maternity Management

The Active Maternity Management program was designed to identify and reduce the risk and costs of pre-term delivery, complications of pregnancy and low birth weight infants. After an initial assessment is conducted with the member , risk factors are communicated to the member in a written format they can share with their physician. Based upon responses to various questions, our system assigns risk categories to help our nurses determine the patient's overall risk level. Depending on the overall risk level, the maternity program nurse offers various types of recommendations to the patient and provider.

A personalized Plan of Care is developed for the member, which provides educational interventions geared towards maintaining a healthy pregnancy, focuses on appropriate care and monitoring during pregnancy, promotes self-management through education and behavioral change techniques and identifies and manages risk through education and care management interventions. Once a

REDACTED

All maternity cases are screened for high risk. The high-risk Maternity Management guidelines and assessments utilized by ActiveAdvice are internally developed based upon criteria established by the American College of Obstetricians and Gynecologists (ACOG) for High Risk Maternity. These are included in the ActiveAdvice system and guidelines.

REDACTED

Minimally, Maternity Management nurses will reach out to a pregnant member at least four times. More as needed based on risk and how early in the pregnancy the member signs up.

5.A.18	Describe the process for maintaining current EBM material and how often your systems are updated. **Our CareEngine rules and related clinical content are reviewed and updated by ActiveHealth's Clinical Development Center in an ongoing quality improvement process. The Clinical Development Center staff is comprised of over 30 board certified clinicians including physicians, pharmacists and registered nurses. They are responsible for the continual review of first-line North American and European journals, specialty society guidelines and FDA communications to identify additions and changes in evidence-based recommendations.**	5 points

These full-time clinicians spend over 300 full-time equivalent hours per week reviewing such data to assure ActiveHealth's gap-in-care program algorithms are the most accurate and up-to-date available in the marketplace today. This results in enhancements to our clinical algorithms three to four times per year. Additionally, all of our Care Considerations are reviewed and approved by a multi-specialty panel of physicians on the faculty of Harvard Medical School.

With regard to our coaching content, our own online resources that support our programs are developed and revised as determined by emerging technology, revised clinical indications and changing needs. Our clinical team, which includes a subset of our medical directors, conducts ongoing monitoring of evidence-based research that may indicate the need to update current guidelines. Emphasis is placed on standards that have been developed by Medical Specialty Boards, American Medical Association's Department of Technology Assessment and the growing body of practice guidelines and outcome research.

Independent, content-specific, board certified specialty physicians are consulted to review draft content as deemed necessary by the guidelines development team. In addition to the clinical content developed internally to support coaching sessions, we incorporate support pages from Healthwise in our coaching process.

ActiveHealth clinical and product teams also continuously review the wire services and journals so we can quickly identify changes that affect the practice of medicine that should be reflected on the member engagement platform. When important changes occur, topics are updated and included in the next quarterly release of MyActiveHealth.

In addition, topics are reviewed and updated on a regular basis. The schedule varies by topic.

- **Topics that have ongoing research and rapidly changing treatment, such as Coronary Artery Disease, are reviewed for update annually.**
- **Topics that change less frequently, such as Bunions, are reviewed for update every two years.**
- **Organizations and people using the Healthwise Knowledgebase may suggest changes or additions to topics. These recommendations are considered during the topic development process and are included in updates if they meet standard criteria and pass the medical review process.**
- **The date of the last update is found at the bottom of every topic page and in the Credits section of each topic.**

Clinical Content Review / Update Process

In terms of the process of creating and updating our clinical content for our programs, we have in place an Integrated Clinical Content Review process (CCR). Reviews of individual program, condition or wellness topic content occurs at least every two years via the Integrated Content Review process. Reviews are staggered in a time-line across two years. If clinical guidelines used as a basis for clinical content are published annually, the condition content will be reviewed annually. As new significant clinical guidelines are updated, or new guidelines are made available, our program content will be reviewed and revised accordingly.

The Integrated Clinical Content Review process involves several steps and input from various clinicians. First, our subject matter expert completes an extensive review of the available medical literature. For wellness, this includes new and/or revised literature topics (smoking, alcohol, diet/nutrition, weight, physical activity, vision, hearing, vaccinations, stress/lifestyle issues, general health maintenance, etc.), related Health Actions, condition identification and risk stratification rules, the Health Assessment, digital coaching content, and program enrollment statistics. The subject matter expert also performs an audit of phone calls between ActiveHealth health coaches and patients engaged in telephonic outreach. The Integrated Content Review process applied to all programs is dependent on clinical content including, but not limited to maternity, condition management, complex case management and Wellness coaching for lifestyle management.

Once all of this information is compiled and organized, the subject matter expert (SME) presents their findings, along with suggestions for changes to any of the content, to the Clinical Development Team. The team, together with the subject matter expert; discuss and decide on any and all changes to our products, Health Actions, etc. The SME will implement the changes and update the appropriate sub-teams.

As an example, after the SME presented a new FDA Alert warning about the cardiovascular disease risks associated with Chantix use and suggested that this new information be passed along to patients, the Clinical Development team developed new content to be delivered during the Health Assessment discussing the possible side effects of this drug. Additionally, new patient-facing content was developed discussing the effects and dangers associated with the use of electronic cigarettes, which are often thought of as safe by many people. Revisions were also made to align our exercise recommendations with current guidelines from the US Department of Health and Human Services. Additionally, the Wellness Assessment content on routine vaccinations was updated to include Human Papillomavirus (HPV) vaccinations for young women.

With regard to Utilization Management program, our primary guideline set is the MCG Guidelines (formerly known as Milliman Care Guidelines), which we also supplement with internally developed clinical guidelines to best define and drive processes that support our clients' requirements.

New guidelines are developed and existing guidelines are revised as determined by emerging technology, revised clinical indications, and changing Utilization Management needs that occur more often than the annual MCG updates or when there is a gap identified within the MCG guideline set. In addition, we develop or modify existing guidelines to meet customer specific requirements. We have extensive experience in the development of guidelines using our fulltime dedicated Medical Directors that work with our Utilization and Case Management teams across the country.

REDACTED

New guidelines are developed and existing guidelines are revised as determined by emerging technology, revised clinical indications, and changing UM needs.

When the criteria are approved, the material is finalized, including a bibliography, acknowledgement of reviewer entity, review date, and date of implementation. The criteria is then distributed and reviewed with Medical Management staff.

If the independent review recommends changes, such changes are incorporated into the draft prior to finalization. If the independent review recommends changes that require judgment or interpretation, the revised draft is resubmitted for second independent physician review before finalizing.

Once signature of approval has been obtained, the guideline is disseminated to ActiveHealth staff and Medical Directors. It is also incorporated into the guidelines section of the medical management decision support application for use by ActiveHealth. In addition, training is delivered either by a bulletin that is sent to all staff or by training sessions delivered to Registered Nurses and staff by trainers and Medical Directors as needed. **MCG are updated annually and the ActiveHealth guidelines are updated as needed, but no less than annually.**	
5.A.19 Describe the workflow for implementing medical decision-making trends and how that information is used to update the medical decision support solution. **Please see our response to Question 5.A.18.**	5 points
5.A.20 Describe your plan for ensuring care for newly enrolled Participants is not disrupted or interrupted for those Participants whose health conditions have been treated by Specialty Care Providers or whose health could be in jeopardy if services are disrupted or interrupted. **ActiveHealth has managed the transition of participants from previous programs and vendors as part of the overall implementation work plan we develop for our clients. The basic premise of the transition plan is that members participating in the current health management program will be notified that the program will be discontinued and a new program will begin. The sole focus of the transitioned population will be to ensure that no member is missed in the transition or "falls through the cracks" from the previous vendor to ActiveHealth.** **To facilitate the transition, a case summary file listing all State of Arkansas members in the current health management programs to be transitioned to ActiveHealth's program is requested. The preferred case summary information includes member demographics (telephone number if available), conditions or lifestyle risks managed, stratification designation and description, and date indicator of last health coach or mail contact.** REDACTED REDACTED **The case summary, or case data, for each member currently engaged with a health coach is reviewed** REDACTED **Members targeted for transition who are identified** REDACTED **receive the standard progressive engagement set of letters and telephone outreach is conducted via the standard process. Transition members who are not identified** REDACTED **and are actively engaged with a health coach in the current lifestyle management program will be treated as referrals into the ActiveHealth program. These members will receive outreach calls from ActiveHealth to engage in the program (provided they have not already responded to the transition notification).** **The transition notification occurs simultaneously with the overall program announcement. This communication will inform the member of the program change and provide a phone number for members to contact ActiveHealth. ActiveHealth utilizes operational reports generated on a weekly basis outlining the remaining members still requiring transition. Transition loads will continue until all appropriate transition members have been loaded into the medical management system.** **All transitional fees are typically included in our pricing.**	5 points
5.A.21 Once a Participant is enrolled and engaged in Medical Management, describe the workflow for the development and implementation of the care plan. **Case Management and Integrated Lifestyle and Chronic Condition Coaching** REDACTED	5 points

REDACTED

REDACTED

. Each subsequent assessment updates the care plan for the member across all conditions and lifestyle risks and presents the member and clinical team with follow-up detail designed to optimize health. Questions are focused on assessing the member's needs in relation to the psychosocial, cultural, functional status, knowledge, and adherence their treatment plan. Assessments also include functional status questions as well as the depression screening PHQ-2. Once the member's needs are identified, the nurse /health coach can work with the member to develop a plan of care. The plan of care will include short and long term goals that will assist the member. REDACTED **The assessment tools also enable our nurses and health coaches to provide member education and communication, specific to the member's condition/lifestyle risk and offer potential opportunities to improve their care. Case managers are able to manage a variety of conditions using their experience as well as the available online tools.** REDACTED

ActiveHealth's approach puts patient-specific information into the hands of physicians, nurses, clinics, community health workers and members. We surround the member in an environment of education and caring, reinforcing our care recommendations with convenient telephone, mail, and fax correspondence, tailored to the lifestyle of each member. Our programs ensure that each member deals with the /health coach each time they call, working to build confidence and trust at every point of contact. Building this relationship ensures members continue to take advantage of the services offered and meet their health improvement goals.

5.A.22	How do you oversee and coordinate continuity of care for Participants enrolled in more than one the Service(s)?	5 points

REDACTED

REDACTED

Once member-derived data is captured via either the member engagement platform or an ActiveHealth nurse/health coach, the information is aggregated with claims data and analyzed by CareEngine. Information added by the member is viewable by the nurse/health coach and vice versa.
We deliver a holistic, person-centric experience that better anticipates our members' needs and activates healthier behaviors and sustained engagement. Identified/stratified members are

have. The results are healthier and more engaged employees, which in turn, drives improved organizational performance and cost savings.

REDACTED

5.A.23 Provide a timeline and response(s) to a Participant using the following examples (use first contact as zero time):

5 points

a. A mother phones regarding frequent asthma attacks for her 4-year-old.
b. A man phones with questions about an elevated A1C and the new diagnosis of Type 2 non-insulin dependent diabetes.
c. A spouse phones regarding her husband's preliminary diagnosis of stage III prostate cancer.

a. A mother phones regarding frequent asthma attacks for her 4-year-old.

Timeline:
First Contact- zero time

REDACTED

Timeline
Second contact-within 24 hours of first contact (ad hoc)

REDACTED

b. A man phones with questions about an elevated A1C and the new diagnosis of Type 2 non-insulin dependent diabetes.

Timeline
First Contact- 0 time

REDACTED

Timeline
Subsequent contact

REDACTED

c. A spouse phones regarding her husband's preliminary diagnosis of stage III prostate cancer.

Timeline
First Contact- 0 time

REDACTED

e

Timeline
Subsequent contacts would be based on member's needs and preferred level of support

REDACTED

5.A.24 Describe how your program will help control the overall costs of both the ASE and PSE plans.

5 points

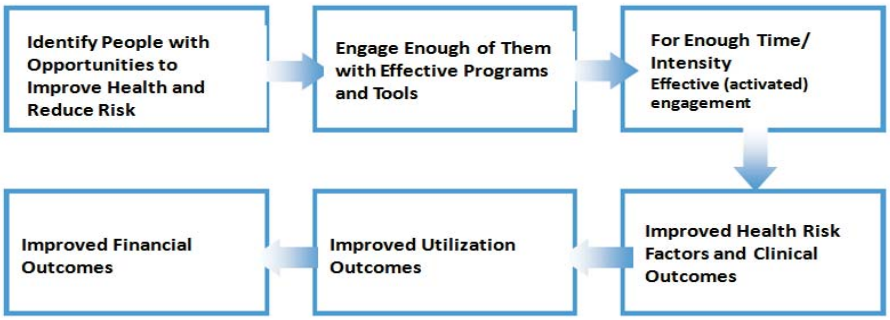
DO NOT INCLUDE ANY ACTUAL COSTS.

ActiveHealth's integrated population health management solutions are designed to help customers improve health outcomes and lower medical costs. REDACTED **s help health plans, employers, state and local governments, and physicians engage at-risk individuals, promote better care coordination and enable sustainable health care models.**

REDACTED

Outcomes Value Chain

We take a member-centric view of Population Health Management and offer programs and interventions that meet a member wherever they exist on a spectrum of health from health to healthy-at-risk, to those with chronic conditions and those with complex or multiple chronic conditions. In each of these circumstances the value we deliver derives from a chain of steps that applies to any program or service we provide. We refer to this as the "outcomes value chain".



We begin by using our best-in-class predictive modeling tools to identify members who have opportunities to reduce their health care risks or improve their health. This might take the form of identifying a gap-in-care, or identifying a member that we believe would benefit from reducing lifestyle risks, or from being enrolled in our chronic condition coaching program.

Once these members with opportunities are identified, we proceed to engage them effectively with the appropriate program or service.

When members have been effectively engaged, the result is that they reduce their risk factors and improve their clinical outcomes. The consequence of reduced health risk factors and improved clinical outcomes is that members avoid adverse events and require less health care utilization. For example, they avoid hospitalizations and emergency room visits. The reduction in health care utilization has the direct effect of producing savings. Fewer hospitalizations mean fewer hospital bills that need to be paid, etc.

ActiveHealth has delivered on exceptional outcomes for our clients, demonstrating the effectiveness of our programs. ActiveHealth's population health management programs have demonstrated significant impact on closing gaps in care, reducing lifestyle-related health risks, improving health outcomes and producing cost savings. The credibility and ROI of our programs is demonstrated not only by the savings we deliver to our clients, but also by the clinical trials we conduct to validate the effectiveness of our programs. Several studies of the impact of our programs have been published in peer-reviewed journals, several in conjunction with third party collaboration. Published studies regarding the success of our programs are available on our home page.

REDACTED

5.A.25 Detail the influence your program has had on the following:

a. Preventative care
b. Emergency Room utilization
c. Disease Management/Appropriate Drug Utilization
d. In-patient admission
e. 31-day re-admissions rate
f. Rehabilitation
g. Hospice Care

5 points

Provide supporting documentation for each example provided.

a. Preventative care

Our program promotes preventive care in several ways. Wellness alerts are sent to members who meet the criteria for evidence based preventive care services.

REDACTED

REDACTED

REDACTED

b. Emergency Room Utilization.

Several studies of the impact of our programs related to reducing hospitalizations and ER visits as well as reducing overall costs have been published in peer-reviewed journals, several in conjunction with third party collaboration. One such study is described below:

2013 CareEngine Study

In our most recent 2013 study to measure the impact and potential of our CareEngine clinical decision support program, we conducted a large-scale retrospective study with data from almost 2 million insured health plan members over a two year period. To help focus on the impact of CareEngine, and in an effort to avoid measuring impacts from other health benefit programs, members in disease management programs were omitted from the study. The results were impressive. In the study group of 131,670 people, we saw an 8 percent reduction in emergency department (ED) visits and hospital admissions, average savings of $2,295 for each resolved Care Consideration and an improvement in 8 of 13 important clinical quality indicators. The improvements were achieved by communicating patient-specific, evidence-based information to physicians and patients, helping both avoid unnecessary or costly services, and encouraging preventive and needed care.

c. Disease Management/Appropriate Drug Utilization

Disease Management

Disease management impacts appropriate drug utilization as well as appropriate drug adherence. The tool that nurses and coaches use when working with your members highlights circumstances when the member is not compliant with a medication-related evidence based guideline. They will use that opportunity to educate the member on the benefits of taking the medication.

The same tool informs the nurse or coach when the member is not being adherent with their medications. Adherence is defined as a proportion of days covered (PDC) > 80%. This gives the nurse/coach the opportunity to explore and mitigate the reasons for poor adherence.

Appropriate Drug Utilization

We impact drug utilization and type of drugs prescribed through the ActiveHealth CareEngine.

REDACTED

d. Inpatient Admissions

Several studies of the impact of our programs related to reducing hospitalizations and ER visits as well as reducing overall costs have been published in peer-reviewed journals, several in conjunction with third party collaboration. Descriptions of two of these studies:

2013 CareEngine Study

In 2013, we conducted a large-scale retrospective study with data from almost 2 million insured health plan members over a two year period to measure the impact and potential of our CareEngine clinical decision support program. In the study group of 131,670 people, we saw an 8 percent reduction in emergency department (ED) visits and hospital admissions, average savings of $2,295 for each resolved Care Consideration and an improvement in 8 of 13 important clinical quality indicators. Applied to ActiveHealth's book-of-business, this would result in savings of $13.58 PMPM. The 2013 study is consistent with our 2005 QualChoice Study referenced in the below paragraph. The improvements were achieved by communicating patient-specific, evidence-based information to physicians and patients, helping both avoid unnecessary or costly services, and encouraging preventive and needed care.

2005 QualChoice CareEngine Study

In our 2005 study, approximately 35,447 members age 12 and above (and who had at least one encounter or pharmacy claim in the preceding year) were randomized to control and study groups. Study group physicians received Care Considerations; control group data was sequestered and run at the completion of the study to determine which Care Considerations would have been issued. Successful Care Consideration resolution rate was significantly greater in the study group, as were "most *impactable*" hospitalizations (neurologic, respiratory, and cardiovascular). Paid claims were $8.07 PMPM lower in the control group after adjustment for trend (as determined by the control group). Hospitalizations were 19 percent lower for the study group compared to the control group and paid claims were $68.08 PMPM lower for the study group compared with control group.

e. 31-day Re-admission Rate:

We track hospital admissions and discharges via receipt of claims data. Members identified with chronic conditions who also have frequent admissions are stratified at higher risk, and therefore are targeted and prioritized for engagement. Our coaching interventions focus on behavior changes and compliance to evidence based treatment guidelines that can have a positive impact on re-admission rates.

REDACTED

Several studies of the impact of our programs related to reducing hospitalizations as well as reducing overall costs have been published in peer-reviewed journals, several in conjunction with third party collaboration. We provided descriptions of two of these studies under item d. (above).

With regard to Case Management, we have a 31-day re-admission trigger for member outreach to our program. Our standard Review List (SRL) in our Utilization Management program services includes Readmission Management.

In addition, our **Transitions of Care** program focuses around reducing readmissions. Outreach to members occurs within 24 to 48 hours of discharge and the nurse interaction includes education around medication adherence, warning signs, and ensuring that there is a follow-up appointment with the physician. Should members have additional or ongoing needs, and if they agree to continue to work with the nurse, the member will be moved into the complex case management program.

f. Rehabilitation

Currently, we do not have any outcomes data on rehabilitation.

G. Hospice care.

ActiveHealth offers a Compassionate Care program, which is sold as an enhancement to the Case Management program ActiveHealth would be pleased to discuss further and provide pricing should the State of Arkansas be interesting in this service. The Compassionate Care program is a telephonic care management program that supports members with advanced illness through the end of life. The goal of the Compassionate Care program is to provide holistic support services to members confronting life-threatening illnesses and educate them and their care givers about care options, such as hospice. Through its case management model, the program gives members access to nurses that are specially trained to comfort and guide those that are struggling with end-of-life care as well as specific medical conditions.

Compassionate Care Case Managers reach out to members, conduct a comprehensive assessment and develop a care plan based upon the member's identified needs and life care preferences. In addition, they collaborate with the member, family, caregiver or member-authorized representative, treating practitioner, health care provider and other programs to coordinate care, with a focus on the member's needs and wishes.

Within our case management and condition management programs, we take a holistic approach and strive to provide an integrated population health management program which provides a variety of program capabilities to cope with a variety of issues, one of which is hospice care.

Our coaches co-manage with other health care professionals for conditions as appropriate, using REDACTED. During implementation, vendors or community resources would be identified, process flows established and embedded into our system for the team to follow if the need arises.

We have various resources and tools to assist our nurses in assessing, providing education and support to the member with end of life care needs. Our End of Life assessment addresses the member's level of understanding of their condition, the impact the condition has on the functional status, pain control, advance directives, palliative care and hospice.

The nurse is able to develop a specific plan of care based on screening and assessing the member's needs. The nurse will administer the plan of care that includes education and providing support to the member and the family as the member faces life decisions. ActiveHealth's cancer management interventions also provide support and care coordination regarding hospice services. ActiveHealth will also assist with coordinating hospice services if needed. We provide End of Life support for members in need of this service by providing information about hospice as well as assessing hospice needs.

5.A.26 What peer review literature sources are utilized by your company to maintain current industry standards in the review process? — 5 points

Our primary guideline set is the REDACTED to best define and drive processes that support our clients' requirements. We have extensive experience in the development of guidelines using our fulltime dedicated Medical Directors that work with our Utilization and Case Management teams across the country.

New guidelines are developed and existing guidelines are revised as determined by emerging technology, revised clinical indications, and changing Utilization Management needs that occur more often than the a REDACTED

REDACTED

5.A.27 Describe the workflow for developing the criteria for both medical/surgical guidelines used for conducting a review.	5 points

Our primary guideline set is REDACTED **to best define and drive processes to support our clients' requirements.**

REDACTED

REDACTED

New guidelines are developed and existing guidelines are revised as determined by emerging technology, revised clinical indications, and changing UM needs.

REDACTED

5.A.28	Describe your process for updating clinical protocols including the frequency of updates. **Please see our response to Question 5.A.18**	5 points
5.A.29	Describe your workflows for incorporating new procedures and/or new technology into clinical protocols. **Please see our response to Question 5.A.1**	5 points
5.A.30	Describe how you are notified of a Participant's adverse outcome (i.e., from emergency room visit to ICU; outpatient surgery to inpatient; re-admissions within 30 days)? **Readmissions, admission to the ICU from the floor, admission to inpatient from an outpatient surgery to inpatient are components that are reviewed as part of our medical necessity review process.** **The goal of the review is to obtain information that will allow the care manager to assess the medical appropriateness at the current level of care. During the review, the care manager collects information needed to certify the requested services using documented, generally accepted clinical guidelines.** **As our personnel are notified of specific adverse outcomes or potential quality of care concerns, the situations are reviewed to determine if the concern is actionable and reportable. An actionable concern is one that may be prevented or diminished through a Medical Director intervention,**	5 points

such as contact and discussion with the treating practitioner. Actionable items are very rare as it is more typical that we are notified after an adverse outcome occurs. If the concern is not actionable, concerns are reportable to our client or their designee (e.g. the carrier responsible for the provider network) if we have been delegated to report identified potential quality of care concerns. Prior to reporting potential quality of care concerns, Medical Directors review the situation to ensure there is a potential quality of care concern.	
5.A.31 Describe your plan for implementing and maintaining an electronic log of all Adverse Benefit Decisions. REDACTED **, all determinations, including adverse determinations, are located. This allows a clinician to review and see all history of each case including every step of the denial process. Reports are developed from these source fields in** REDACTED **Additionally, we comply with the state of Arkansas regulation of publishing Arkansas state resident utilization statistics quarterly on our website.**	5 points
5.A.32 Describe your workflow for obtaining medical records for Participants when adverse outcomes are identified? Include the process for handling any related charges for obtaining medical records. **ActiveHealth's policy is that we only report potential quality of care concerns when it is contractually required. During implementation, the correct entity would be identified. We can assist the organization responsible for the provider network in obtaining medical records related to adverse outcomes.**	5 points
5.A.33 How are you notified of a sentinel event (i.e., diabetic ketoacidosis, ruptured aortic aneurysms)? Provide your workflow for tracking the sentinel event. **ActiveHealth has a Policy for how to handle Potential Quality of Care Concerns (UM). Since ActiveHealth does not manage provider networks, ActiveHealth is usually not required to report PQOC events.**	5 points
5.A.34 Describe how your organization personalizes responses to each patient. **Our programs are personalized for the member in the following ways:** REDACTED	5 points

REDACTEDREDACTED

MyActiveHealth and the Personal Health Record are also customized for each member based on their current health status or all the available data as discussed above. Specific REDACTED **The member is also always free to update and customize their PHR based on their interests.** REDACTED **. Lastly, the names of the member's care team members are displayed and members can also add the names of other care team members if they chose.**

Our Lifestyle and Condition Coaching program as well as our REDACTED **weave a behavior change coaching model that theory. This combined behavior change approach sets us apart from our competitors because we have built these methods into all engagement channels to provide a consistent experience whenever and wherever the member connects. I** REDACTED **is a form of collaborative conversation for strengthening a person's own motivation and commitment to change. It is designed to strengthen an individual's motivation for and movement toward a specific goal.**

REDACTED

Designed around 'teachable moments' such as after a biometric screening or HbA1c testing, *Health Events* are messages generated to members enrolled in our coaching programs whenever they have had a change in their health status that can relate to opportunities to improve health behaviors. These messages generate very high engagement, and are intended to get members connected with appropriate program services to work on specific areas of health improvement.

Personalized member communications: We promote our programs from

REDACTED

	Our program continually recommends additional topics to members so that they remain engaged. Our approach is to provide for knowledge checks throughout the modules via REDACTED REDACTED **Our telephonic coaching programs are also personalized. Each coaching interaction is personalized and tailored to the participant. The unique needs of participants with certain medical conditions (e.g., diabetes, asthma, and cardiovascular disease) or needs (e.g., teens, pregnant women, etc.) are specifically addressed in the analysis and planning process, with the goal of helping them achieve their specific and individual health goals. All action plans and discussions are individualized for each participating member based on individual need, including medical conditions and medications, stage of change, barriers currently impeding successful weight loss, unique dietary needs, current activity level, and so forth. Each member works with his/her respective coach to set goals and develop an action plan.** REDACTED **. These techniques, together with member-specific clinical content, enable our system to identify or behaviors important to the participant's clinical circumstances.** **We have also recently introduced a short assessment in our Lifestyle Coaching program that will help members identify the gaps of "where they are currently with their health" and "where they want to be." The assessment collects each member's preference for engagement and communication, allowing us to customize our program recommendations based on the member's preference and profile. The overall goal of this assessment is to increase intrinsic awareness and motivation, helping to create that "a-ha" moment for the member to recognize the value of participating in a health and wellness program.**	
5.A.35	What are your policies and procedures for addressing and/or reporting any quality of care issues identified for Participants enrolled in any Services. **Every formal verbal or written complaint from providers and members relating to the ActiveHealth operations will be received, documented, and reported to the quality department. The aggregate number of complaints we receive is very small and calculates The person who receives the complaint at ActiveHealth makes every attempt to research and resolve the complaint at the time of the call. The person who receives the complaint will report any serious complaints or complaints that cannot be resolved to their supervisor who will conduct additional research and resolve the complaint. Part of the research may include listening to the recording of the call, although we do not share recorded calls with a client for confidentiality purposes. Complaints that may impact the client or need client intervention are reported to the account manager who will work with the client. Complaints related to clinical issues are reviewed by a Medical Director.**	5 points

	Evaluation and resolution of the complaint will include the following: • **Listening to the provider or member complaint.** • **Collecting and evaluating all relevant supporting information.** • **Documenting the complaint.** • **Contacting the provider or member to discuss the resolution.** **Our standard is to resolve complaints within twenty working days. When areas for improvement are identified, a corrective action plan is developed to include communication of the plan to the personnel involved. All complaints that cannot be resolved amicably, and/or all complaints requiring further evaluation and action will be forwarded to the client for further direction, which may include an appeal process.** **Complaints are submitted to the Quality Improvement team, which tracks them to identify trends and areas for improvement. The complaint summary report is presented to the Quality Improvement Committee on a quarterly basis with the primary goal of identifying areas for improvement.**	
5.A.36	Describe your workflow for managing an EBD request for independent, external review. **A process is available for all types of initial inpatient and outpatient medical necessity reviews - including preauthorization/precertification, admission, concurrent, and retrospective. An ActiveHealth medical director becomes involved in a review determination if there is any question of the requested treatment not meeting the criteria for medical necessity. Generally, in any questionable situation, the nurse will refer a case to our medical director.** **Specialty match occurs for physician review where required by regulation and is standard for all appeals.** REDACTED **For specialists not represented, we access a very wide range of sub-specialists through our External Review Organization, and have always in the past been able to meet our needs for a sub-specialist.** **After reviewing the case, the medical director has the option to refer the case and the decision to our External Review Organization for Specialty Review and determination. This type of review referral is uncommon, occurring only a few times per year.** **We primarily use the External Review Organizations for appeals, but on occasion we have used an External Review Organization for an initial review when the request is not addressed in available guidelines and would benefit from a sub-specialty review.**	5 points
5.A.37	Describe your process for coordinating with the pharmacy claims administrator (i.e. prior authorization for prescriptions, specialty drugs). **ActiveHealth's team works closely with the EBD's third-party vendors and established appropriate referral rules and the rules of engagement, including criteria and processes for referral to the State's Pharmacy Benefit Manager, MedImpact (EBRX Pharmacy) or any other Pharmacy Benefit Manager and pharmacy resources. Medical staff involved with the State's program can access**	5 points

REDACTED . **We also provide monthly (or more frequent) data feeds reflecting members enrolled and invited to enroll in ActiveHealth programs. We also receive membership listings from health plans and third parties, allowing us to flag or exclude members who would be co-managed. The frequency and format of this feed is mutually agreed upon.**	
5.A.38 Provide a description of additional services available, not included in this RFP, that your organization could provide to assist Participants of the plan in Medical Management. **ActiveHealth uses a clinically-driven, technologically-based approach to care management that enables physicians and patients to work together to make better clinical decisions. Our suite of solutions beyond what is included in our response includes:** • **ActiveHealth's Health Risk Assessment** – ActiveHealth strongly supports the industry best practice of administering a Health Assessment to collect member and identify existing and emerging health issues. Our 20 plus years of experience in administering Health Assessments has shown that REDACTED we are able to present and close more opportunities for health improvement, and that contributes to overall cost savings. ActiveHealth offers our proprietary, internally developed Health Assessment that is available on . Our online Health Assessment provides members with REDACTED Our goal is to combine the benefits of collecting the data with a consumer friendly process that is easy for members to complete. • **ActiveHealth's Value-Based Formulary** – Our Value-Based Formulary is a customized formulary based on a member's personal profile and evidence-based sources. The customized formulary program provides a formulary and co- pay structure that provides those individual members who derive the most clinical benefit from specific drugs with the most financial incentive to use those drugs. This program motivates members to take their required drugs and ensures contraindicated drugs are not inadvertently administered. • **Onsite Health Programs** – Our optional onsite health solutions provide "on the ground" support and resources to drive total health awareness and increase engagement at client sites.	5 points

- **Biometric Screening**
  - We have experience offering on-site screening programs throughout the country through our outside vendors. Our vendors offer Total Program Management. We ingest the biometric screening results in our programs so that we can enhance identification of clinical health issues, potential adverse events and care improvement opportunities and alert the member and the member's physician regarding these. The data also is pre-populated into all medical health records, including the member's HRA, so they member can work on improving any out-of-range metrics and well as the members coach.

- **ActiveHealth's Social networking Platform including Challenges**
  - This program consists of group coaching and activity challenges that the full population can participate in, delivered in an online portal that is housed on the MyActiveHealth site for seamless integration. The online group coaching is interactive and is delivered online by a live coach providing a convenient way for members to improve their health in a group setting. It offers a one-to-many video-base coaching solution delivered by ActiveHealth coaches on a variety of lifestyle and condition management topics.

- **Active Rewards Center**
  - Within the MyActiveHealth portal is a member facing incentive tracking tool. Points, dollars and other ways to incentivize the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members are able to track their progress on a daily basis and see the actual dates they completed activities and the points earned for each activity. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive.

5.B Case Management (CM)

5.B.1 Provide a complete trigger list including the specific range of conditions or diagnoses of your current Case Management services, using EBD's dollar threshold criteria for both Small and Large cases. — 5 points

The following is a list of diagnoses that trigger a nurse to evaluate the potential benefit Case Management services may offer a member. This list is not intended to be all-inclusive. The diagnoses listed here often are accompanied by service needs that a case manager can provide, such as coordination of services, member advocacy, education, and coordination of benefits. Re-admissions for the same diagnosis and multiple admissions are also screened to determine if Case Management services will benefit the member and client. ActiveHealth will work with EBD to establish a time frame for the implementation of any changes to the trigger list.

REDACTED

REDACTED

REDACTED

5.B.2	Describe the process including criteria for developing a Case Management program. Provide an example of a Case Management program (i.e. diabetes management). **ActiveHealth's approach puts patient-specific information into the hands of physicians, nurses, clinics, community health workers and members. We surround the member in an environment of education and caring, reinforcing our care recommendations with convenient telephone, mail, and fax correspondence, tailored to the lifestyle of each member.**	5 points

Our programs ensure that each member deals with the [redacted] nurse/health coach each time they call, working to build confidence and trust at every point of contact. Building this relationship ensures members continue to take advantage of the services offered and meet their health improvement goals.

The goal of the Case Management Program is to identify members with complex and/or catastrophic disease states at risk for high cost/utilization and/or actual or perceived gaps in care. Case Management (CM) involves the identification, assessment and interventional management of patients with complex and/or catastrophic disease states.

In order to identify or assess the population to target the members that would have the most opportunity for case management programs, we first do data analysis of the population to understand what clinical profiles engaged in case management result in the most opportunities for engagement and positive outcomes. ActiveHealth looks at our competitors, listen to what our customers want, and look at accreditation standards. All of this will determine the targeted population for identification. Cases that are or have the potential to be catastrophic or complex in nature (i.e., cancer, stroke, etc.) and tend to incur high costs may be identified via several processes. There are a variety of ways to identify the targeted population, which can include:

- **Automatic identification of cases from Utilization Management cases triggered due to the case diagnosis, procedure or length of stay (LOS);**
- **Internal reporting used to identify members with multiple admissions;**
- **Client high dollar claims report; Referral from utilization management and customer service staff, providers, facilities, the client (health plan, TPA) and Participants;**
- REDACTED
- **Health Assessment screening, if available and integrated with ActiveHealth systems; and**
- **Evaluation of members currently in sub-acute or long term care facilities.**

The outreach strategy is determined based on what would best meet the population needs to provide the most opportunity for engagement, keeping in mind accreditation standards. Outreach modalities could include calls to members as well as discharge planners, or letters. Assessments are developed within a framework to drive to specific outcomes. Interventions derived from the assessment help the nurse to have a dialogue with the member using [redacted] to develop the plan of care together with the member.

Patients who are assessed as potentially benefiting from the Case Management program are managed by clinicians who assure that an appropriate plan of care is in place that will provide for optimal clinical and cost outcomes. Once the plan of care is in place, the plan is monitored and adjusted as necessary. Criteria are used to evaluate appropriateness for entry and exit into the Case Management program.

Example of case management program developed:

Behavioral Health Case Management

Behavioral Case Management identifies members with specific Behavioral Health or Substance Abuse conditions, assesses for gaps in care and develops a plan of care with the member in support of their treatment plan to support optimal member outcomes.

	Participants who are identified as potentially benefiting from, and agree to participate in, the Behavioral Health Case Management program are assisted by Behavioral Health clinicians who coordinate a plan of care with the member's provider. Once the plan of care is in place, the plan is monitored and adjusted as necessary to provide optimal clinical and cost outcomes. If the member screens positive for Case Management and consents, we request the patient's treatment plan as agreed upon by the patient and their Behavioral Health /Substance Abuse provider(s) and conduct an assessment of the member. We then develop a Case Management plan of care based on the assessment and the treatment plan. Behavioral Health Case Management will not include activities that either initiate or alter a Plan member's mental health treatment. Care is coordinated solely by each member's provider(s). The objective of the Care Management plan is to support the treatment plan and to promote optimal outcomes for the member. We can implement Behavioral Health Case Management where a third party vendor provides the underlying Behavioral Health Utilization Management. In this circumstance, we develop integration processes during implementation.	
5.B.3	Describe your process for managing Participants with congestive heart failure. **Within our case management program we identify members via referral,** REDACTED **Our case management outreach for heart failure is in alignment with our standard outreach process of 2 calls and an unable to reach letter. Upon engaging with the member, the case manager will connect with the member, determine the member's goals and address any condition specific goals as well.** **The case manager will work with the member to develop a care plan that will include goals and action items to address any barriers identified. Case management goals and action items to attain the member's goals may not be related to their chronic conditions. However, some of those barriers may be condition specific. If the member has a diagnosis of heart failure, the case manager will review key objectives and action items related to heart failure.** **Interventions are focused around achieving these goals:** **Members will:** • **Have an understanding about Heart Failure** • **Be compliant with their heart failure medications** • **Monitor intake and weights daily in order to reduce fluid overload** • **Have oxygen available as needed** • **Understand heart failure warning signs –when to call the doctor**	5 points
5.B.4	Describe your process for managing Participants with chronic obstructive pulmonary disease. **Within our case management program we identify members via referral,** REDACTED **Our case management outreach for COPD is in alignment with our standard outreach process of 2 calls and an unable to reach letter. Upon engaging with the member, the case manager will connect with the member,**	5 points

	determine the member's goals and address any condition specific goals as well. **The case manager will work with the member to develop a care plan that will include goals and action items to address any barriers identified. Case management goals and action items to attain the member's goals may not be related to their chronic conditions. However, some of those barriers may be condition specific. If the member has a diagnosis of COPD, the case manager will review key objectives and action items related to COPD.** **Interventions are focused around achieving these goals:** **Members will:** • **Have an understanding about COPD** • **Be able to identify and reduce triggering factors** • **Be compliant with their COPD medications** • **Understand when to use their quick relief and controller medications in order to control their COPD symptoms** • **Understand COPD warning signs –when to call the doctor** • **Have an action plan**	
5.B.5	Describe your process for managing Participants with asthma including any age-related variations. **Within our case management program we identify members via referral,** REDACTED **Our case management outreach for Asthma (Adult or pediatric) is in alignment with our standard outreach process of 2 calls and an unable to reach letter. Upon engaging with the member, the case manager will connect with the member, determine the member's goals and address any condition specific goals as well.** **The case manager will work with the member to develop a care plan that will include goals and action items to address any barriers identified. Case management goals and action items to attain the member's goals may not be related to their chronic conditions. However, some of those barriers may be condition specific. If the member has a diagnosis of Asthma (Adult or pediatric), the case manager will review key objectives and action items related to heart failure.** **Interventions are focused around achieving these goals:** **Members will:** • **Have an understanding about asthma** • **Be able to identify and reduce triggering factors** • **Be compliant with their asthma medications** • **Understand when to use their quick relief and controller medications in order to control their asthma symptoms** • **Understand asthma warning signs –when to call the doctor** • **Have an action plan** • **Pediatric- have a school action plan**	5 points

5.B.6	Describe how you monitor the effectiveness of your Case Management services including the criteria used for identifying cost savings. Provide statistics you have regarding your performance in these areas during each of the following years 2015, 2016, and 2017.	5 points

Our Case Management reports contain Case Management enrollment figures and Case Management summaries for each member in the program, typically on a monthly basis. The Case Management summary mixes text narrative with automated data points such as the plan of care and interventions scheduled or completed. If rate negotiations occur, a cost / savings report is also included.

We also provide financial reports on a quarterly, semi-annual, and annual basis. These reports include quantitative results such as savings via case coordination and negotiations.

REDACTED

We are able to provide timely case management reports that include cost of requested services before discount, cost after reduction/ discount, and total avoided costs.

We also monitor adherence to program guidelines and procedures, and we are also able to track grievances and complaints.

We conduct a satisfaction survey for all members who enrolled in our Case Management program and who have been enrolled for 60 days, and have conducted at least one follow-up assessment. REDACTED

REDACTED

The objective of the survey is to measure member satisfaction with the Case Management program, measure the member's benefit from the Case Management program, rate member satisfaction with the assigned Nurse Care Manager, and identify any areas of concern or opportunities for improvement based on member satisfaction survey results. Survey results include response rates and percentage of respondents' answers for each possible response.

We utilize the satisfaction surveys as another tool within our quality improvement program to improve our programs over time. We look for opportunities for improvement and trends within the responses. The responses are used to fine-tune our program and help us evaluate future enhancements that will benefit both the State and their member population.

Results

With regard to EBD's population, Case Management member satisfaction survey results during 2017 (3/1/17 – 12/31/17) demonstrated 99% overall program satisfaction, defined as very satisfied or mostly satisfied. Neutral responses have been excluded from the Overall Satisfaction rate.

REDACTED

REDACTED

Having provided Population Health Management solutions for our clients for more than a decade, we have provided the following snap-shot of the results we have provided with regard to State clients for their overall ActiveHealth programs.

REDACTED

REDACTED

5.B.7	Describe your process and related criteria for measuring your Case Management services as it relates to Participant satisfaction. Provide statistics supporting your performance in this area.	5 points

ActiveHealth conducts member satisfaction surveys for all members enrolled in our Case Management, condition management, and lifestyle coaching programs, and who have had two contacts with their health coach or nurse case manager. Members are surveyed through an automated telephonic survey conducted by an independent third party vendor. A survey is administered after a member has the second contact with their coach.

REDACTED

Objectives

The objectives of the surveys are to measure member satisfaction with each program; measure the member's benefit from each program; rate the member's satisfaction with their health coach or nurse care manager and identify any areas of concern or opportunities for improvement based on the member satisfaction survey results. Survey results include response rate and percentage of respondents' answers for each possible response.

Results

With regard to EBD's population, Case Management member satisfaction survey results during 2017 (3/1/17 – 12/31/17) demonstrated 99% overall program satisfaction, defined as very satisfied or mostly satisfied. Neutral responses have been excluded from the Overall Satisfaction rate.

We utilize the satisfaction surveys as another tool within our quality improvement program to improve our programs over time. We look for opportunities for improvement and trends within the responses. The responses are used to fine-tune our program and help us evaluate future enhancements to benefit our clients and their member population. **Client-specific member satisfaction surveys are also available.**	
5.B.8 What percentage of your total population was referred for Case Management during each of the following years 2015, 2016, and 2017? REDACTED **Initial screening based upon claims and pharmacy data or admission details does not always accurately reflect whether a patient is an appropriate target for case management. Additionally, because our predictive model incorporates both case and disease management triggers, a patient may be better served by using our disease management program in combination with some short term case management, rather than case management alone. This is why we have combined the role of case manager and disease manager to optimize care plan development under a single nurse based upon each individual's unique needs.**	5 points
5.B.9 Describe your Company's view of your role when working with the patient, family, attending physician and hospital staff? **ActiveHealth's Case Managers, upon receiving consent from the member, will:** • **Work in partnership with the treating physician and patient** • **Monitor the care plan** • **Work jointly with the care provider and member to make recommendations or modifications to the plan** **Case Managers will contact members and the frequency of contact will be based on the member's acuity. For example if the acuity is complex, the nurse may contact the member weekly to monthly; if the member's acuity is medium or between stable and complex, the nurse may contact the member every month to every other month; if the member is stable but has ongoing needs, the nurse will contact the member every other month to quarterly.** **Case management interventions include, but are not limited to the following:** • **Facilitate communication with member and/or caregiver and case manager, vendors, and/or providers** • **Provide education to member and/or caregiver regarding disease and best methods to achieve stability, improve functioning and overall health status** • **Provide support to member and/or caregiver** • **Coordinate care among single or multiple providers** • **Facilitate access to appropriate level of care** • **Advocate for patient with provider, vendor, etc.** • **Refer to network and/or community resources** • **Negotiation of rates. ActiveHealth will collaborate with utilization management**	5 points

• **Arrange for extra-contractual benefits or extension of benefits when a maximum has been reached, based on client approval** • **Facilitate terminal care** • **Recommend changes in treatment plan** • **Involve Medical Director or Designee as appropriate** **The case manager develops a detailed care plan in conjunction with the providers of care and the patient. The plan identifies services to be delivered, along with the frequency, duration and goals of these services to meet the member's goals. The case manager also facilitates communication with the member, care-giver, vendors, and providers; provides education and support to the patient regarding the patient's illness; coordinates care among the various health care providers and facilitates access to the appropriate level of care, including referral to community-based resources; and advocates on behalf of the patient with the health care providers and vendors. The case manager also verifies benefits and assists in arranging services, negotiates rates with out-of-network vendors and may negotiate cost savings for the medical services.** **Case managers will refer cases for consultation with an ActiveHealth Medical Director when there are questions about a member's status and plan of care. Examples may include: the member is not showing improvement; the proposed treatment is not considered the standard of care; the proposed treatment is investigational, or the proposed treatment can be rendered in a lower level of care setting. The ActiveHealth Medical Director will review the treatment plan or plan of care and will make outreach calls to providers (e.g., the member's treating physician) to clarify the plan of care, as well as offer assistance in coordinating services.**	
5.B.10 Describe your company's process for maintaining successful relationships when coordinating services for Participants with payers, physicians, mid-level providers, hospitals and community resources. **The Case Manager develops a detailed care plan in conjunction with the providers of care and the member. The plan identifies services to be delivered, along with the frequency, duration and goals of these services to meet the member's goals. The Case Manager verifies benefits and assists in arranging the services. The Case Manager monitors the care plan and works jointly with the care provider in making recommendations or modifications to the plan. The Case Manager coordinates care when there are multiple providers; facilitates access to the appropriate level of care; advocates for the member to the provider; and when needed, negotiates rates with out-of-network providers.** **An ActiveHealth Nurse may also have direct contact with the provider in obtaining clinical information for the purpose of reviewing the plan of care for members in lower levels of care to include: Acute Rehab, Subacute, SNF, LTAC facilities, outpatient therapies, and DME Services, Home Care, etc. ActiveHealth case management staff work with the provider in order to provide coordination of care. An ActiveHealth nurse can refer a case for consultation to the ActiveHealth Medical Director when there are questions about the treating provider's plan of care or member's status. Examples may include: the member is not showing improvement; the proposed treatment is not considered the standard of care; or the proposed treatment is investigational.** **An ActiveHealth Medical Director will review the treatment plan of care and will make outreach calls to providers for clarification and consultation to assist in coordination of care for the member. ActiveHealth physicians and nurses will call providers to review and understand the plan of care information and to discuss opportunities to change the care setting and reduce costs. For example: IV therapy may be delivered via inpatient and it could be reassigned to IV therapy at home or an outpatient setting. We also call providers when the treatment plan deviates from evidence based standards identified by the CareEngine systems.**	5 points

5.B.11 What are your procedures to identify and assess alternative services and/or treatment protocols? a. If you identify alternatives to treatment what is your procedure to get those approved? b. Who do you think would need to be involved in that process?	5 points

Case managers are often tasked with finding alternative funding for members with complex conditions. Case managers use tools such as the Dorland Case Management Resource guide to assist with identifying resources within the local area of the member. During the implementation process, we work with the client to identify specific local / community resources that we will use to support members as appropriate during the case management process. These resources can be identified within our assessments as customized interventions.

The case manager can also contact the plan administrator to evaluate if benefit exceptions will be considered. ActiveHealth considers investigational or experimental treatment to be those procedures that do not have a specific approved clinical protocol or an accepted standard of care, defined and documented for the condition in question.

We can also work with the State of Arkansas to develop a list of experimental/investigational procedures and tests that should be reviewed under the plan design or, if they are very costly, should be used only in highly specific circumstances.

We recommend reviewing procedures and tests that may be showing signs of over-utilization, have a higher denial rate, and that show variability in practice patterns.

Our review would entail determining if the requested procedure is FDA-approved (a procedure may be FDA-approved and still be considered experimental) for the specific condition in question, and involve Board-certified specialists in the relevant clinical area as needed.

In addition, we will work with social services at the facilities to identify possible resources for the member. Other resources include the Pharmacy Benefits Manager (PBM) and review of alternative and less expensive treatment options, such as generics.

Our Case Management program includes the ability to re-direct care to lower cost facilities within the network.

REDACTED

Network and plan design are carefully reviewed during the implementation process and documented within the ActiveHealth clinical system. During pre-certification review, our care managers are

REDACTED

ActiveHealth's staff is then able to combine this information with the plan design detail within our system to inform members and providers that the requested facility or physician is not included in the network and explain potential penalties and redirect them to in-network resources if possible. ActiveAdvice also enables our care managers to advise patients of providers, facilities and vendors, by specialty or type, that are in their network locally.

a. If you identify alternatives to treatment what is your procedure to get those approved?

Case Managers are often tasked with finding alternative funding for members with complex conditions. Our case managers use tools such as the Dorland Case Management Resource guide to assist with identifying resources within the local area of the member.

During the implementation process we work with the client to identify specific local / community resources that we will use to support members as appropriate during the case management process. These resources can be identified within our assessments as customized interventions. The case manager can also contact the plan administrator to evaluate if benefit exceptions will be considered. In addition, we will work with social services at the facilities to identify possible resources for the member. Other resources include the Pharmacy Benefits Manager (PBM) and review of alternative and less expensive treatment options, such as generics.

Within the context of our Utilization Management program, the Utilization Management nurse may refer to the case manager to discuss with the customer additional services that may provide more benefit and assist in avoiding more costly services for the member. The case manager would discuss this option with the customer for an exception of benefits if the additional services may assist in avoiding more costly services. A document including proposed cost and services is documented and signed by all parties (the customer, the claims payer, the facility or entity providing the service, and the case manager).

b. Who do you think would need to be involved in that process?

The following people need to be involved in these alternative and complementary treatment decisions: the member, member's family, member's physician, our medical director, the State health plan medical director, the State health plan executive director or others designated by the State health plan.

Should there be a situation where the member and plan may benefit from an extra-contractual benefit agreement, typically, the State or Arkansas, ActiveHealth case manager, and their supervisor, the claims payer, and the entity that is providing this service would be involved in this process.

5.B.12 Describe the criteria your company uses for defining the severity levels related to the Services currently provided.

5 points

REDACTED

We work with our clients to modify the number of persons or percent of population in each of these categories, depending on our client population needs and their disease, condition, or wellness situation.	
5.B.13 Describe the workflow currently used by your case manager's when/if they reach someone on the Participant's care-team other than the Participant. **ActiveHealth's Case Managers, upon receiving consent from the member, will:** • **Work with the member's care team to develops goals, milestones and interventions that make up and support the plan of care.** • **Work in partnership with the treating physician and member** • **Monitor the care plan** • **Work jointly with the care provider and member to make recommendations or modifications to the plan** **An ActiveHealth Nurse may have direct contact with the provider in obtaining clinical information for the purpose of reviewing the plan of care for members in lower levels of care to include: Acute Rehab, Subacute, SNF, LTAC facilities, outpatient therapies, and DME Services, Home Care, etc. ActiveHealth case management staff work with the provider in order to provide coordination of care. An ActiveHealth nurse can refer a case for consultation to the ActiveHealth Medical Director when there are questions about the treating provider's plan of care or member's status. Examples may include: the member is not showing improvement; the proposed treatment is not considered the standard of care; or the proposed treatment is investigational.** **An ActiveHealth Medical Director will review the treatment plan of care and will make outreach calls to providers for clarification and consultation to assist in coordination of care for the member. ActiveHealth will call providers to review and understand the plan of care information. ActiveHealth physicians and nurses contact doctors to discuss opportunities to change the care setting and reduce costs. For example: IV therapy may be delivered via inpatient and it could be reassigned to IV therapy at home or an outpatient setting. We also call providers when the treatment plan deviates from evidence based standards identified by the CareEngine systems.**	5 points
5.B.14 Describe the workflow currently used by your case managers when contacted and/or contacting other medical providers about a Participant's care. Including Participants in either an active or closed status. **The case manager develops a detailed care plan in conjunction with the providers of care and the member. The case manager works jointly with the member's physician(s) and other care providers in making recommendations or modifications to the plan. The case manager coordinates care when there are multiple providers; facilitates access to the appropriate level of care; advocates for the member to the provider; and when needed, negotiates rates with out-of-network providers.** **An ActiveHealth Nurse may have direct contact with the provider in obtaining clinical information for the purpose of reviewing the plan of care for members in lower levels of care to include: Acute Rehab, Sub acute, SNF, LTAC facilities, outpatient therapies, and Durable Medical Equipment Services, Home Care, etc. ActiveHealth case management staff work with the provider in order to provide coordination of care. An ActiveHealth nurse can refer a case for consultation to the ActiveHealth Medical Director when there are questions about the treating provider's plan of care or member's status. Examples may include: the member is not showing improvement; the proposed treatment is not considered the standard of care; the proposed treatment is investigational; or the proposed treatment can be rendered in a lower level of care setting.**	5 points

An ActiveHealth Medical Director will review the treatment plan of care and will make outreach calls to providers for clarification of the treatment plan and consultation to assist in coordination of care for the member. ActiveHealth physicians and nurses contact doctors to discuss opportunities to change the care setting and reduce costs. For example: IV therapy being delivered in an inpatient setting could be reassigned to IV therapy at home or an outpatient setting. We also call providers when the treatment plan deviates from evidence based standards identified by the CareEngine systems. **ActiveHealth Medical Director involvement with the program is as follows:** • **Formal case reviews and outreach as needed** • **Informal case consultations** • **Grand Rounds - Formal care presentations, analysis and recommendations** • **Doc is In - which is on demand access to a medical director for on the spot case consultation.** • **Clinical education program delivery:** • **Clinical content updates training** • **Regular in-services for clinicians** REDACTED	
5.B.15 Describe your process for incorporating tele-medicine services. **Telemedicine claims are billed same as any other service and would come through on the medical claims file.**	5 points
5.B.16 Describe the process for distributing cases among case managers. How are cases managed across multiple case managers for continuity of care for Participant's? **Cases are assigned as appropriate by clinical supervisors to optimize the nurse's expertise with the member's needs.** REDACTED	5 points
5.B.17 Provide your company's current criteria for: • Participant enrollment • Participant engagement • Participant compliance If necessary describe your plan to adapt EBD's criteria. **ActiveHealth has traditionally defined engagement on a programmatic level by calculating the volume and percent of members participating in programs. With our refreshed focus on engaging members where, when and how they want to engage, we are broadening our engagement definition to track engagement at a population level with drill downs into the various engagement modalities: Health Assessment completion; on-line activities such as interacting with health actions, documenting trackers, and completing digital coaching sessions;**	5 points

	participation with our social community platform; telephonic (individual or group) and/or on site coaching; interacting with our newer engagement methodologies such as text and mobile applications. As our integrated, multi-touch platform provides individuals the ability to conveniently engage, according to their preference, in activities that help drive lasting behavioral change, we recognize and report back on the meaningful touch points across the continuum. **Specifically regarding active telephonic engagement, engagement is defined as a member who has undergone at least an initial assessment and is involved in ongoing communications with their dedicated nurse/health coach in managing their health conditions. Our transparent reporting outlines metrics around members actively engaged (high intensity) with a nurse, those members engaged with a nurse periodically (low intensity, which includes members who have requested this level of engagement, or have graduated or been stepped down to a maintenance level), and those members engaged through other modalities, such as online engagement. Members who are telephonically engaged with a nurse and who have not had an encounter within 180 days are stepped down and no longer counted as actively engaged telephonically.**	
5.B.18	Provide your goal/target for Participants consent to Medical Management? **With regard to Case Management, across our book-business:** REDACTED	5 points
5.B.19	Provide your goal/target for Participant engagement of no less than 2 calls with certified case manager. REDACTED	5 points
5.B.20	What is your current standard for responding to a Participant's request for contact? If different from the RFP requirement, what is your plan for implementing EBD's timeframes? REDACTED	5 points
5.B.21	If the assigned Case Manager is not available, describe the process for addressing the Participant's needs. REDACTED	5 points

5.B.22 Describe your process for confirming Participant eligibility, provider network status, and covered services before recommending a care plan. REDACTED **and if there is an error or change to an individual record, it can be sent and then processed in the next scheduled batch. Any changes to the eligibility of an individual member can be sent to ActiveHealth and the record would be updated in the next scheduled set of data processed.** **With regard to plan benefits, when a new client is implemented, their key plan coverage and review parameters** REDACTED **The Utilization Management Nurses and Case Managers who will be working with the State's population are also required to attend an orientation and training session to review key plan information and any other issues unique to the client's utilization review and case management program.** **In terms of provider networks,** REDACTED **ActiveHealth's staff is then able to combine this information with the plan design detail to inform members and providers that the requested facility or physician is not included in the network and explain potential penalties and redirect them to in-network resources, if possible.** REDACTED **The Case Manager uses this information when developing the care plan in conjunction with the providers of care and the member. The care plan identifies services to be delivered, along with the frequency, duration and goals of these services to meet the member's goals. The Case Manager verifies benefits, assists in arranging the services and may negotiate cost savings for the medical services.**	5 points
5.C Utilization Management (UM)	
5.C.1 How often do you review participant utilization? **If our UM Nurse is able to certify a member's admission based on the** REDACTED **, the UM nurse will assign an approved length of stay based on the severity of the member's condition and the complexity of treatment planning and discharge planning. It usually ranges from two to three days. All utilization and case management functions are provided telephonically. Practitioners are notified by telephone and written notification is provided to the covered person(s). The written notification includes the next review date, the new total number of days recommended and the date of admission.**	5 points
5.C.2 Describe your company's workflow for notification of high utilization Participants. **By maximizing on a fully integrated approach, ActiveHealth can identify members that have a high likelihood of needing case management based on triggers from diagnoses, multiple hospitalizations, and multiple emergency room visits.**	5 points
5.C.3 Describe your Company's workflow for reviewing a Participant's current medication(s) and the correlation it has to the treatment of their medical diagnosis. REDACTED	5 points

REDACTED

Additionally for those patients who are engaged by one of our care management nurses, medication review occurs with every engagement, including cataloging of over the counter, nutraceutical, and prescription medication use.

REDACTED

5.C.4 Describe the process used to advise providers when it appears that a Participant may be utilizing multiple physicians of the same specialty to obtain medications in the same therapeutic class?	5 points

When a member engages with a care manager the nurse will review the member's condition as well as all medications. In situations where there is a question around the treatment plan including medications, the nurse would refer the case to the ActiveHealth Medical Director. The care management platform, powered by payer data, clinical and member-derived data enables the ActiveHealth team to detect not only poly pharmacy but also indications of issues with compliance, including misuse and overuse. The medical directors in consultation with the nurses will identify those opportunities for improvement/clarification and reach out to the treating provider(s).

REDACTED

5.C.5 Provide an overview of the clinical criteria/coverage policies available to your provider community including the level of access and any restrictions to that access. **ActiveHealth has made the MCG guidelines available on our website.** **We have provided access to MCG Cite Guideline Transparency MCG Cite Guideline Transparency at https://www.mcg.com/how-we-help/health-plans/cite-evidence-based-clinical-decision-support-for-payers/cite-guideline-transparency/**	5 points
5.C.6 Describe your company's process for defining a procedure as cosmetic, and any associated policies related to obtaining pre-authorization and/or notifying a Participant of their financial responsibilities. **A cosmetic procedure is one that is designed to improve appearance but has no role in improving the health of the individual involved. Our guidelines contain many examples of procedures that can serve both a cosmetic and a medical function and our UM department conducts regular reviews of such cases to determine medical necessity. We do not address benefits issues nor do we administer benefit information; instead, we try to develop workflows with our clients that ensure members are seamlessly guided to benefit specialists for questions about benefits coverage for any issue.** **We review the patient's clinical data using our guidelines to deliver a standardized opinion on the medical necessity of a procedure or treatment for a specific member's clinical situation. The Medical Director is involved in this determination if there is any question of the requested treatment meeting the criteria for medical necessity. Examples include blepharoplasty, reduction mammaplasty, and abdominoplasty.** **Generally, in any questionable situation, our Medical Director or a physician specialist will determine its appropriateness and the level of care. Verification of available benefits is the first step followed by requests for clinical documentation from all involved providers and health professionals for the recent past (generally less than two years) related to this type of procedure. Once documentation is received, the nurse reviews the materials in conjunction with our clinical guidelines to determine if medical necessity can be established.**	5 points
5.C.7 Describe your company's current workflow for determining the medical necessity of a continued hospital stay including the method of notifying both the Participant and the provider of your decision. **In addition to pre-certification, pre-notification and medical necessity reviews, our program includes concurrent review of hospital admissions. The goal of the continued stay review is to obtain information that will allow the care manager to assess the medical appropriateness of continued stay at the current level of care. Another purpose of the concurrent review is to assess the patient's discharge plan, and initiate discharge planning as appropriate; and determine whether the member requires case management services.** **Once the service has been determined as medically necessary and an initial length of stay approved, our nurse will assign the date for the next review being the first non-covered day according to the last date of the approved length of stay. Concurrent review is a real time assessment of ongoing medical services/treatment to determine continued medical necessity and appropriateness of care.**	5 points

	During the review the care manager collects information needed to certify the requested services using documented, generally accepted clinical guidelines. Only the clinical information obtained at the time of the concurrent review is utilized to make a review determination. Medical records are not routinely requested at this stage of review. Continued stay reviews contribute to evaluation, not only for discharge, but also for real-time identification of members requiring case management. **The intensity of service, the severity of illness and recovery milestones must be demonstrated in order to approve the continued stay. Practitioners are notified by telephone and written notification is provided to the covered person(s), provider and facility. The written notification includes the review date, the new total number of days approved and the date of admission. When treatment has been approved, the decision will not be reversed. In the case of a denial, the practitioner is notified by telephone, and written notification is provided to the covered person, and the practitioner and facility. The written notification includes the date of the last recommended day, appeal and peer-to-peer discussion instructions, and information regarding the clinical rationale for the non-recommendation.**	
5.C.8	Describe your company's plan and process for making out-of-network referrals and ensuring Medically Necessary Covered Services are provided via the referral. **If the use of a participating provider is not a possibility due to such factors as distance or availability of service, we refer the case to the health plan to develop a Letter of Agreement and negotiate a temporary contract and discounted fees with the non-participating provider.**	5 points
5.C.9	Describe your company's current workflow for a request which is received for a planned medical or surgical admission that fails to meet the medical necessity criteria. Include each stage of the process specifically outlining in the workflow when the physician-to-physician communication is initiated? **ActiveHealth reviews all Inpatient Admissions for medical necessity. Verification of eligibility and available benefits is the first step followed by requests for the clinical rationale, expected length of stay, and requested level of care for the service or procedure. Once the information is received, the nurse documents the appropriate diagnosis and procedure codes and requested length of stay and reviews the request against our clinical guidelines (Milliman Care Guidelines supplemented by internally developed guidelines as clinically indicated) to make the authorization decision and if authorized, assign the initial length of stay.** **If it is determined while performing a review that a planned medical or surgical admission fails to meet the medical necessity criteria, the decision notification procedure includes both a telephonic and letter component indicating this outcome for all cases. In the case of a denial, the provider is notified by telephone, and written notification is provided to the covered member, and the practitioner and facility. The written notification includes the date of the last recommended day, appeal and peer-to-peer discussion instructions, and information regarding the clinical rationale for the non-recommendation. The UM nurse calls the requesting provider to communicate the denial decision which includes the rationale as to why the denial decision was made. This call is made on the same day that the ActiveHealth Medical Director completes the decision review. Also during this same call, the nurse offers the appeal rights and a peer-to-peer discussion with the reviewing medical director. The Medical Director's name and direct phone number are also given to the provider.** **Peer-to-peer review is offered to 100 percent of cases where a denial decision is being made based on available utilization management information. We attempt to contact all treating physicians when the medical director is not able to approve the case after a referral from UM staff.**	5 points

5.C.10 Describe your process for monitoring provider transparency related to evidence based medical (EBM) outcomes. **Providers and members have the ability to provide pertinent clinical feedback on a Care Consideration that is maintained in the member-centric record. Each Care Consideration is accompanied by references to the supporting medical literature and includes a survey form to capture physician feedback and updates to the member's clinical profile. We believe that it is essential to give the physician the opportunity to give us feedback. This feedback loop allows us to gather more data suitable for incorporation into the patient's record and may provide information not otherwise available in the administrative data, e.g. a past allergic reaction. In fact, physician feedback might even alter the CareEngine decision to send the member a Care Consideration message. If a physician wants to discuss the message, we are staffed to support inbound calls and always have a physician available for a direct physician to physician conversation.** **In terms of measuring compliance, through an automated process in the CareEngine System, we are able to track at a member specific level, the Care Considerations that have been identified and messaged. The system continues to track the Care Consideration in order to see if the data shows that it was acted upon and the gap was closed. Once the data is evident, it is added back into the member's longitudinal electronic record which is continuously assessed by the CareEngine. In this way, these closed gaps become part of the record and are then aggregated and reported back to the client. If the gap is not closed, the system will automatically trigger the messaging to recur at intervals predetermined by our clinical team.** REDACTED	5 points
5.C.11 Detail any value-based program incentives (i.e. PCMH, CPC+, ASO, etc.) offered for best practice care. **ActiveHealth Management has been industry-leading in the effort to provide both clinical integration technology and integrate clinical resources for wellbeing and population health solutions into Accountable Care Organizations (ACOs) and health systems across the country.** REDACTED	5 points

5.C.12 Provide sample copies of all reports, including but not limited to: a. Participant utilization b. Re-admission rates c. Gap analysis d. Co-morbidities e. Financial (i.e., provider discounts) f. Clinical criteria g. Appeals related to Medical Management (and their results) **Below is a list of the current reports available to the State. The reports are posted to EBD Secure Email Task system. We have also included samples with our proposal.** **Monthly:** • **CM-TotalPart-PHI (standard report)** • **MATE-TotalPart-PHI (standard report)** • **UM-ESR Report (standard report)** • **UM-PLCR-PHI (standard report)** • **High Profile Report - (custom manual report provided by Linda Sprauer in Clinical Operations)** • **Nurseline Triage Report (standard report from Citra)** • **Nurseline Operations Report (standard report for Citra)** **Quarterly:** • **State of AR UM-Precert (standard report)**	5 points
5.D Behavioral Health and Substance Abuse (BHSA)	
5.D.1 Describe your team structure, training of new staff, levels of authority, self-auditing in relation to BHSA. **Our EBD model is based on a multidisciplinary team approach (medical, behavioral) staffed with the appropriately licensed clinicians (nurses, masters level licensed behavioral health staff) and additionally utilizes clinical support teams to provide integrated care management for Participants who qualify for multiple program interventions. The team is supported by board certified physicians including psychiatrists for clinical questions, peer to peer discussions and medical necessity denial and appeal support.** **The initial training program is completed prior to a nurse taking on a caseload of active Participants.** REDACTED **We supplement the new staff with focused information about the special populations that may be enrolled in the program. Coaches also receive corporate training in cultural and senior sensitivity.**	5 points

Case managers receive ongoing training in the specific conditions covered by our program and in other aspects of Participant support and care management, including motivational interviewing. REDACTED **Additionally, ActiveHealth assists our nurses in meeting continuing education requirements by providing onsite training and underwriting external training sessions that our staff attends.**	
5.D.2 Describe your company's BHSA Utilization Review process. • Credential requirements for staff • Training and monitoring of Utilization Review staff • Pre-authorization requirements • Utilization review criteria for determination of clinical appropriateness • Clinical information gathered for review • Denial notifications to Participants and providers **Behavioral Health Management identifies Participants with specific Behavioral Health (BH) or Substance Abuse (SA) conditions or BH comorbidities. Our Utilization Management (UM) program assesses Participants for appropriate (medically necessary) level and types of care for BH conditions. The Utilization Management program (UM) also uses clinical rules to trigger identification for case management based upon risk. Claims and clinical data are applied to clinical analytics for the purpose of identifying gaps-in-care and for identifying Participants who are high risk and/or have high utilization of outpatient BH services. UM identifies Participants who need case management for stepping down to a lower level of care or discharge to home and also supports the Participant's overall plan of care in complete support of their provider's treatment plan, resulting in optimal clinical outcomes for the Participant. Triggers for identification to the BH care management programs include Bipolar, Major Depression, Eating Disorders, Schizophrenia, and Anxiety as a co-morbidity. Substance abuse triggers include abuse as a comorbid condition.** REDACTED **. Candidates that can benefit and agree to participate in the BH Case Management program are engaged by Behavioral Health clinicians. If the Participant screens positive for Case Management and consents, we request the patient's treatment plan as agreed upon by the patient and their BH/SA provider(s) and conduct an assessment of the Participant. We then develop a Case Management plan of care based on the assessment and the treatment plan. BH Case Management will NOT include activities that either initiate or alter a Participant's mental health treatment. Care is coordinated solely by each Participant's provider(s). The objective of the Care Management plan is to support the treatment plan and to promote optimal support and outcomes for the Participant. The Participants' care will be managed in collaboration with treating providers while they are in intensive levels of care (inpatient, detox or rehab, residential) and supports Participants across transitions in care settings to lower levels of care. Once the plan of care is in place, the plan is monitored and adjusted as necessary to promote treatment compliance, provide optimal clinical and cost outcomes.** **Participants are identified for behavioral health care management based upon clinical diagnosis, level of care triggers, treatment history including readmissions or claims triggers (high cost claimants), nomination of provider or health plan. Additionally, Participants who have primary medical conditions, but have been assessed for behavioral health comorbidities are considered for potential BH program support.**	5 points

	Behavioral Health and Substance Abuse services include evaluation of the appropriateness, medical need and efficiency of behavioral health and/or substance abuse services, according to established Milliman criteria, American Psychiatric Association, and American Society of Addiction Medicine (ASAM) guidelines. **All medical directors have current Board Certification in their specialty. Specialty match occurs for physician review where required by regulation and is standard for all appeals. ActiveHealth's primary and back-up medical directors for EBD are licensed in the state of Arkansas. ActiveHealth's medical directors perform pre-certification reviews if there is any question of the requested treatment not meeting the criteria for medical necessity.** REDACTED	
5.D.3	What criteria does your company use to determine if a Participant needs immediate placement by a mental health professional? **The ActiveHealth behavioral health clinician or nurse will review cases to determine if the Participant meets medical necessity and determine if the Participant is in the appropriate level of care, based on clinical guidelines. Reviews can occur for the different levels of care including Acute Inpatient, Residential, Partial Hospitalization, Intensive Outpatient based on agreed client review requirements. Substance Abuse reviews are managed in the same manner to determine medical necessity and appropriate level of care which can include Acute Detox, Residential, Partial Hospitalization and Intensive Outpatient. ActiveHealth can review specific behavioral health such as ECT and psychiatric testing. Referrals to BH Case Management occur as part of our Utilization management process. As part of the care management process for Participants with primarily medical conditions, BH comorbidities are considered as part of treatment plan with potential for BH support and referrals considered. All Participants are assessed for Depression using the PHQ 2 assessment. Participants already diagnosed with Depression are monitored using the PHQ9 assessment. The Participant's care is monitored through discharge and across transitions in care in order to reduce readmissions. If, as part of the discharge planning focus, it is determined that the Participant is newly diagnosed with a mental health condition and does not have a mental health provider in order to deliver follow-up care, the case manager would work with the discharge planner or Participant to identify a local in network provider if one is available. Other instances where a case manager would identify a mental health professional for the Participant could include: a) while interviewing the Participant that the Participant has self-reported that they do not have a mental health provider involved in their treatment plan or b) Participant has an ongoing mental health condition where the Participant has decompensating issues identified, the nurse/clinician will assist the Participant in locating a mental health provider referrals within available provider network.**	5 points
5.D.4	How do you assist a Participant in connecting with a mental health professional? **Care is coordinated solely by each Participant's provider(s). The objective of the Care Management plan is to support the treatment plan and to promote optimal outcomes for the Participant. All Participants are assessed for Depression using the PHQ 2 assessment. Participants already diagnosed with Depression are monitored using the PHQ9 assessment. Seamless integration will occur between the BH Case Management and the BH medical management. The BH Case Manager will work with the Participant on medical management and requests for Behavioral Health Treatment. The BH manager will assist in steering Participants to in-network providers at the most appropriate level of care. Additionally if it is determined that the Participant or their family can benefit from community resource referrals (AA, NAMI, support groups etc.) the care manager will assist with identifying these supports.**	5 points

5.E Disease Management	
5.E.1 Describe the process including criteria developing a disease management services. Provide an example of a Participant with multiple co-morbidities enrolled in disease management. **ActiveHealth's health strategy for EBD Participants with chronic conditions is to focus on their overall well-being by addressing health and wellness issues across the health care spectrum: from healthy to at-risk, acute and chronic, to palliative care. ActiveHealth's experience over the past two decades indicates that** REDACTED	5 points

	Once engaged, we approach care management of Participants with multiple conditions and issues from a holistic perspective. Instead of using a disease specific hierarchy we balance our approach across what appears to be the most clinically significant issue with the Participant's perception of what is most important to them. **For example, an EBD Participant may be identified with Diabetes and Chronic Low Back Pain. From a clinical perspective, the Diabetes may appear to be the more significant issue, however if the back pain is interfering with the Participant's functional status to such an extent that they are having difficulties complying with their diabetes plan, we will prioritize our focus on the back pain. We also frequently find that Participants with chronic conditions also have lifestyle issues, specifically related to weight, and by incorporating coaching about weight loss and healthy or condition specific diet in our care management approach, we are able to support the Participant in achieving improvements in their chronic conditions.**	
5.E.2	How long have you had the Disease Management program in place? **We have been providing disease management services through our NCQA accredited disease management program since 2003.**	5 points
5.E.3	Provide the workflow for identifying and enrolling Participants in your DM services. **Our enrollment process has been specifically designed to reduce barriers for Participants to access the program. The process can be summarized in three unique steps including enrollment, outreach and engagement. A brief summary of each is as follows:** **<u>Enrollment</u>** **Before enrolling a Participant, we identify Participants for Disease Management interventions by** REDACTED **<u>Outreach</u>** **Once the Participant condition has been identified and validated, our outreach process starts. Low risk Participants receive a program introductory package, which introduces the program, builds program awareness, notifies them that they may self-refer for telephonic engagement and encourages them to engage with our digital coaching platform.** **Moderate and high risk participants receive an introductory telephone call in addition to the introductory package. The objective of the telephone call and letter are to introduce the program, build program awareness and encourage nurse engagement. Moderate and high risk Participants are then selected for additional outreach with the objective of promoting Nurse - Participant engagement. These Participants receive a second invitation telephone call followed by an invitation letter, then followed by up to two additional outreach telephone calls made by Customer Service Agents interspersed with two additional outreach letters. If the Participant has not engaged after the outreach campaign, they receive one additional automated telephone call. At any point in the outreach process Participants may opt to engage with a Nurse which completes the outreach process and the engagement process begins.** **All identified Participants receive outreach using a combination of email, phone call and or/letter based on clinical intensity as well as presence and consent to use email and consumer segment. The objective of the outreach is to connect Participants immediately to MyActiveHealth, our patient engagement platform so Participants can get started with coaching right away using our digital coaching platform. From MyActiveHealth Participants can message with a coach as well as schedule their own coaching appointment. Additionally, Participants who are higher intensity receive additional outreach using the methods described above to promote one to one coaching.**	5 points

Engagement

The engagement process includes targeted Participant assessment and supportive coaching to assist the Participant in establishing goals and a personalized plan of care to achieve the goals. Our ActiveHealth registered nurses act as the Participant's "personal health coach" providing one-on-one education and support specific to the Participant's individual health care needs. At the onset of engagement, Participants are assigned a Nurse who will work with them to manage their condition and support them in meeting their healthcare goals.

REDACTED

. Participant interaction with the Nurse coach may include , education on key clinical targets related to all of the Participant's condition(s), warning signs for condition-related complications, at risk and lifestyle issues such as smoking or stress and other individualized educational and goal-setting interventions. To reinforce issues discussed during the telephone calls, a follow-up letter summarizing the engagement, including any Care Considerations discussed, is sent to the Participant along with condition or issue specific brochures. Another important role of the Nurse is to coach and advocate Participant communication with his/her physician(s). This helps to reinforce the importance of the Participant actively participating in their health care. The overall result is a comprehensive patient-centric approach to care management not limited to individual disease states.

REDACTED

. The nurse will also suggest the Participant participate in various activities , such as reviewing health videos, reading articles, documenting biometrics such as weight and blood pressure and participating in other interactive programs.

REDACTED

It is important to note that all Participants of the population – those identified with a chronic condition as well as those who do not have a condition - benefit from the

REDACTED

5.E.4 Provide the workflow for managing Participants in your DM services.

5 points

Managing Participants engaged in the EBD program is a key differentiator of ActiveHealth. Successfully driving clinical outcomes is contingent upon sound processes to manage each Participant as an individual. We are able to effectively work with Participants, meet them where they are in their change process and help drive motivation and sustainable behavior change – which in turn creates better outcomes. Participants who achieve a specific health improvement goal often act as an ambassador to their coworkers or family members by providing testimonials and referrals about the program, encouraging further participation.

REDACTED

Coaching includes identifying issues, exploring base motivation to make lifestyle changes,

REDACTED

and establishing a plan or strategy to achieve the goals. Each coaching session explores the success in sticking to the plan and moving closer to goal achievement, as well as education and support to encourage and motivate the Participant to continue on the path towards lifestyle changes that last. If barriers exist, we explore ways to overcome the barriers; if the Participant is not making progress, we may need to re-explore motivation and re-set some of the goals. We aim to support Participants in making changes that last, versus a quick one time fix.

Another important role of the coach is to advocate Participant communication with his/her physician(s). This helps to reinforce the importance of the Participant actively participating in their health care.

REDACTED

education on key clinical targets related to all of the Participant's condition(s), warning signs for condition-related complications, at risk and lifestyle issues such as smoking or stress and other individualized educational and goal-setting interventions. At the end of each call, the coach will schedule the next appointment with the Participant. To reinforce issues discussed during the telephone calls, a follow-up letter summarizing the engagement, REDACTED **discussed, is sent to the Participant along with condition or issue specific brochures. Participants receive appointment reminder calls 24-48 hours prior to any scheduled appointment. If the appointment is missed, we make additional attempts to reschedule the missed appointment.**

REDACTED

REDACTED **Therefore, data and activities related to identification, outreach and engagement are readily available to any coach supporting the Participant and allows for seamless integration between programs.**

REDACTED

We will use email messaging to communicate with Participants who are engaged

REDACTED

The most significant challenge in managing a Participant in the program has been in intrinsically motivating individuals to stay engaged. In our experience, senior management support, incentive administration, social networking, coupled with a strong communication campaign strategy leveraging multiple forms of media, has proven a very effective combination to drive participation and to keep individuals engaged in the programs.

5.E.5 Provide a list of the co-morbidities you actively manage.

5 points

We have the ability identify and manage up to the following conditions in our disease management program.

REDACTED

REDACTED

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5.E.6 Provide an overview of your experience managing Participants with multiple co-morbidities? 5 points

ActiveHealth programs focus on the whole Participant and the interactions among all co-morbidities. REDACTED REDACTED REDACTED **. This ensures an extremely broad and comprehensive range of clinical issues, including those not specifically identified by the disease or condition categories, are covered by our program. Regardless of whether we are coaching the Participant about chronic conditions or lifestyle issues,** REDACTED REDACTED

REDACTED

We prioritize our outreach to Participants based on the clinical risk score. Once engaged, we approach care management of Participants with multiple conditions and issues from a holistic perspective. Instead of using a disease specific hierarchy we balance our approach across what appears to be the most clinically significant issue with the Participant's perception of what is most important to them.

For example, a Participant may be identified with Diabetes and Chronic Low Back Pain. From a clinical perspective, the Diabetes may appear to be the more significant issue, however if the back pain is interfering with the Participant's functional status to such an extent that they are having difficulties complying with their diabetes plan, we will prioritize our focus on the back pain. We also frequently find that Participants with chronic conditions also have lifestyle issues, specifically related to weight, and by incorporating coaching about weight loss and healthy or condition specific diet in our care management approach, we are able to support the Participant in achieving improvements in their chronic conditions.

Another example, a Participant with Coronary Artery Disease engaged in disease management who does not score positive for depression via the Clinical Stratification and Identification process, but does screen positive for depression during their initial intake call with our Nurses, would be targeted for outreach. REDACTED **During telephonic interactions, the disease management nurse will discuss with the Participant important steps to take to both better manage their CAD, such as dietary changes, cholesterol monitoring, exercise, etc., and the importance of discussing their depression symptoms, adherence to any medications prescribed, etc. This occurs even though depression may not be a specifically identified condition.**

REDACTED

REDACTED

. Participant interaction with the nurse coach may include discussion of Care Considerations, education on key clinical targets related to all of the Participant's condition(s), warning signs for condition-related complications, at risk and lifestyle issues such as smoking or stress, and other individualized educational and goal-setting interventions. To reinforce issues discussed during the telephone calls, a follow-up letter summarizing the engagement, , is sent to the Participant along with condition or topic-specific brochures. Another important role of the nurse coach is to advocate Participant communication with his/her physician(s). This helps to reinforce the importance of the Participant actively participating in their healthcare. The overall result is a comprehensive patient-centric approach to care management not limited to individual disease states.

We have successfully managed many EBD Participants who have comorbidities. For example, we identified one Participant with multiple risks including hypertension, diabetes, and high cholesterol. Our Nurse Health Coach reviewed warning signs of hypoglycemia and hyperglycemia with the Participant. The Nurse also educated the Participant on helpful ways to manage diabetes through diet and exercise, such as counting carbs, using the glycemic index, and keeping a food journal to understand how glucose is affected by different foods. As a result, the Participant began eating smaller portions, decreased carbs in her diet, and replaced soda with water. Her fasting glucose decreased significantly and she lowered her BMI – she was able to eliminate one diabetic medication and reduce the amount of another. We worked with another Participant after identifying her for outreach because of hypertension, osteoarthritis, and stress. The Nurse Health Coach educated the Participant on the impact of stress on physical health and the benefits of exercise. The Nurse also discussed outlets to relieve stress, such as exercising on a stationary bicycle. Additionally, the Nurse recommended a routine colonoscopy because the Participant was past due. The Participant had several positive outcomes as a result of her interactions with the Nurse, including a reduced BMI, daily exercise, stress relief due to starting a new hobby, and timely removal of polyps during her colonoscopy.

5.E.7 Provide an example of managing two Participants with the same co-morbidities, but differ in age, gender and overall health?

5 points

While the underlying clinical protocols would be similar, there are variations to address any unique comorbidities. Even individuals with common factors such as age, sex and overall health would be managed differently based on other unique factors, such as where the Participant is along the acceptance/reluctance change spectrum.

We are continuing to evolve our approaches to engagement and innovation. Currently, we leverage a proprietary data and analytics approach that allows us to stratify Participants based on health risk/profile. We call this the Health Index.

REDACTED

REDACTED

We have learned through our experience in managing a wide range of Participant demographics, across a broad spectrum of large employers and public entities is the service delivery model cannot be tailored by the vendor - it must be tailored by the Participant. Some prefer telephonic interaction with a live coach while others prefer electronic-based interaction.

A single service delivery model or overly simplified, one-size-fits-all Participant management process may not effectively address the needs of all Participants. Participant management and service delivery models must be flexible and as diverse as the membership served.

REDACTED

5.E.8	Provide a description of how you measure the results of your Disease Management services and provide examples.	5 points

REDACTED

We take a Participant -centric view of Population Health Management and offer programs and interventions that meet a Participant wherever they exist on a spectrum of health from healthy to healthy-at-risk, to those with chronic conditions and those with complex or multiple chronic conditions.

REDACTED

REDACTED

REDACTED

REDACTED

An example of our savings and outcomes results can also be described by using the below case study from an actual client. Actual member names have been changed.

REDACTED

REDACTED

5.E.9 Describe how you would accommodate a Participant that is only available to staff during the evenings or weekends?	5 points

In addition to our standard hours for Disease Management programs of 8:00 a.m. to 8:00 p.m. Central Time, Monday through Friday, we have the following custom hours for EBD:

CM:

7:00 a.m. – 7:00 p.m. CT, Monday through Friday

UM:

8:00 a.m. – 7:00 p.m. CT, Monday through Friday

DM:
8:00 a.m. – 8:00 p.m. CT, Monday through Friday and
8:00 a.m. – 1:00 p.m. Saturday

Maternity
8:00 a.m. – 8:00 p.m. CT, Monday through Friday
8:00 a.m. – 1:00 p.m. Saturday by appointment only

The Nurse Advice Line service operates 24 hours a day, 365 days per year. We have an integration processes in place between the call center and the Nurse Advice Line. We have established data sharing protocols so that Participants may be referred between the Nurse Advice Line program and the other ActiveHealth programs.

REDACTED

5.F Maternity Management Services (MMS)

5.F.1 Provide an overview of your company's current Maternity Management Services. How long has your Maternity Management Services been in place?

5 points

The Active Maternity Management program is designed to identify and reduce the risk and costs of pre-term delivery, complications of pregnancy and low birth weight infants. This is done through an initial assessment (data collection about present and past obstetrical and medical history, lifestyle factors and test results) and periodic follow-up questionnaires. Upon completion of the initial assessment, risk factors are also communicated to the Participant in a written format that they can share with their physician. Based upon responses to various questions, the system assigns risk categories to help our nurses determine the patient's overall risk level. Depending on the overall risk level, the maternity program nurse offers various types of recommendations to the patient and provider. A personalized Plan of Care is developed for the Participant, which provides educational interventions geared towards maintaining a healthy pregnancy, focuses on appropriate care and monitoring during pregnancy, promotes self-management through education and behavioral change techniques, and identifies and manages risk through education and care management interventions.

REDACTED

All maternity cases are screened for high risk. The high-risk maternity management guidelines and assessments utilized by ActiveAdvice are internally developed based upon ACOG guidelines for High Risk Maternity. These are included in the ActiveAdvice system and guidelines.

Our Nurses follow-up on cases using the maternity management module within our ActiveAdvice system, which provides a management and tracking system for pregnancy cases within the program. This module allows the Case Manager to track physician visits and details such as the number of week's gestation, patient's weight, patient's blood pressure, patient's urine analysis, fetal heart rate, fetal movement, fetal height, fetus position, pre-term labor signs, cervix exam results, and edema.

Minimally, maternity management nurses will reach out to a pregnant Participant at least four times. More as needed based on risk and how early in the pregnancy the Participant signs up. If a Participant is involved in the program at an early stage of the pregnancy, ActiveHealth nurses are able to utilize several maternity assessments throughout the course of the program:

- **The initial assessment,**
- **The routine follow-up assessment,**
- **The hypertension in pregnancy assessment,**
- **The diabetes in pregnancy assessment,**
- **Pre-term labor assessment,**
- **The 36 weeks assessment,**
- **The post-partum assessment.**

The diabetes, hypertension and pre-term labor assessments are utilized as necessary, depending on the Participant's health status.

In addition to being educated on how to effectively communicate with their physician(s), Participants are educated on how to maintain a healthy pregnancy and are advised regarding changes pertinent to current stage/trimester of pregnancy. They are encouraged to discuss these topics with their OB physician so that modifications can be tailored to their individual needs. Written materials, that are reviewed and updated annually, accompany the aforementioned letter. These materials identify specific questions and or key points of concern that Participants are encouraged to discuss with their health care providers. In addition, during the verbal interaction between the Maternity Care Manager and the Participant, the importance of communication and the relationship with their health care provider is stressed.

ActiveHealth's Maternity Management program will also:

- **Facilitate coordination of care directly with physicians when working with high risk Participants that require services and exceed normal parameters for routine OB care, such as home monitoring services.**
- **Produce evidence-based Care Considerations, which identify gaps-in-care, and send them to the Participant and their treating physician when generated for enrolled Participants.**

Our Maternity Management program has been provided since 1995.

5.F.2 Provide the following information from each of the following years 2015, 2016, and 2017 regarding your Maternity Management Services:

REDACTED

5 points

REDACTED

5.F.3 Describe your company's process for identifying high risk Participants. REDACTED	5 points

REDACTED

Once the Participant is reached, the nurse evaluates the Participant's current health status, obstetrical history, and medical history including the presence of any co-morbid conditions such as diabetes, hypertension, asthma, or HIV. REDACTED REDACTED **. Our assessment process evaluates Participants for complications of previous pregnancies or deliveries that may place expecting mothers at a higher risk, or require increased surveillance during this pregnancy. Our Nurses also identify any gaps in pre-natal care and encourage adherence to the Participant's medical treatment plan.**

The initial assessment provides key information that might otherwise not be available via claims. Based on the results of the initial screening, our tool recalculates and updates the Participant's risk level assignment.

Once a risk level is determined, follow-up calls are scheduled at appropriate intervals. If the Participant is determined to be high-risk, the interactions with the Participant will occur monthly unless the Participant circumstances warrant more frequent contact. High risk Participants also receive a post-partum call two to four weeks following delivery.

5.F.4 Provide a list of education materials available to Participants. Include an example of the material on a CD or flash drive.	5 points

REDACTED

5.G Predictive Modeling	
5.G.1 Provide an overview of the claim analysis process used for predictive modeling, including application benefits and restrictions.	5 points

REDACTED

REDACTED	
5.G.2 Provide the workflow used to identify Participants with co-morbidities include the workflow for both chronic and at-risk conditions. REDACTED	5 points

REDACTED

5.H Nurse Line

5.H.1 Describe your 24/7 Nurse Help line. How long has your Nurse Help Line been in place?

5 points

REDACTED

5.H.2 Describe your system's guidelines used to provide recommendations to Participants.

5 points

REDACTED

REDACTED	
5.H.3 Describe additional resources provided by your help line such as a medical library. REDACTED	5 points
6 – EMPLOYEE ASSISTANCE PROGRAM (EAP)	
6.A Program Information	

6.A.1 Provide a brief description of each type of service listed in the Emotional Well-being category. Confirm that a service is or is not currently provided. If you offer additional services not currently listed, they may be added in the appropriate category. Emotional Well-being: • Grief and loss • Personal relationships • Marriage and family issues • Divorce and separation • Mental Health issues • Violence and crisis management • Financial planning	5 points

Emotional Well-being:
When it comes to support for emotional well-being, we offer our members a spectrum of choices. Phone, face-to-face, and tele-video (online) counseling options help ensure that members can use their sessions how they want. This increases the likelihood of engagement. Additional information follows:

Grief and loss
Often times, special situations are wrought with high intensity emotions that can be difficult to understand and manage. Employees and their families are often coping with multiple different feelings and thoughts and are not able to cope effectively with the situations. We treat members with empathy and respect and as owners of the treatment process. However, in special situations, members require additional attention and support.

Coping with death and dying requires an individual's ability to cope with different and transient emotions. No two persons go through the stages of grief in the same manner or timeline and, as such, require very different treatment services.

Similarly, marital strife, miscarriages and stillbirths all include stages of grief and bereavement that are not neatly packaged or easily understood by the member, their family, or their support network. It is Aetna's philosophy that immediate and aggressive attention will meet the needs of persons who are coping with special situations.

To meet these needs, we implement the following practices which are individualized to meet the specific needs of each member:

- **Comprehensive assessment of member's needs**
- **Referral to a culturally competent provider specialized in coping with chronic illness and bereavement issues**
- **Assessment of member's stage of grief**
- **Psychotherapy and treatment aimed at addressing grief and bereavement issues**
- **Treatment and collaboration with family members as they offer support to the member**
- **Follow up with any additional work life and natural/community supports to assist member through grief**

The above are basic services. Each service has numerous components that we individualize to meet the specific needs of the member. Our worklife benefit can assist with additional resources and support groups.

Personal relationships
Marriage and family issues
Divorce and separation

The primary purpose of the EAP is to provide confidential and timely assistance to employees who experience personal problems – of any sort - that may affect job performance or quality of life in general. We recognize that the types of services we provide cannot reasonably be limited to a list.

As we all know, everyday life can present us with both unforeseen challenges and crisis situations. We not only meet the everyday issues that life presents, but also provide support to our members during critical and potentially overwhelming times. To do so, we incorporate both expertise and flexibility.

We will provide counseling and assistance for all such issues that arise out of the course of daily living. This may include, but is not limited to:

- **Family and marital discord**
- **Work/school/other personal relationship issues**
- **Depression and stress management**
- **Anxiety**
- **Legal and financial problems**
- **Grief and bereavement**
- **Substance abuse**

We address any issue that may have an effect on your employees' quality of life and workplace effectiveness.

We know that for an EAP program to be truly effective, employees should use the program to help manage work and life issues before they become unmanageable. That's why Aetna has taken the traditional EAP one step further and put an emphasis on motivating employees to use this important benefit. Our company philosophy is to extend support to every aspect of the employee's needs, including areas that may not traditionally fall within the scope of EAP services, such as guidance toward other available benefits and services.

Mental Health issues
We're here for our members with mental health issues. We know that mental health and wellness and mean different things for each organization and person. That's why our solutions are highly customizable and flexible. Services we provide in these areas include:

Counseling and Emotional support

- **Goal setting**
- **Motivational support for a healthy living plan**
- **Relationships and managing conflict**
- **Handling stress**
- **Caregiving for children, an elderly family member, or a loved one with a disability**

Life transitions such as:

- **Starting your first job**
- **Moving out on your own**
- **The birth or adoption of a child**
- **Empty nest**
- **Retirement**

Life assistance resources

- **Eldercare**
- **Childcare**
- **Smoking cessation**

- **Weight loss**
- **Financial issues, to promote financial wellness**
- **Specific chronic disease information**
- **Advocacy resources and help accessing support systems**
- **Daily living/convenience services**
- **Relocation**
- **Career counseling**
- **Tutoring/education assistance**

Online resources

- **Member website: ResourcesForLiving.com**
- **Mobile app**
- **myStrength™**
- **MindCheckSM**
- **Televideo counseling**
- **Discount programs**

<u>Seminars and onsite trainings</u>

We have a library of presentations and topics that appeal to members which we continually update and expand. Some examples of workshops and trainings we have provided over the last several months to customers are as follows:

Health and wellness topics:

- **20 minutes of relaxation**
- **Adopting a healthy lifestyle**
- **Brain health**
- **Taking sleep seriously**
- **Wellness for busy people**

Personal improvement:

- **Assertiveness**
- **Change mastery**
- **Goal setting for life and work**
- **Resilience**
- **Stress management**

Workplace topics:

- **Alcohol and drug-free workplace**
- **Coping with organizational change**
- **Effective communication at work**
- **Stress management at work**
- **The work and home balancing act**

<u>Violence and crisis management</u>

Our Organizational Risk Management Center provides specialized support to help workplaces and communities respond to crises. Tragic events and crises — whether local, national or international — can disrupt any workplace. Our crisis support service can make the difference in how fast and how well employees and their families recover in their jobs and their lives. Components of the service include:

• **Outreach after a crisis or tragic event, available 24/7** • **Immediate support and referrals for individuals in crisis from one of our phone clinicians** • **An experienced crisis consultant speaks with you to gather information about the event and begin to make a plan** • **Intervention that may consist of:** - **Clinical consultation to assess your unique situation** - **Review of available options** - **Written materials designed to help those affected by the event begin their recovery** - **Help communicating appropriately about the situation to employees** - **Onsite consultation with managers** - **Meetings with employees** - **One-on-one debriefings** **We have policies and procedures in place for clinicians regarding assessing and addressing a member's potential for workplace violence. All clinical risk assessments address harm to self and/or others, and assess the member within the context of their work and any safety risks they may present to the workplace. The clinicians have a suicide risk assessment and homicide/workplace violence risk assessment process.** **We escalate the majority of cases where there is a concern about workplace violence to Our ORMC management consultants or to an onsite counselor, if applicable. They obtain the necessary releases and will communicate directly with your internal experts to address any potential concerns related to workplace violence.** **If there was any is any imminent risk to your employees, they we take immediate action in collaboration with you, to protect their workforce regardless of whether or not we have releases in place. If there is imminent risk to anyone involved in the situation, their safety trumps the at-risk employee's right to privacy.** **<u>Financial planning</u>** **Employees receive a free 30-minute phone financial consultations for an unlimited number of issues. Staff financial counselors can help with a wide variety of issues, including financial planning.**	
6.A.2 Provide a brief description of each type of service listed in the Physical Well-being category. Confirm that a service is or is not currently provided. If you offer additional services not currently listed, they may be added in the appropriate category. Physical Well-being: • Diet/Nutrition • Importance of daily activity • Pain management **• Diet/Nutrition – CONFIRMED see below** **• Importance of daily activity – CONFIRMED see below** **• Pain management – CONFIRMED see below** **Understanding that unhealthy lifestyle habits can lead to chronic conditions like heart disease and diabetes, we are delivering an integrated lifestyle/well-being and chronic condition solution for EBD. An integrated program for lifestyle/well-being and chronic condition management is an approach that allows us to focus on the bigger picture.** **Your members won't have to choose from a menu of programs that would help accomplish their health goals. We're removing a layer of complexity. And, because we're focused on the bigger picture, we can**	5 points

work on their specific goals while keeping an eye out for opportunities that should be a higher priority.

Our program is NCQA-accredited for chronic condition management as well as lifestyle/well-being management.

We have content, programming and support for 10 lifestyle areas of focus, and can CONFIRM the service is currently being provided for EBD in our bid which is in line with the requirements as outlined in Section 6.10 as follows:

- **Reviewing biometric data of the Recipients.**
- **Provide recommendations for appropriate disease management programs based on results received from the biometric screening.**
- **Communicate with the Recipient throughout the year (i.e. through participation with a Disease Management program).**
- **Connect the Recipient with community resources, such as materials or staff, to assist with education necessary for an effective knowledge base to support the management of Recipients' overall health.**
- **Coordinate Wellness Program activities with all other Medical Management services to ensure continuity of care.**

Diet/Nutrition

ActiveHealth's NCQA-accredited Lifestyle/Well-being Coaching provides individually customized coaching for nutrition management as one of the 10 focus areas. The Lifestyle/Well-being Coaching program provides access to online digital coaching, live group coaching, webinars, and access to programs via mobile devices, including our member app. We also offer campaigns, challenges and bi-monthly webinars to all members, which can focus on nutrition in addition to other health topics. Many members engage in more than one modality. Mobile device access features a refreshed responsive user interface which allows users to enjoy all of the desktop features, on their smartphone or tablet. Our mobile app features topic areas focusing on managing weight, improving nutrition, and being more active.

Additional Lifestyle/Well-being Focus Areas are:

- **Exercise Management**
- **General Health Education**
- **Metabolic Syndrome**
- **Nutrition Management**
- **Pre-Diabetes**
- **Pre-Hypertension**
- **Sleep**
- **Stress Management**

<u>Importance of daily activity</u>

ActiveHealth offers online digital coaching for physical activity, as well as webinars on topics which include physical activity. We also off campaigns to promote physical activity; online physical activity challenges; and physical activity tracking, including integration of activity data from fitness tracking devices. The MyActiveHealth online engagement platform allows members to keep track of their physical activity and see improvements over time. The platform allows data from fitness devices to automatically update user progress within the program, enabling members to sync data from their preferred device types, such as activity monitors, pedometers, blood pressure cuffs, and weight scales.

In addition, ActiveHealth's NCQA-accredited Lifestyle/Well-being Coaching program can also provide

members with online live group coaching, and access to programs via mobile devices, including our mobile App. Currently our app features topic areas focusing on being more active, managing weight, and improving nutrition. An interactive chatbot experience within the App was designed with motivational interviewing principles that help members prioritize their goals. If needed, members can communicate with their health coach through secure messaging. **Regardless of whether the member is telephonically engaged, they will have access to our proprietary interactive digital coaching product accessible through the MyActiveHealth website, which includes modules on over 200 health topics/conditions, including physical activity. MyActiveHealth also offers an extensive library of chronic conditions and lifestyle management content.** **We can develop a series of custom webinar campaigns for the State's population (or wellness champions) which can include health education and awareness regarding physical activity and staying active. This increases engagement by informing or reminding members of the new programs and incentives tied to participation. We can create targeted campaigns with certain member segments in mind, based on demographic insights, with a directed call to action to call our clinicians for support or guidance when medical questions arise, combined with cost benefit messaging of doing so. We have an in-house design team that can create and execute custom campaigns in as little as two or three weeks, and we can also leverage additional approved, outside resources, when necessary.** **Pain management** **One of the conditions covered by our disease management program for EBD is chronic back and neck pain. Our Nurse Coaches ascertain if the member has adequate pain control and educate the member on pain treatments as needed.** **ActiveHealth Nurses Coaches conduct pain scale and assessments as part of the care assessment and management process.** **Our digital coaching program includes chronic pain management as one of our main categories.** **Our digital coaching program accessible within the member platform serves as both a supplement to a Member who is working with a health coach as well as an additional engagement avenue for Members who are low to moderate risk, who have not responded to outreach efforts, or who prefer to work at their own pace rather than telephonically with a coach.**	

6.A.3. Provide a brief description of each type of service listed in the Work Relationships category. Confirm that a service is or is not currently provided. If you offer additional services not currently listed, they may be added in the appropriate category. Work Relationships: • Co-worker relationships • Adjusting to change • Management issues • Stress management • Retirement planning • Discrimination **<u>Co-worker relationships</u>** **We offer telephonic and face-to-face counseling for all relationship issues, including coworker relationship issues.** **In addition, Aetna Resources For Living offers a full range of web-based tools and resources on a variety of behavioral health, work/life balance and healthy living topics.**	5 points

Members also have access to relevant content that spans every life stage or planning need, including:

- **Career**
- **Self-improvement**
- **Relationships**

Adjusting to change

Aetna Resources For Living has a library of presentations and topics that appeal to our customers. Our goal is to take a fresh look at typical topics, such as change management, and to make those trainings more engaging and relevant.

We also offer resiliency training to employees and managers. Our training series includes:

- **Executive training on creating a culture of organizational resiliency with clarity around mission, values and ethics**
- **Leadership training for managers/supervisors on how to develop resilient teams and identify employees at risk**

Management issues

Our goal is to lead not only your employees, but also your management staff, to the right information, assistance and care to address their specific needs. Aetna Resources For Living provides comprehensive services to managers and supervisors regarding a wide variety of workplace issues such as special programs, training and participation on risk management committees.

We have a dedicated team that can assist you with all of your workplace support needs. You can contact this team through the EAP toll-free number or through our dedicated workplace support toll-free line.

We include unlimited telephonic management consultation services in our standard EAP offering. We train counselors to address workplace consultation issues. They collaborate with the employer's management team and provide a supervisory consultation. This may include a variety of services, including the use of a management referral into the EAP, crisis intervention guidance or assistance in monitoring an employee's substance abuse recovery. The process involves:

- **Discussion with the supervisor regarding the nature of the problem**
- **Assessment of potential risk issues**
- **Review of historical information**
- **Previous interventions**
- **Determination of goals for the supervisor and employee**

Our website provides our customers with information about services available through the EAP/worklife benefit. Our website offers the following services for managers:

- **Resource library of materials for responding to traumatic events in the workplace**
- **Training services including information about the types of training and our catalog**
- **Quarterly manager's newsletter**
- **Supervisor orientation for managers or supervisors about the comprehensive services available**

- **Instructions on how to refer employees, both informally and formally**

- **Resource links for managers including links to government and regulatory referrals in the areas of:**

  - **Workplace compliance**
  - **Workplace accommodations**
  - **Domestic violence**
  - **Alcohol/drug abuse**
  - **Critical incidents**
  - **Fitness for duty**

In addition, we also offer a series of management resources that educate managers in better understanding and addressing employee issues. Our website contains the latest information on employee culture and workplace issues (such as bullying and safety). A manager's guide is available to managers to aid in the development of their team member's skills.

Stress management
We provide consultation to support all psychosocial factors that may contribute to stress and stress related conditions, such as health, career and lifestyle choices. This begins with the first call.

SIGNAL®
Our proprietary SIGNAL System® measures the member's level of distress at the time they first call. SIGNAL provides statistically valid feedback to clinicians and members about their individual distress levels and improvement in global functioning. This lets our clinicians know how effective the services are in improving the members' distress levels and whether other services may be indicated.

myStrength
We provide members with myStrength, an online emotional wellness portal that can help your employees with mild or moderate depression and anxiety. Members can use it on its own or to complement other Aetna Resources For Living services.

Like a health club for the mind, myStrength offers practical ways to improve emotional and overall well-being. These include:

- **Personalized eLearning programs**
- **Simple tools**
- **Trusted resources**
- **Daily motivation**

Resiliency
We provide resiliency and stress management training to assist employees in managing their stress. This is available onsite or online. In addition, our EAP Clinicians focus on callers' strengths and abilities.

Worklife
Our worklife consultants take as much time as needed with callers to fully understand all care concerns. Together, they may find care options of which the member hadn't been aware. Because of their expertise, our worklife consultants are often able to educate and inform members about the many services available to help solve problems.

Mobile App
Our mobile app is another way that we provide the tools and services our members need — on their schedule.

Retirement planning

Employees receive 30-minute phone or face-to-face attorney consultations for an unlimited number of issues. Beyond the initial 30 minutes, they can also receive a 25 percent discount with the attorney. We provide help with a wide variety of issues, including retirement planning. On-line information and resources are available, as well. **<u>Discrimination</u>** **Employees receive 30-minute phone or face-to-face attorney consultations for an unlimited number of issues. Beyond the initial 30 minutes, they can also receive a 25 percent discount with the attorney. We provide help with a wide variety of issues, including** • **Harassment** • **Discrimination** • **Other work-related disputes** **Please note, however, we do not include legal matters against the employer in our legal services. However, if the employer wants CLC, Inc. to handle the referral, we include that service with written approval from both the employer and Aetna's legal department.**	
6.A.4. Provide a brief description of each type of service listed in the Legal/Aging category. Confirm that a service is or is not currently provided. If you offer additional services not currently listed, they may be added in the appropriate category. Legal: • Will/Living will assistance • Estate planning Aging: • Retirement planning • Caregiver resources • Living with a disability **<u>Legal:</u>** **<u>Will/Living will assistance</u>** **<u>Estate planning</u>** **Employees receive 30-minute phone or face-to-face attorney consultations for an unlimited number of issues. Beyond the initial 30 minutes, they can also receive a 25 percent discount with the attorney. We provide help with a wide variety of issues, including estate planning and will preparation. On-line information and resources are available, as well.** **<u>Aging:</u>** **<u>Retirement planning</u>** **<u>Caregiver resources</u>** **<u>Living with a disability</u>** **The worklife team provides members with comprehensive support for advance care planning. Each member receives a thorough, caring assessment from a worklife consultant to determine the specific needs of the family.** **They prepare a referral package of vetted service providers and connect the member to the appropriate resources. Services include:** • **Legal – will/estate planning, medical power of attorney**	6 points

• **Financial – assessing financial situation for cost of care, durable power of attorney** • **Hospice/palliative care services** • **Support groups – medical related groups for patients and/or family members** • **Lead agencies for specific medical conditions** • **Health care – specialty clinics, home health agencies, hospitals** • **Living options – home modifications, in-home care, assisted living, nursing homes** • **Planning for a funeral**	
6.A.5 Provide a brief description of each type of service listed in the Addiction & Recovery category. Confirm that a service is or is not currently provided. If you offer additional services not currently listed, they may be added in the appropriate category. Addiction & Recovery: • Alcohol issues • Drug(s) issues **We can assist in the following three ways:** **<u>EAP counseling and referral</u>** **When members call us, we use an interactive approach and motivational interviewing techniques to determine the presenting problem and any underlying problems. We use clinically validated tools for our clinical assessment. These tools help assess for risk, global functioning, productivity challenges and health challenges such as alcohol or other substance misuse. We can refer the member, as appropriate, to a face-to-face provider who specializes in substance abuse issues.** **<u>Mandatory substance abuse referrals</u>** **To manage substance abuse cases, management consultants conduct the initial clinical assessment and gather information regarding potential problems. We track the case from initial contact by the employee, through assessment and evaluation, to monitoring of compliance with recommended interventions and case closure. Our system allows us to track follow-up and compliance activity. The management consultant maintains contact with the supervisor, human resources, medical departments or other company designee as determined by case needs.** **When we identify chemical dependency or substance abuse as a primary or secondary issue, we refer to the appropriate specialist in the member's area. Within our provider network, we recruit specialists within the chemical dependency (CD) field. A minimum of 3 to 5 years in direct CD services are required, and specialty credentials within CD services are preferred. We follow up with the provider at specified intervals for mandatory referrals.** **<u>Mandatory referral process -</u> In the event of a mandatory referral involving chemical dependency or substance abuse (and with the proper release of information forms signed), the management consultant will confirm compliance with recommended treatment. We coordinate the completion all appropriate information release forms at the start of the referral process.** **Typically, the supervisor would contact our management consultant to initiate the mandatory referral**	5 points

process. The process involves a discussion with the supervisor regarding the nature of the problem, assessment of potential risk issues, review of historical information, previous interventions, and determination of goals for the supervisor and employee. **The employee then contacts the same management consultant who talked to the supervisor. We complete a brief clinical intake to determine the extent and severity of the presenting problem. This information includes, at a minimum:** • **Determining types of substances and amounts used** • **Personal and family history of substance use** • **Determining general support systems available for the employee** • **Obtaining information regarding any medical issues caused by, or that may be affected by, possible drug use** • **Determining any imminent risk issues that need to be addressed immediately** **The management consultant advises the employee of the next steps for treatment. If the employee's position falls under the guidelines of the Department of Transportation (DOT), we would arrange for a substance abuse professional (SAP) to evaluate and assess the employee.** **We develop policies and procedures for handling such situations in consultation with, and at the direction of, your human resource department. For mandatory referrals, we will follow-up with the provider at specified intervals.** **SAP Services** **Aetna Resources For Living has its own specialty network of Substance Abuse Professionals (SAP) for DOT referrals. Our network of credentialed providers includes 450 licensed substance abuse professionals (SAPs). They have a current SAP certification and are up to date with relevant training. Additionally, we have four SAPs in our Organizational Risk Management Center. Our SAP providers will:** • **Perform SAP evaluations** • **Make treatment recommendations** • **Conduct the SAP re-evaluation** • **Follow-up testing recommendations** **The providers maintain complete documentation of all SAP cases through comprehensive, detailed notes and customized forms.** **Our staff does not provide the SAP services directly. Aetna Resources For Living management consultants will set up SAP services for a referred member and monitor the member's compliance in conjunction with the SAP provider, providing DOT case management services. Charges are on a per-case basis.**	
6.A.6 Describe the contract requirements and contract period for your EAP counselors. Describe how AR Employees who live throughout the state will access your services. **Providers seeking participation in our network must submit an application and successfully complete the credentialing process. We ensure that we are in receipt of all applicable information about the provider's practice, including specialties and languages spoken. Prospective providers must include primary verification of all credentials, including evidence of malpractice insurance coverage.** **All network providers must be able to provide individual therapy sessions.** **We begin the selection and credentialing procedures in the following situations:** • **Contact of specific practitioners and/or provider groups meeting our practitioner specialty needs in**	5 points

a given market
- **Practitioner and/or provider group contacts us or designee noting interest in joining our network**
- **Review of network need for the specialty is made through a standardized process to determine the pursuit of the requesting practitioner or group**
- **Contact of specific practitioners and/or provider groups a customer refers**

<u>Credentialing process</u>

The practitioner completes the standardized credentialing application to include a current practitioner signature attesting to the following:

- **Reasons for any inability to perform the essential functions of the position, with or without accommodation**
- **Lack of present illegal drug use**
- **History of loss of license and felony convictions**
- **History of loss or limitation of privileges or disciplinary activity**
- **Current malpractice insurance coverage**
- **The correctness and completeness of the application**

Primary verification of the following is submitted when applicable to the practitioner specialty:

- **Educational degree**
- **Licensure**
- **Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration**
- **Board certification (physicians only)**
- **Education and training specific to the specialty**
- **Work history**
- **Malpractice insurance**
- **Liability claims history**
- **License sanctions**
- **Medicare/Medicaid sanctions**

The peer review committee reviews all completed credentialing applications and credentialing files for approval. Where credentialing results do not meet standard credentialing requirements, the committee performs focused peer review as needed.

We notify the practitioner in writing of the peer review committee decision.
The accepted practitioner completes the contracting process and, upon contract execution, we enter practitioner specific data allowing the practitioner to begin receiving referrals.

If denied, we advise the practitioner in writing and provide information on filing an appeal when applicable. Appeal options are offered to currently contracted practitioners and pre-contracted practitioners (when applicable).

We review ongoing monitoring of participating practitioner Medicare and Medicaid sanctions on a monthly basis.

We review ongoing monitoring of participating practitioner state sanction information based on the frequency of the release of the information from the applicable state.

All EAP providers are also subject to complete review during the recredentialing process. We request, review and analyze the same data as during the initial credentialing process. Recredentialing occurs at least every three years, depending upon specific state requirements. **With respect to employees who live throughout the state, members may access any of our providers locates in Arkansas. We have included a provider listing for your review.** **Our EAP network is robust and continually growing. Lack of provider availability is generally not an issue. We have stringent access standards for both rural and urban areas and we are proud that the vast majority of our members have access for care within these standards. We easily support employers in one location - or in multiple locations. Most areas of the country and all metropolitan statistical areas are open to new providers, and we welcome employer-clients and members recommending providers to include. Our EAP network has providers with a wide range of clinical expertise, as well as a wealth of experience in addressing home and work-related issues.**	
6.A.7 Describe your process for suicide interventions. Detail all methods, i.e. telephonic, in-person, group settings, etc. **Depending upon how the member accesses EAP services, the call center clinician, onsite counselor or affiliate provider would conduct a comprehensive risk assessment to determine what would be the most clinically appropriate course of treatment for suicidal risk.** **This may include immediate triage to a mental health facility/ER if there is imminent risk or accessing behavioral health and/or EAP services if the member did not pose a serious threat to themselves or others. The clinician case manages the case through the appropriate course of treatment. They identify any concerns/obstacles the member might have regarding return to work and address them. The clinician might obtain a release of information from the member to coordinate the member's successful re-entry back to work and follow up with the member once they are back on the job, to determine whether they are in need of any additional support once they have returned to work.**	5 points
6.A.8 Do your protocols and practices differentiate between worksite death / grief counseling and family-related death / grief counseling? **A worksite death would most likely be handled initially by our Critical Incident Stress Management (CISM) team. For example, Aetna Resources For Living received a call from one of its customers stating that a beloved employee, age 42, was killed in a motorcycle accident on his way to work. Two of his coworkers witnessed the accident. We had counselors onsite within two hours to provide grief counseling to the employee's immediate workgroup. We set up individual counseling for the two coworkers who witnessed the accident. We also assisted the deceased employee's family with making funeral arrangements and provided grief counseling to family members two weeks after the employee's death.** **From that point on, all employees are free to call the EAP for additional counseling services.** **A family-related death would best be served by standard telephonic and face-to-face counseling. Our in-house clinicians will refer to a qualified provider for face-to face services and to worklife for additional information and referrals, such as support groups or applicable on-line resources.**	5 points

6.A.9 Describe what resources are available for AR Employees with financial issues / home foreclosures / debt management issues?

5 points

Financial Services - overview

Employees receive 30-minute phone financial consultations for an unlimited number of issues. Staff financial counselors can help with a wide variety of issues.

ID theft: Certified fraud resolution specialists provide phone fraud resolution consultations for up to 60 minutes per each new issue, with an unlimited number of issues.

Tax Assistance: We also include tax return assistance and consultations in the initial 30-minute session at no cost. We use certified public accountants, enrolled agents and former tax attorneys to prepare a personal income tax return at a 25 percent discount.

FEATURE	BENEFIT	COVERED ISSUES
Phone financial consultations provided by staff financial counselors	30 minutes per new issue* Unlimited number of issues	• Budgeting • Credit • Debt • Retirement • College funding • Buying vs. leasing • Mortgages/refinancing • Financial planning
Phone tax consultations provided by staff CPA and enrolled agents	30 minutes per new issue* Unlimited number of issues	• Tax questions • Tax preparation • IRS matters
Phone tax levy/garnishment resolution	30 minutes per new issue* Unlimited number of issues	• Tax levies • Garnishments
Community services	Free to member	• Referrals to assistance programs tha may be able to help
Web-based information and tools	Free to member	• Legal and financial forms • FAQs • Articles • Financial calculators • Online free will service and more
*25 percent discount beyond initial 30 minutes		

6.A.10 What assistance / advice / material is available for AR Employees dealing with elder / parental home care?

5 points

We begin by supporting our members with elder care issues from the first time that they call. . We create and deliver various programs to support this mission. The EAP and worklife staff includes specialists specifically trained and who specialize in treating the geriatric population.

We maintain a proprietary national database of *regulated* elder care providers. This means that the elder care provider must meet the licensing, registration and certification requirements in the state of operation.

Elder care services cover a broad spectrum and are available through:

• **Private organizations** • **Non-profit organizations** • **Government agencies on the federal, state, county and local level** • **Community organizations.** **In all cases, we refer only to *regulated* providers when applicable.** **We provide eldercare worklife kits:** **Elder Caregiving – If you're caring (or expecting to provide care) for an elderly relative or friend, you'll appreciate the educational materials in this kit including data sheets on home safety, managing medications and nutrition for elders.**	
6.A.11 What protocols / practices are in place to assist AR Employees with eating disorders? **Our EAP clinicians conduct a comprehensive assessment with each member. This includes determining the nature and severity of the mental health or substance abuse issue. We base clinical recommendations on the member's individual needs, severity of symptoms and level of functional impairment.** **Please note, however, the intent of our EAP is to provide effective, short-term oriented services. This is standard across all EAPs.** **We have found that, in general, it is best to treat the following scenarios outside the EAP benefit. Members who:** • **Need any level of care other than routine outpatient services** • **Have long term or chronic behavioral health needs** • **Require intensive behavioral health care** • **Require medication intervention** **Eating disorders may require more intensive care than the EAP can provide. We can, however, guide the member to the full array of benefits available to them, provided that we are given all such pertinent information.**	5 points
6.A.12 Detail issue escalation & resolution practices for issues of child / spousal abuse. At what point are police / authorities involved? **The EAP clinician would take whatever steps necessary to protect the member and any other person at risk. In the event that a member presents as an immediate threat to the physical well-being of himself/herself or someone else, we ensure that every possible resource is available for a successful disposition.** **In many cases, contact with an EAP professional will de-escalate the situation and provide access to the appropriate clinical resource to meet the member's need. In an emergency where significant risk exists, we deploy our procedure for handling emergencies and enlist the assistance of appropriate resources to immediately address the situation.** **<u>Procedure</u>** **All call center staff responding to members on the 800 line dedicated to accessing services will inquire into the nature of the call, and ask if it is an emergency situation. If the call is an emergency, the customer support associate will signal for the EAP professional to take over the call and handle the emergency.**	5 points

We assess all callers for the level of risk. We determine this risk rating with the first question(s) asked. The risk rating will guide the EAP clinician's line of questioning and they will triage the case accordingly.

In the case of an emergency, we follow the procedures below:

- **If the EAP clinician becomes aware of a client who is or appears to be in imminent danger of potential harm to himself /herself or others, a supervisor will also be contacted at once. A second EAP staff will be enlisted to assist in the emergency as needed.**
- **A connection must be maintained in whatever medium the caller is using.**
- **The EAP clinician will make every effort to obtain the caller's name, address and telephone number. The EAP clinician will clarify and document exact location of the caller if different from the home or work address.**
- **The EAP professional will determine if the caller is alone; if not, then the EAP will attempt to find out who is present and ascertain if they can be helpful in the situation.**
- **The second EAP staff will be available to contact the caller's local police department as indicated.**
- **Should the case require contact with the local police the second EAP staff will provide all necessary information and direct the police to the caller's location. The EAP clinician will stay on the telephone with the member until the emergency service has arrived.**

We comply with the practice to assert duty-to-warn when there is clear evidence of danger to the client or other persons (Herlihy and Sheely, 1988; Pate, 1992; Tarasoff v. Regents of the University of California, 1976).

6.A.13 Describe any processes for facilitating access to legal services. — 5 points

Legal Services - overview

Employees receive 30-minute phone or face-to-face attorney consultations for an unlimited number of issues. Beyond the initial 30 minutes, they can also receive a 25 percent discount with the attorney. We provide help with a wide variety of issues.

Mediation services are also covered in the same fashion. Employees have access to "do-it-yourself" legal forms and document preparation in addition to a comprehensive website that provides over 5,000 legal and financial forms and other tools.

FEATURE	BENEFIT	COVERED ISSUES
Phone or face-to-face attorney consultations	30 minutes per new issue Unlimited number of issues	• Domestic/family • Civil • Landlord/tenant • Criminal • Estate planning • Immigration • Motor vehicle
After-hour phone attorney consultations	30 minutes per new issue Unlimited number of issues	• Criminal • Incarceration • DUI

Phone or face-to-face mediation consultations	**30 minutes per new issue. Unlimited number of issues.**	• **Domestic** • **Contractual disputes** • **Landlord/tenant** • **Civil** • **Real estate** • **Landlord tenant** • **Collections**	
HR mediation consultations – Available to HR only. Employees cannot access this service.	**30 minutes per new issue. Unlimited number of issues**	• **Harassment** • **Discrimination** • **Other work-related disputes**	
Free online will for all members and eligible dependents	**Free and unlimited – available on website**	• **Simple will** • **Power of attorney** • **Living will**	

6.A.14 Explain what differentiates you from your competitors in the EAP marketplace, in 200 words or less.

5 points

We are committed to helping people find resources for living the best life possible. We promote our EAP offerings as "improvement-related" rather than "problem-related." Our brand, "Resources For Living," demonstrates our commitment to shed the stigma around "EAP" and the negative connotations that have hindered utilization.

Our "glass half full" brand differentiates us from other providers - Members call us if they're dealing with a mental health emergency and when they just want to find the nearest yoga studios. We take the stigma out of contacting the EAP by promoting our service as "Everyday help for everyday living".

We connect members with the benefits and services for where they are at that moment. We offer access and resources through technology:

- **Mobile app**
- **Website**
- **Tele-video counseling**
- **Face-to-face and telephonic counseling**
- **Online cognitive behavioral therapy tools: myStrength**
- **Emotional wellbeing tools: MindCheck**

As the world changes, our products evolve. New technology provides increased access for our members. We are more than a crisis hotline. We provide support and resources to help our members navigate the challenges of everyday life. Everyone needs a little help sometimes. We are there 24/7 to connect your people with the support and resources they need on their schedule.

6.B General Services

6.B.1 How will you assist the plan in maximizing medical cost avoidance now and throughout the lifetime of the contract?

5 points

We would do so through the promotion of EAP services through a targeted effective care management plan. We have found that when members first access the EAP for services, prior to behavioral health or medical care, there can be as much as a 20% savings when the member is then guided to in-network

care. **We treat every employee with dignity, confidentiality and compassion and deliver all services with the employees' needs at the heart of our work. We allow our employees to lead or augment care by considering other important influences in their lives that may provide valuable support. We believe the best way to manage cost and care is in the right setting, with the right provider, at the right time.**	
6.B.2 Provide a description of your approach and methodology of how you will assist EBD in identifying strategies that lead to medical cost savings? **We believe that the best way to mitigate health care costs is by offering comprehensive, high quality, holistic and fully integrated services and by being proactive in identifying and addressing issues that contribute to the high cost of health care.** **On an individual basis, we reduce costs by ensuring that we identify and address a member's needs in the most comprehensive manner possible. This means that, rather than conducting a quick assessment to address only the issue at hand, we conduct a full assessment of the member and identify <u>any</u> issues that may be contributing on a larger scale to the member's employment or life problems.** **By simultaneously addressing the member's acute and ongoing problems, we are able to intervene with the member to address the underlying issues that contribute to future health care services. Our upfront and more aggressive collaboration with disability, health, and other vendors has helped members obtain needed services during the early stages of illness where treatment costs are less costly and more manageable.** **To achieve these type of results, we have worked hard to develop an EAP network that has a 98 percent overlap with our behavioral health network, thus allowing for smooth transition between EAP and behavioral health services for those members who would benefit from additional services.** **Similarly, we offer a comprehensive worklife product that touches every aspect of a member's daily life, including legal, financial, child and elder care, adoption, relocation, education, daily life, transportation, and other needs. For example, our emergency child care service can help EBD's employees who are suddenly faced with child care needs to find a licensed and available provider within a few minutes, thus decreasing the stress of independently finding this type of care and increasing productivity. Our wellness programs can provide assessment, educational programs, incentives, and other services that increase an employee's willingness and interest in participating in such programs, thus positively impacting future health care costs.** **On an organizational basis, we reduce cost by investing in proactively identifying those members who require additional services. Within the EAP, our proactive identification of members as high risk for or requiring more focused services is a function of our holistic approach to treatment as well as our ability to effectively transition members from EAP benefits to continued services under their medical benefit.**	5 points
6.B.3 Provide a description of your approach and methodology for calculating ROI for accounts of our size, including benchmarks used for quantifying. **The appropriate and timely use of the EAP results in effective management of employee work and life needs, positive results in the requested categories, and financial and cost efficiencies for clients. Since our inception, we have forged ahead in developing and implementing programs that accurately evaluate our EAP's impact on a number of categories.**	5 points

According to the United States Department of Labor, Employee Assistance Programs (EAPs) can save employers between 5 and 16 dollars for every dollar invested.

We continuously evaluate our EAP program to ensure optimal outcomes for members. We focus on timely access to services, quality of our participating provider network, strength of our clinical programs and the knowledge and ability of our clinical staff. The true measure of our EAP program, however, is how members respond to our services and how we positively impact their lives through these services. We use tools such as the SIGNAL system to measure before and after impacts of our EAP.

Aetna Resources For Living's capacity to evaluate the program's impact for specific customers is dependent on the availability of aggregate employee data the customer provides. In the requested categories, the EAP examines the program results against the prior year's employee experience. If the customer is unable to provide aggregate employee data, we base the program evaluation on the performance metrics we adhere to, as well as the results of the member quality survey that follows every member service request. These satisfaction survey results are found in the customer reporting package. The survey includes, but is not limited to, the following questions:

- **Overall, how satisfied are you with the services you have received from the Employee Assistance Program?**
- **Did the service of the program meet your needs?**
- **Would you use the program again in the future if you needed to?**
- **Did you have to wait to receive the services from the program?**
- **How satisfied are you that the program staff treated you respectfully?**
- **How satisfied were you with (specific category of service rendered)?**

The goal of the evaluation process is to identify any barriers in our ability to offer employees the types of services needed to positively impact any of the above issues and to enhance program offerings that would increase our ability to address employee needs. In addition to using either aggregate employee data or satisfaction survey results, we also obtain confidential case information on processes that have either worked well and have been impactful or those where a change is required. As needed, our quality management program can develop and implement specific programs that address any of the above issues as well.

We calculate return on investment (ROI) potential according to the specifics of your program. We will be happy to engage in a focused discussion to determine realistic and attainable ROI metrics for a customer's employee population.

<u>Absenteeism</u>

We evaluate absenteeism through:

- **Comparison of aggregate employee data**
- **Evaluation of an incentive-based program that addresses increased absenteeism**
- **Effect of proactive or ongoing outreach and training programs for employees on issues**

related to absenteeism **<u>Use of sick time</u>** **We evaluate the use of sick time through:** • **Comparison of aggregate employee data** • **Evaluation of effectiveness of a program focused on identifying the primary reasons for sick time use** • **Evaluation of the processes that would positively impact employee use of sick time for issues that are not related to the employee's health** **<u>Job performance</u>** **We evaluate job performance through:** • **Comparison of aggregate employee data** • **Evaluation of effectiveness of training for managers and supervisors on usual and customary job performance issues and addressing them** • **Evaluation of effectiveness of proactive training for employees on addressing job performance issues in a positive manner**	
6.B.4 Provide a description of your approach and methodology for monitoring provider compliance related to patient care, including provider incentives. **Our approach to quality assurance includes several key initiatives – including provider relations at the forefront. We continually assess operation and services to provide members with solutions to their health care needs. Our commitment to NCQA and URAC accreditation, credentialing standards, physician performance evaluation, provider satisfaction and electronic connectivity initiatives demonstrate our dedication to quality of care and service.** **Our network management staff is responsible for developing network participation and contracting with providers in each local market. There are varying levels of network employees, and each may require different qualifications. Our senior network manager, for instance, oversees all network development and management and typically has at least five years of experience in negotiating complex arrangements with all types of providers. A bachelor's degree is required, and a MBA or Master's degree is preferred. Depending on market size, there may be additional network managers with three to five years' experience in the health care industry. Generally, they will have prior negotiating experience or significant related experience.** **Our provider relations staff handles the day-to-day management of our physician network, including recruiting. Staff members will have at least two years of related experience in the health care industry. We prefer a bachelor's degree, but will honor equivalent work experience.** **Our Credentialing and Application Management (CAM) unit queries the national provider databases to verify the provider's credentials. CAM staff qualifications include but are not limited to the following:** • **Two years of college or equivalent experience** • **Medical or medical terminology background** • **Paralegal experience, a plus** • **Attention to detail** • **System expertise**	5 points

• **Strong analytical skills** • **Ability to interact at various levels with different audiences** • **Strong customer focus** • **Independent work skills** **The network medical director reviews the application for compliance. We require our physicians to maintain a current license and working knowledge of new procedures and trends in medicine and to maintain memberships in medical societies and participation in various medical conferences and seminars, as appropriate.** **Also, our provider relations staff members work closely with our network development team to review recent performance, quality management, and overall provider network data to determine the subject matters that are most relevant to provider services. We strive to provide training and education opportunities that address identified gaps in performance or treatment and that will positively impact the services offered to members.** **Each region of the country has a provider panel that meets each month to discuss individual cases, clinical initiatives, and assists with our local provider training efforts. This panel consists of behavioral health providers who share their work with other medical practice leaders for optimum outcomes, data, products, service management, and consultations.**	
6.B.5 Provide an overview of how you intend to engage AR Employees in your services? **<u>General information</u>** **We begin all efforts to educate and engage employer populations by working with your benefits, wellness or human resources staff to ensure that there is realistic expectation of what the EAP can and cannot accomplish on an organizational level.** **For any EAP program to be successful, it is important that employees know about the program, realize the scope of its offerings, and are aware of the program's benefits.** **Clearly, employees are concerned about how the use of the EAP is perceived within the work setting and the degree of confidentiality of information provided within the EAP sessions. As such, it is important that your team has a good understanding of the EAP, its operation, and how it can impact employee productivity and satisfaction.** **Your assigned EAP account executive will begin with an *Intro to EAP training for the management and HR staff within your organization*. During this training, the account executive reviews the types of services available through the EAP and uses the training sessions as a framework to better understand and determine additional services that might benefit your organization.** **Many such training sessions evolve into a discussion forum between the account executive and client representatives in better defining how the EAP would address both the customer's and the employees' needs. From these meetings, both parties obtain a significant breadth of information that allows them to best use and offer the needed services.** **We offer two types of communication for our customers. The first is training for the management, human resources or benefits staff who will serve as the internal face of the EAP benefits. For this staff, we provide a training program that offers in-depth information on the following:**	5 points

- **How sessions are conducted**
- **Confidentiality of information**
- **Process for referring employees to the EAP, including mandatory referrals**
- **Recommendations on presenting the EAP as an option to employees, especially those who are reluctant to use these services**
- **Working with supervisors who will also be involved in the EAP process**

We will work with your team to provide the second training, which involves orientation for your staff on the actual EAP services offered. We aim these at increasing employee comfort and use of this important benefit.

We include information on:

- **Accessing the EAP**
- **Confidentiality of EAP information**
- **Use of the EAP in addressing work-related issues**
- **Use of the EAP in addressing work/life issues**
- **Additional services offered as a component of, or part of, the EAP program**
- **EAP assessment, consultation, and referral process**
- **Provider network**
- **Working with the employee and supervisor in addressing work issues**

We believe that it will be the mutual role of both EBD and our organization to provide information to employees about the scope and breadth of the program that enables them to understand the role the program plays in their ability to be productive on their job. We provide assurances to the employees about the confidentiality of the sessions (within rules of the law) and the role of the sessions in improving the employee's working situation.
Should you prefer a self-directed approach, we offer self-managed training through online employee and manager orientations, which you can easily access from your dedicated EAP member website. Online orientation for managers or supervisors about the comprehensive services available provides instructions on how to refer employees, both informally and formally and reviews the training and education needs and requests.

In addition, we provide your management team with several additional electronic resources, including:

- **Management Services Guide**
- **Manager's Guide to Making Effective EAP Referrals**
- **Manager's Resource Guide for the Workplace**

6.B.6 Describe your experience in dealing with multiple employer locations?

5 points

While we do not currently track customers who have multiple locations, we have over 1,200 EAP clients, many of whom have multiple locations in all 50 states. For example, we provide EAP benefits to 52 of the Fortune 500 companies. We also manage customers with employees who travel abroad to international locations. We provide services through one of the largest domestic networks in the U.S. and international coverage in over 130 countries.

6.B.7 Provide an example of how you increased utilization of your services with an account relative to our size, including data to support increased utilization. **Aetna had a successful initiative to increase utilization for the worklife benefits with a national account customer. This customer had incentivized wellness programs in place and wanted to include the EAP. This was an opportunity for us to drive the incentive to the EAP, raise awareness and increase utilization in focused areas such as worklife, legal and financial benefits.** **We included the EAP the health & wellness portal for their members and had direct links applied for easy access. As a result, the customer could also track access and provide the incentive for completion. The requirements for completion were clearly stated on the health and wellness site, with associated links, which made it user friendly for the members.** **This particular customer has had a significant increase of millennials in their workforce. This population prefers high-end technology to access and complete their benefits or available resources.** **Within six months, the utilization was three times what we had seen historically. There also were promotions to their members through newsletters, corporate website, benefit website and health/wellness portal. These all have the capability to link and toggle to one another for a user friendly experience. Aetna Resources For Living worked closely with this customer to provide topic specific articles and resources. For example, childcare resources are an important need for the majority of this population, so there was creative work completed to meet these requests.** **We received a call volume increase from 401 calls per quarter to 1,227 per quarter we implemented the wellness program and integrated EAP initiatives.**	5 points
6.C On-Line Capability	
6.C.1 What tools are available to allow EBD the ability to extract data? How are these tools accessed? **There are a few tools at the EBD's disposal to extract data, primarily DART and Active Analytics.** **<u>DART</u>** **We currently provide our Data Analytics and Reporting Tool (DART) to the EBD. DART is a comprehensive, web-based data analysis and reporting tool providing the EBD with access to their data directly from their desktop via any Internet connection.** **DART delivers the powerful tools needed to analyze and detect trends and opportunities, reduce costs and increase efficiencies. DART has been highly successful at meeting clients' needs for data warehouse level reporting that includes program details such as clinical, participation, risk level, cost, and many other areas of concern. This capability allows EBD or AHM in support of EBD's request, to manipulate your data in an almost infinite manner to provide detailed or high level reporting across all of our programs and your plan designs.** **<u>Active Analytics</u>** **We have recently developed an on-demand self-service reporting platform, called Active Analytics,**	5 points

available to EBD as well at no additional charge. We would be happy to set this up for EBD. Active Analytics features include access to dashboards and web-native reports primarily around engagement and program metrics. **A limited number of log-ins are available to EBD staff members included in the products and services purchased. Active Analytics supports 24/7 access to two foundational methods for sharing information about EBD's population:** **1. Dashboards are updated routinely to support the time frames required by the metrics; and** **2. Reports** **The Interactive dashboards allow EBD to select and run metrics for the full population or a subset of the population based on any number of attributes about a member (e.g. location, division, etc.) as defined by EBD. In setting up the data ingested by ActiveHealth and supplying attributes in the data supplied to us about a member (e.g. the worksite for a member, a region in which that worksite sits, and/or by another type of population grouping), the dashboards show metrics for any number of population attributes. In addition to interacting with data, the dashboards allow the metrics to be exported on demand in multiple formats (PDF, excel, etc.) as well as allow some commonly used filters (i.e., see metrics for employees only, for dependents only, and/or for both, etc.). The dashboards also allow EBD to select different measurement end dates and different time frames, such as calendar year-to-date or a rolling 12 month view.** **ActiveHealth is able to display key performance metrics that tell a value story to EBD about how ActiveHealth analytic engines find Health Opportunities and then help to address and improve the Health Opportunities. Our book of business is a robust benchmark that serves over 20 million lives and ActiveHealth is able to give context to the metrics shown by offering anonymous peer benchmark comparisons. This allows EBD to see how their populations are engaging compared to other similar peers; this powerful peer comparison allows ActiveHealth expert leaders to consult with EBD to get the optimal outcomes.**	
6.C.2 Detail what services / features / functions are provided to employees through your website/portal? **<u>MyActiveHealth Member Engagement Platform</u>** **The gateway to ActiveHealth's Disease Management and Wellness program for EBD is our fully integrated member engagement platform, called MyActiveHealth, which provides the resources and tools needed to better manage their health and well-being.** **MyActiveHealth includes a claims-populated personal health record; a comprehensive, proprietary health assessment should EBD be interested; digital coaching programs *(Your Health Goals* and *Your Health Education)*; member-specific recommended Health Actions; social communities; secure email messaging with ActiveHealth coaches; appointment setting for Group Coaching; wellness and condition tracking; activity and biometric device integration. The engagement platform is mobile enabled and we also offer a companion mobile app. We have provided details on these platform capabilities below.** **MyActiveHealth is accessible via smartphones, including the iPhone (iOS operating system), BlackBerry, Android devices and Windows Phone, and supports calendar reminders.** **Platform Capabilities:** **Personal Health Record - a full featured, claims-populated repository of health information which helps members maintain accurate records of medical tests/procedures, hospital visits, immunizations, and medication and supplements in one centralized location. This section also provides a centralized location called "My Resources" for members to track all insurance information (including health, dental, vision,**	5 points

pharmacy, and others) and members of his or her personal "Health Team".

Health Assessment - Our proprietary, internally developed Health Assessment that provides members with real-time actionable clinical feedback, and is integrated within our overall program and the CareEngine, which is at the foundation of all of our programs. We strive to deliver an assessment that can be completed within 5 to 7 minutes, uses a foundation of health literacy and can be translated into beneficial recommended actions for the member.

Upon completion of the Health Assessment, the member is presented with an interactive list of Health Actions (further described below), which are derived via the complex clinical algorithms in the CareEngine. The list may include discussing Care Consideration alerts with their physician, participating in other programs such as health coaching, making lifestyle changes or other actions.

Health Actions - through the platform we message "Health Actions" to members to find ways to improve their individual health, and we share these Health Actions with their doctors and our health coaches. Our personalized Health Actions are based on data analyzed by the CareEngine, which is at the core of our member engagement platform. Not only does the CareEngine take in all medical, pharmacy and lab claims, but it also takes in member demographics and self-reported information and keeps track of our members' digital footprints as they engage with our online tools/resources. As an example, members who have been identified for program engagement will receive different messaging when a Health Action is generated, helping them engage in a more sustained activity such as digital coaching or working directly with a coach. Noting and analyzing this data supports and differentiates our program as we know what our members are interested in.

Health Events - An expanded library of Health Event messaging will also drive greater engagement. Health Events are messages generated to members enrolled in our Health Your Way program whenever they have had a change in their health status that can relate to opportunities to improve health behaviors. These messages generate very high engagement today, and going forward, Health Events will be integrated with longer term engagement opportunities such as digital or telephonic coaching.

Digital Coaching - Your Health Goals and Your Health Education

Your Health Education **offers hundreds of online digital coaching modules that motivate behavior change via an engaging and consistent framework.** ***Your Health Education*** **is designed with behavioral economics in mind intended to support members in their health and well-being journey. These modules are dynamic and interactive, as the program incorporates logic based on the member's responses and clinical profile and presents tailored and relevant information to the user. Modules are 5 to 7 minutes in length and offer a variety of topic formats including: videos, slide shows, articles and games. Our program will continually recommend additional topics to member so that they remain engaged.**

Digital coaching capabilities drive engagement — in 2016, our members completed more than six topics each averaging 25 minutes per visit. The programs are designed to encourage repeat member engagement using an online currency called Hearts. The more the member engages, the more Hearts they earn. Through the accumulation of Hearts, the member's reward level moves upward and each level offers unique reward opportunities.

We have expanded our digital coaching features so that in addition to the current digital coaching program, we are have also added a personalized goal setting experience called "Your Health Goals".

Your Health Goals **is focused on supporting lifestyle changes by supporting continual engagement and improving outcomes with a proven behavior change model. The approach is simple: The member selects a goal, links their values, confidence and barriers to that goal and makes a weekly vow. For seven days the member is presented with fun and engaging activities to help them develop the skills to overcome their barriers; enhance their confidence and develop new and healthier habits. The activities include**

great tips, tricks and tracking supported by helpful and easy-to-use tools like recipes, articles, videos, challenges and more.

Social Communities and Discussion Groups

These are patient-focused networks built around a particular condition or lifestyle goal to give individuals and their families the access to leverage the support of others experiencing a similar health situation in a safe and secure environment. Accessible via MyActiveHealth, Social Communities allow members to interact online with other individuals with challenges and goals similar to their own in a de-identified manner, asking questions on the various topics as well as providing feedback to others. Social Communities topics include: Diabetes, Depression, Cancer, High Blood Pressure and Cholesterol.

Our Social Communities site is moderated by MedHelp, a vendor that ActiveHealth partners with to facilitate functionalities for our Social Communities. MedHelp has a team of certified professionals who moderate the forums to ensure the following:

- **Recommendations are clinically accurate and not offering harmful advice.**
- **To step in if people are making self-abuse comments.**
- **To ensure that there is no inappropriate language.**

ActiveHealth also provides member forums from our social communities' platform. This feature allows members to interact digitally with members across MedHelp's entire book of business membership (15 million participants) to ensure that our social communities are active and have high participation. ActiveHealth staff also moderates forums.

Wellness/Condition Trackers – The member engagement platform comes with built-in health and activity trackers. We offer 16 trackers to members who can view tracker metrics and monitor progress (e.g., changes in blood pressure, shifts in weight) on a health tracker dashboard in the member engagement platform interface. The majority of trackers are updated based on wearable data that feeds directly into platform, although some trackers can be manually updated.

Individual Challenges – we offer individual personal challenges based on physical activity trackers, including: Steps Taken, Sleep, Weight, Calories Burned, and Caloric Intake. Members track their physical activity by linking their approved physical tracking device or app to our platform which automatically uploads data to Rewards Center to promote ongoing engagement by ensuring members are rewarded for attaining their health goals. We can also facilitate reporting for any corporate-oriented challenges that a customer may organize to ensure the client's members get rewarded. We also partner with best-in-class vendors to offer organized team challenges/fitness events that members access via our member engagement platform.

Apps and Device Integration - we have partnerships with popular physical activity device companies and apps which allow members to directly connect their physical activity tracking devices and apps to the platform for real-time tracking and sharing of health and physical activity information. We also plan to integrate HealthKit, an Apple digital health platform that will allow members to share health data on their iphone or Apple Watch.. For ActiveHealth members, HealthKit will synchronize data to share within our MyActiveHealth platform, and we can use this data to pre-populate our health assessment and trackers, and provide personalized Health Actions to members. HealthKit and Apple Watch will require the member to download the ActiveHealth app and use the app to initiate the connection between ActiveHealth and HealthKit.

Appointments - the member dashboard features an "Appointments" dropdown to access a centralized appointment calendar featuring upcoming treatments or doctor's visits. Members can also schedule appointments directly with an ActiveHealth nurse or coach. Notifications can be added to appointments, and our member engagement platform will then send email and text reminders to the member prior to the appointment.

Health Decision Support (HDS) - is a patient decision support program provided through a partnership with Emmi Solutions and gives members access via our platform to videos and other multimedia programs to learn about treatment options and decisions for 300+ health conditions and topics. HDS offers an in-depth focus on the management and decision making process around acute health conditions and treatment options. For example, members can watch a video detailing the risks and benefits of specific shoulder surgery options. HDS also integrates with Health Your Way's personalized care recommendations and offerings.

Online Resources Library

The Library landing page of the member engagement platform connects members to Your Health Education modules along with a number of other health-related resources, including:

- **Wellness Center - includes a number of webinars which discuss an array of health-related topics, including mindfulness, a balanced diet, aging, and exercise**
- **Healthy Recipes - provides a number of healthy recipes from the National Heart, Lung, and Blood Institute separated into different categories. Categories include "Main Dishes", "Sides and Snacks", "Delicious Salads", "Low Sodium", "Gluten Free", "Vegetarian", and others**
- **Health Information - offers a search engine through Healthwise Knowledgebase for members to search through a number of interactive tools, health topics, learning centers, and a general "Topics A-Z" search**
- **Interactive Tools and Videos- provides a number of videos and online tools for members to view on topics including: Asthma & Respiratory; Bones, Joints, and Muscles; Children's Health; Diabetes; Heart & Circulation**
- **Audio Files - lists over 35 links to audio files related to a variety of health topics including Allergies; Ear, Nose, and Throat; First Aid; Hormones; Mental and Behavioral Issues; Senior Health; and others**

Mobile App

ActiveHealth's mobile app amplifies user engagement by providing a personalized member experience powered by predictive analytics coupled with access to our clinical health coaching staff. The ActiveHealth app is offered in conjunction with our member engagement platform (MyActiveHealth) and our Wellbeing program (Lifestyle Coaching and/or Chronic Condition). The ActiveHealth app is available in both the App Store (for iPhones) and Google Play (for Android devices).

The app helps individuals monitor their health, learn about healthy habits, and achieve improved health through behavior changes by offering a personalized goal setting experience called *Your Health Goals*. The goals currently available are focused on healthy eating, improved physical activity and weight management. Our interactive chatbot offers a friendly conversational style to help members identify and focus on attainable goals.

Timely check-ins keep members engaged and motivated. The experience is fully synchronized across the mobile and website experiences. We will continue to build our program with additions such as: moving more, eating healthier, quitting smoking, becoming compliant with medication, sleeping better, and coping with stress. Using motivational interviewing and behavioral economics techniques, our app is specifically designed to identify a member's unique intrinsic motivators to create an action plan with 'nudges' along the way to guide them in the right direction on the path to their best health.

6.C.3 Do you offer podcasts / e-books for download? If so, provide a sample list of the available topics. **Yes, we offer webinars and e content for download and viewing by the member. The member's primary Nurse Care Manager or health coach has the ability to recommend online features or materials to the member such as our digital coaching modules specific to the member's condition(s) or lifestyle issues. This includes articles, videos, podcasts, and other tools, based on the member's clinical profile. The Coaches also distribute educational content online through the MyActiveHealth engagement platform, e-mail, text and by mail. A sample list is not available.**	5 points
6.C.4 List the top 3 accessed topics in the last quarter? Last year? **For the last quarter and last year, the top 3 topics were:** • **Fitness/Exercise** • **Cholesterol** • **Weight Management**	5 points
6.C.5 Describe the process for selecting, reviewing and adopting the material selected. Is the selection process handled in-house or outsourced? **The majority of resources on MyActiveHealth are internally sourced; however, our content and tools are supplemented by third party content, including informational sites like National Institutes of Health (NIH) and American Cancer Society, and through our partnership with Emmi for online health-related videos, Healthwise and the Harvard Medical School faculty. MyActiveHealth's online content provided through Healthwise and the Harvard Medical School faculty includes a broad array of information on medications, health topics, tests and procedures, as well as information on support groups and other community-based resources. We carefully select our education partners to assure they have their own extensive due diligence process. For example, Healthwise, who provides some of the content on our MyActiveHealth member website, performs a thorough creation process for their content involving clinical reviews, consumer content testing and detailed validation prior to being sent to ActiveHealth for our internal Clinical Content Review (CCR) process, discussed further below. Healthwise is updated on a quarterly basis. During this quarterly update, new items are added, obsolete content is removed, and edits are made for current content that need to be updated. This process is under the direction of our clinical team with careful review of each update or edit.** **Our own online resources that support our programs are developed and revised as determined by emerging technology, revised clinical indications and changing needs. Our clinical team, which includes a subset of our medical directors, conducts ongoing monitoring of evidence-based research that may indicate the need to update current guidelines. Emphasis is placed on standards that have been developed by Medical Specialty Boards, American Medical Association's Department of Technology Assessment and the growing body of practice guidelines and outcome research.** **Our new Digital Coaching behavior change model, Your Health Goals, was developed in conjunction with Ken Resnicow of the University of Michigan and uses an evidence based behavior change model and custom developed tailored content to deliver a highly personalized behavior change experience. Our combined approach bringing together MI techniques with principles of self-determination theory in the model we build with Ken Resnikok is what truly differentiates us from our competitors. We have built these methods into all coaching channels so that we provide a consistent experience whenever and wherever the member connects, unlike our competitors who have a variety of solutions that have been stitched together without these baseline elements providing a jarring experience for the member as they engage with multiple channels. This platform has been developed to work in concert with the CareEngine, to bring both a behavioral and personalized preference element to compliment the clinical resources of the CareEngine.**	5 points

Digital coaching content is created and maintained by the Digital Health Coaching (DHC) Product Team who work with clinical subject matter experts to ensure our content is in line with most recent medical literature, and leverages predictive modeling and other data analytics to deliver content which is optimized for relevance.

Independent, content-specific, board certified specialty physicians are consulted to review draft content as deemed necessary by the guidelines development team. In addition to the clinical content developed internally to support coaching sessions, we incorporate support pages from Healthwise in our coaching process.

ActiveHealth clinical and product teams also continuously review the wire services and journals so we can quickly identify changes that affect the practice of medicine that should be reflected on the member engagement platform. When important changes occur, topics are updated and included in the next quarterly release of MyActiveHealth.

In addition, topics are reviewed and updated on a regular basis. The schedule varies by topic.

- **Topics that have ongoing research and rapidly changing treatment, such as Coronary Artery Disease, are reviewed for update annually.**
- **Topics that change less frequently, such as Bunions, are reviewed for update every two years.**
- **Organizations and people using the Healthwise Knowledgebase may suggest changes or additions to topics. These recommendations are considered during the topic development process and are included in updates if they meet standard criteria and pass the medical review process.**
- **The date of the last update is found at the bottom of every topic page and in the Credits section of each topic.**

Clinical Content Review / Update Process

In terms of creating and updating our clinical content for our programs, we have in place an Integrated Clinical Content Review process (CCR). Reviews of individual program, condition or wellness topic content occurs at least every two years via the Integrated Content Review process. Reviews are staggered in a time-line across two years. If clinical guidelines used as a basis for clinical content are published annually, the condition content will be reviewed annually. As new significant clinical guidelines are updated, or new guidelines are made available, our program content will be reviewed and revised accordingly.

The Integrated Clinical Content Review process involves several steps and input from various clinicians. First, our subject matter expert completes an extensive review of the available medical literature. For wellness, this includes new and/or revised literature topics (smoking, alcohol, diet/nutrition, weight, physical activity, vision, hearing, vaccinations, stress/lifestyle issues, general health maintenance, etc.), related Health Actions, condition identification and risk stratification rules, the Health Assessment, digital coaching content, and program enrollment statistics. The subject matter expert also performs an audit of phone calls between ActiveHealth health coaches and patients engaged in telephonic outreach. The Integrated Content Review process applied to all programs is dependent on clinical content including, but not limited to maternity, condition management, complex case management and Wellness coaching for lifestyle management.

Once all of this information is compiled and organized, the subject matter expert (SME) presents their findings, along with suggestions for changes to any of the content, to the Clinical Development Team. The team, together with the subject matter expert; discuss and decide on any and all changes to our products, Health Actions, etc. The SME will implement the changes and update the appropriate sub-teams.

As an example, after the SME presented a new FDA Alert warning about the cardiovascular disease risks associated with Chantix use and suggested that this new information be passed along to patients, the Clinical Development team developed new content to be delivered during the Health Assessment

discussing the possible side effects of this drug. Additionally, new patient-facing content was developed discussing the effects and dangers associated with the use of electronic cigarettes, which are often thought of as safe by many people. Revisions were also made to align our exercise recommendations with current guidelines from the US Department of Health and Human Services. Additionally, the Wellness Assessment content on routine vaccinations was updated to include Human Papillomavirus (HPV) vaccinations for young women. **Lastly, central to ActiveHealth's member-centric holistic approach to communicating care-gaps to providers is our clinical content. Our proprietary CareEngine system includes a robust set of clinical rules and analytics, which are embedded and integrated into all programs. These rules and analytics are derived from evidence-based, peer-reviewed medical literature, including first-line North American and European journals; major, national medical specialty guidelines; FDA warnings; and other independent third-party sources. This information is reviewed by our internal Clinical Development Team as well as outside clinical experts, as needed, and is used to build the clinical rules set embedded in CareEngine and refined continuously as new medical evidence emerges.**	
6.C.6 Describe the difference between materials available on the site in a "public" format vs that available to an AR Employee with a unique login/password. **Our member engagement platform (MyActiveHealth) is available only to eligible EBD members who must first register on the platform the first time they access, and log in with their password for ongoing access.**	5 points
6.C.7 Describe an AR Employee's ability to maintain a "profile" on the site. **For each member, a single integrated patient record in the CareEngine is developed through frequent (e.g., weekly) data inputs including patient medical claims data, pharmacy data, laboratory value data, patient-derived data (e.g. Health Assessment responses, biometric screenings, telephonic nurse or coach engagement data, etc.), clinical data (e.g., EMR/HIE), financial data and consumer data. We format all data received and transfer it to the ActiveHealth Data Vault, which then sends it to the CareEngine for analysis. Personalization of each member's record within MyActiveHealth occurs after CareEngine ingests the member-specific data we receive through data sharing between the two platforms. When members register online for access to MyActiveHealth, they will see their own personal pre-populated data. On an ongoing basis, each member can supplement the auto-populated data by completing the Health Assessment, entering data within their Personal Health Record and others areas of their personal MyActiveHealth pages and by completing activities within the site.**	5 points
6.D EAP Network Coverage	
6.D.1 Detail your ability in providing health and wellness programs focusing on weight management, increased physical activity, nutritional education, tobacco cessation, strength training, or other similar programs designed to enhance the physical wellbeing of the member. **The Lifestyle/Well-being Coaching programs provide access to telephonic coaching, online digital coaching, live group coaching,, webinars, and access to programs via mobile devices, including our member app. Our mobile app features topic areas focusing on managing weight, improving nutrition, and being more active. Throughout 2018 and into 2019, members will find additional engaging information on diabetes management, diabetes prevention, hypertension, and smoking cessation.** **ActiveHealth uses a unique model of coaching which blends together proven techniques in motivational interviewing, the latest behavior change science, and customized goal setting to help members reach their weight management goals.** **Our Lifestyle/Well-being Coaching programs provides individualized coaching sessions which include ten Lifestyle/Well-being Focus Areas:**	5 points

• **Exercise Management** • **General Health Education** • **Metabolic Syndrome** • **Nutrition Management** • **Pre-Diabetes** • **Pre-Hypertension** • **Sleep** • **Stress Management** • **Tobacco Cessation** • **Weight Management** **Coaching staff include individuals with the following backgrounds:** • **Registered Nurse** • **Registered Dieticians** • **Nutritionist** • **Health Educators** • **Exercise Physiologists** • **Weight Loss Therapists** • **Tobacco Cessation Specialists** **All of our coaches are certified in health coaching and tobacco cessation. Additionally, we do a great deal of on-going training on tobacco cessation and interventions appropriate for members across the change continuum.**	
6.D.2 Detail your ability to provide predictive / risk scoring for members to assist with identifying individuals most at risk for significant health events and opportunities for early intervention and management. **We deliver a 360-degree view of each member using sophisticated and integrated clinical, consumer, behavioral and predictive analytics available. This can be provided through DART and our standard reports provided to EBD, as well as through our new Active Analytics self-service reporting platform. ActiveHealth's predictive model within our proprietary CareEngine® analyzes patient medical claims data, pharmacy data, laboratory value data, patient-derived data (e.g. Health Assessment responses, biometric screenings, telephonic nurse or coach engagement data, etc.), clinical data (e.g., EMR/HIE), financial data and consumer data to risk stratify the population and identify patients who may be potential candidates for clinical intervention.** **Within CareEngine exists a set of clinical algorithms we call Clinical Stratification and Identification that are used to identify an individual's overall and condition specific clinical risk to identify appropriate candidates for EBD's Integrated Wellness and Disease Management Coaching program outreach. We then apply these insights to anticipate, identify and engage individual's as they move through the different phases of the health spectrum, resulting in more timely and appropriate support.** **In addition, CareEngine applies rules involving our unique and proprietary Active Health Index (AHI) to determine opportunity for improvement and financial impact of improvement to stratify members per program intensity (risk) level. Our groundbreaking Health Index identifies an individual's ideal health score versus their actual health score, allowing us to more specifically understand the member's risks and develop unique care plans, based on an individual's risk factors. In addition, the population's overall high, medium and low risk member groupings and the ongoing improvement of members moving to a lower risk category can be measured and reported to clients.**	5 points

6.D.3 Please indicate how EAP coverage will be provided in each county. List the Provider Name, Address, Method of Delivery (phone, in-person, individual, group, other), and Hours of Operation of all providers in each county in Arkansas. If no provider currently can be identified in a county, please indicate with "None Identified". EXAMPLE: **Jefferson County** Provider: Family Counseling Services Address: 123 Sweet Street, Pine Bluff, AR Method of Delivery: individual and group counseling, in-person and telephonic services; specialization in on-site trainings for employees and managers. Hours of Operation: 24/7 phone access; in-person 7a-6p 7 days/week **We have included our EAP Provider listing with complete network details.**	5 points
7 – OPERATIONS AND SYSTEMS	
7.A Privacy, Security, and Legal	
7.A.1 Describe your plan and processes for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's (HIPAA) mandates. **We have policies, procedures and technologies in place to protect sensitive information against inappropriate and unauthorized use and disclosure. Examples include:** • **Written privacy and security policies** • **Privacy and security awareness training for all employees** • **Integrity and access controls** • **Message authentication and/or encryption** • **Firewall and proxy server technologies** **We restrict access to protected health information (PHI) to those employees who need it to provide products or services to our members through "role-based access control" (RBAC). We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. Access to our facilities is limited to authorized personnel, and we protect information we maintain electronically through use of a variety of technical tools.** **In addition, as part of our privacy and security compliance programs, the Privacy Office has identified specific individuals to serve as privacy and security managers. We assign managers to our business units. They serve as the initial point of contact and are responsible for day-to-day enforcement of Aetna's privacy and security policies and the procedures that support them.** **Finally, adherence to privacy and security policies and procedures is subject to ongoing monitoring. For example:** • **Both our Internal Audit department and Compliance Assessments Team periodically perform assessments on the company's privacy policies and procedures. As needed, corrective action plans are developed to address the findings of the Internal Audit reviews.** • **Key business areas (e.g., member services) incorporate review of employee adherence to privacy policies in ongoing quality management efforts.** • **We conduct an annual review of our security program to ensure the necessary controls are**	5 points

in place to meet HIPAA Security requirements and to ensure the program is continually enhanced to address evolving security threats. Aetna subject matter experts review each HIPAA requirement to confirm our compliance. They are also required to provide supporting evidence of compliance. We completed our most recent security reviews by May 5, 2017.	
7.A.2 Detail your disclosure process to patients as well as how protected information will be disclosed with third parties. **Vendors, including brokers, consultants and Stop Loss carriers, who are under contract to provide services to customers, may obtain member health information concerning eligibility and benefits if they are able to supply member identity information (i.e., the member's name, ID number and date of birth). They may receive claim status information, if they are involved in the member's health care treatment or payment, and if they can provide details about a specific claim, such as the provider's name and date of service. Claim status information includes confirmation of receipt (or non-receipt) of a claim and whether it has been paid, rejected or is pending.** **Vendors under contract to provide services to a self-funded customer may receive sensitive member-specific health information (e.g., diagnosis and treatment-related information), if (i) the customer has signed either a Master Services Agreement (MSA) with approved confidentiality, non-disclosure, and indemnification provisions or a Plan Sponsor Letter Agreement; and (ii) the vendor has signed our vendor agreement that contains confidentiality, non-disclosure, and indemnification provisions approved by Aetna. Alternatively, the vendor could provide us with a member's signed authorization to disclose the information or make the request to Aetna while the member is present.**	5 points
7.A.3 Provide a detailed description of your policy for records and information management addressing storage, transfer, destruction, accuracy and confidentiality. **Our Records Retention and Destruction program includes:*** • **Policy and procedures** • **Records retention schedule** • **Legal hold procedures** **Policy and procedures** **Our policy is the primary guide on retention policies, retention processes and related information. The Records Retention and Destruction program director, department records managers and unit records managers ensure implementation of the policy, monitors it and enforces compliance. We train our records managers in records retention and destruction and evaluate them on their performance during annual reviews.** **Records managers are also responsible for creating department-specific procedures, updating them annually and posting them on our intranet site.** **<u>Records retention schedule</u>** **This is the official source for informing employees how long to keep each type of business record. The schedule is posted on our intranet site.**	5 points

Legal hold procedures

We post these procedures on our intranet site. They describe the process for keeping records subject to an actual, threatened or reasonably anticipated lawsuit (including arbitration proceedings, government investigation or similar proceeding.) The procedures explain the process for sending a legal hold notice to custodians, as well as the roles and responsibilities of the custodian. We require the custodians to acknowledge that they received the notice and take a training course on legal holds. We send reminders periodically to remind custodians of their obligations.

Additional information

Records cleanup event

We conduct an annual records cleanup event. This event supports compliance with the Records Retention and Destruction, Information Privacy, and Information Security policies. The program director works with our real estate services department on planning and promotion. Each of our office receives posters and banners to promote the event, as well as additional secure paper shredding bins.

All employees are required to participate in the event. We provide the necessary tools and educational materials to employees to perform the actions needed to adhere to our policies and procedures.

Employees are required to complete an online certification stating they have completed their records cleanup and are complying with all policies and procedures. Temporary and contract workers are also required to comply. Records managers or privacy managers conduct training for employees who disagree with any of the certification items.

Employee training

We train employees on our records retention and destruction standards each year through the business conduct and integrity exam. The training includes sections on information privacy and security. Corporate compliance monitors the completion rates. We report results to our executives and chief executive officer.

All new employees must complete this training within 30 days of their first day of work. We monitor to be sure employees complete training.

Employees working from home

We have a growing population of employees who work from home. Steps to address records retention and destruction (and other security issues) with this group include:

- **Retaining paper records in locked, Aetna-issued cabinets**
- **Giving shredders to employees with Aetna printers**
- **Blocking administrator rights from computers (so personal printers cannot be used, for**

example)

- **Limiting the use of CDs or USB ports**
- **Requiring employees to sign an agreement to follow all privacy and security standards**
- **Requiring employees to sign an annual renewal letter**

Records storage and shredding

We employ an offsite records storage vendor to manage inactive records. The vendor monitors incoming boxes to be sure all data is complete. The vendor provides a certificate to us when destruction is complete. We meet quarterly with the vendor to discuss goals and explore ways to strengthen our Records Retention and Destruction program. Backup tapes are kept for 90 days.

The vendor provides secure shredding and equips each of our offices with locked bins for paper and electronic media. Electronic media includes:

- **Diskettes**
- **Compact discs**
- **DVDs**
- **Magnetic tape cartridges**
- **Reels**
- **Cassettes**
- **Movie films**
- **Microfilm**
- **Microfiche**

We review the "chain of custody" controls from the vendor and are satisfied it meets our privacy standards.

Highlights include:

- **Secured shredding on-site service, including:**
  - **Secure, locked consoles in the office**
  - **Regularly scheduled pick-ups by uniformed, security-trained personnel**
  - **Cross-cut shredding technology**
  - **Secure chain-of-custody**
  - **Certificate of destruction after each service**
- **Vehicles have a high-grade commercial security system, using hardware and software, to create a "best-in-class" mobile security structure. This includes:**
  - **Cargo doors that are alarmed even when the vehicle is in motion**
  - **Cargo doors that are secured with high-security door locks**
  - **Vehicles that won't start without an approved alarm key**
- **Facilities have:**
  - **Advanced security systems and perimeter monitoring equipment**
  - **Video surveillance systems that record the activities in the facility entrance and production area**
  - **Closed-circuit television surveillance of entrances, exits and production lines**
  - **Strict badge/security processes governing admittance**
  - **Fire-suppression systems**

• **Shredding facilities use the following protocols:** - **Adhere to and certified through National Association for Information Destruction, Inc., AAA and Payment Card Industry Data Security protocols.** - **Paper shredded using pierce and tear (cross-cut) methods.** • **All electronic media is either burned or smelted:** - **Destroy material with industrial incinerators reaching 1,600 degrees Fahrenheit.** - **Special equipment reduces material to base components. These particles are then washed and palletized into a final form.** **<u>Review and amendment</u>** **The Records Retention and Destruction program director reviews the policy and procedures on an annual basis to confirm that it complies with new or revised laws and regulations and makes necessary amendments.** ***This document summarizes various parts of Aetna's Records Retention and Destruction program. Aetna's policies and procedures, records retention schedules and legal hold procedures would supersede any conflicts that might exist in this document.**	
7.A.4 Describe the methods used for ensuring that information management processes comply with applicable State or Federal laws and regulations and contain protocols for ethical use of records. **We adjust our policies, procedures and systems, as necessary, to conform to specific HIPAA requirements on an annual basis. Our Privacy Office coordinates such reviews and works closely with Law and Regulatory Affairs.** **Under the direction of Aetna's Privacy Office, we maintain policies and procedures that comply with all applicable federal and state laws, including but not limited to the HIPAA Privacy and Security regulations and the Gramm-Leach-Bliley Act (GLBA).** **<u>Ethics</u>** **We communicate our commitment to conduct business in compliance with all applicable laws and regulations and with the highest degree of integrity through the following methods:** • **Code of conduct: Updated annually or more frequently, as required, and made available to all employees through our intranet and third parties through www.aetna.com.** • **Aetna Values Wheel: Values are Integrity, Excellence, Inspiration and Caring and Aetna's commitment to these values is communicated/reinforced continuously in executive, senior and middle management presentations, as well as through www.aetna.com and AetNet (our intranet site).** • **Business conduct and integrity training: Code of Conduct training for all employees, suppliers and board members – mandatory upon hire and annually thereafter.** • **Manager training for appropriately responding to compliance/ethics-related complaints and concerns – delivered once to all managers. New managers trained upon hire or promotion.** • **"Compliance First" videos, published on AetNet.**	5 points

• **Ad hoc AetNet articles (e.g., covering real situations/consequences, spotlighting employees who have acted with integrity or simply to reinforce key messages).** • **Mandatory quarterly "Leading with Integrity" manager-led staff discussions on compliance/ethics topics.** • **Compliance & Regulatory Affairs intranet site (a link to which appears on the AetNet home page).** **In addition to the above, most business units develop a compliance/ethics communication plan each year to develop and deliver targeted messaging to local staff members.**	
7.A.5 Describe your HIPAA policies, procedures, and training related to quality and provider data. **We are fully compliant with all HIPAA requirements that have been issued to date. We confirm that we are compliance with HIPAA privacy and security rules for data transferred to outside parties.** **We have policies, procedures and technologies in place to protect sensitive information against inappropriate and unauthorized use and disclosure. Examples include:** • **Written privacy and security policies** • **Privacy and security awareness training for all employees** • **Integrity and access controls** • **Message authentication and/or encryption** • **Firewall and proxy server technologies** **We restrict access to protected health information (PHI) to those employees who need it to provide products or services to our members through "role-based access control" (RBAC). We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. Access to our facilities is limited to authorized personnel, and we protect information we maintain electronically through use of a variety of technical tools.** **In addition, as part of our privacy and security compliance programs, the Privacy Office has identified specific individuals to serve as privacy and security managers. We assign managers to our business units. They serve as the initial point of contact and are responsible for day-to-day enforcement of Aetna's privacy and security policies and the procedures that support them.** **Finally, adherence to privacy and security policies and procedures is subject to ongoing monitoring. For example:** • **Both our Internal Audit department and Compliance Assessments Team periodically perform assessments on the company's privacy policies and procedures. As needed, corrective action plans are developed to address the findings of the Internal Audit reviews.** • **Key business areas (e.g., member services) incorporate review of employee adherence to privacy policies in ongoing quality management efforts.** • **We conduct an annual review of our security program to ensure the necessary controls are in place to meet HIPAA Security requirements and to ensure the program is continually enhanced to address evolving security threats. Aetna subject matter experts review each HIPAA requirement to confirm our compliance. They are also required to provide supporting**	5 points

evidence of compliance. We completed our most recent security reviews by May 5, 2017.

Training

All of our employees (including third-party suppliers and consultants) are required to complete our Business Conduct and Integrity (BCI) training program. The program includes two components, an online training course and a Code of Conduct Acknowledgment, wherein each employee certifies reading, understanding and complying with Aetna's Code of Conduct, Privacy and Information Security policies and also provides an opportunity to disclose potential conflicts of interest. BCI training takes place during the first week of employment and then annually thereafter — and completion is tracked.

The BCI training course includes the following modules:

- **Compliance**
- **Conflicts of interests**
- **Privacy**
- **Information security**
- **Workplace behavior**
- **Fraud, waste and abuse**
- **Records management**
- **Handling Supplier Engagements**

We conduct the BCI training online through our secure intranet. The Ethics Office of our Compliance & Regulatory Affairs (C&RA) organization electronically monitors the training through a training tracker tool, which follows up with each employee until we reach 100 percent completion.

Employees with job responsibilities that include use or disclosure of personal information and/or protected health information must complete additional training on specific protection procedures and assisting members in exercising their HIPAA privacy rights. This training is deployed and tracked in the business areas where the employees are located.

Further, every employee has access to business area Privacy Managers who are responsible for coordinating education on process changes and serving as the local point of contact for privacy concerns. Business area Privacy Managers receive extensive training and have direct reporting into Aetna's Privacy Office. All employees, including contractors, are also required to complete a stand-alone Information Security Awareness training course within seven days of hire.

Aetna's Code of Conduct can be viewed at www.aetna.com/about-us/corporate-governance/code-of-conduct.html

7.A.6 Disclose any event where your employees have committed acts that compromise member information, regardless of whether it is PHI or not. If none, what procedures do you have in place which have ensured this?

5 points

We have always made information privacy and security a priority. We have policies, procedures and technologies in place to protect member and other non-public data from unauthorized use and disclosure. Unfortunately, despite our best efforts, privacy breaches do occur from time to time.

When they occur, we follow a rigorous process to immediately halt any ongoing breach and to

mitigate the impact of the event to our customers. This includes notifying members, plan sponsors and regulators, as required under HIPAA and other applicable state and federal laws, and taking other steps such as offering free credit monitoring when a member's financial information is exposed. We also address the root cause of the breach to strengthen controls, where necessary, to prevent a reoccurrence. **We only provide specifics to impacted customers. We do, however, report such information to the HHS website.**	
7.B Systems and Data Sharing	
7.B.1 Describe your plans for developing and maintaining your management information system(s). **Keeping with our commitment to providing the highest quality of service to our customers, we have developed a comprehensive Business Continuity Management (BCM) Program to manage business disruptions.** **The mission and purpose of the BCM Program is to:** • **Improve our resiliency against any disruption of services** • **Ensure we have the ability to deliver services to our customers during events that negatively impact operations** • **Provide a defined framework to identify critical operations, associated risks and impacts and develop appropriate recovery strategies** • **Validate plan strategies and capabilities through testing and maintenance** **The BCM Program is responsible for:** • **Determining the company's objectives and statutory duties based on the organization's operating environment with regards to business continuity** • **Identify activities, assets and resources, and their respective criticality to the business that may comprise business operations** • **Setting and documenting the business continuity responsibilities of the organization, based on Management directives** • **Maintaining the Business Continuity Policy, standards, and technical controls for the organization, including the review of policy and standards on a regular basis** • **Determining and supporting proper methodologies and processes for business continuity** • **Communicating business continuity responsibilities including a formal training and awareness program in accordance with the applicable program requirements and maintaining the records** • **Maintain the Business Continuity Management (BCM) program including regular program reviews, updates to documentation and associated procedures** • **Implementing a program to exercise and test business continuity procedures and crisis**	5 points

management plans on a regular basis • **Implementing performance objectives depending up on the results of the hazard identification, risk assessment, and business impact analysis to address both short-term and long-term needs defined by the organization** **Recovery** **In the event of a Core data center disaster, the recovery time objective (RTO) to resume most production processing is four days from disaster declaration for all mainframe and mid-range systems, and five days for LAN systems. Portfolios of highly available applications, such as Web and Pharmacy, have RTO's of six hours or less. These applications use mirroring and/or load balancing and Active/Active technologies between the data centers to make sure that the reduced RTO's can be met. Our voice and data network backbones are fully redundant using SONET ring and MPLS technology and are recovered within one hour of a data center outage.** **Our data center recovery strategy and its application RTO's are consistent with or better than industry standards.**	
7.B.2 Describe your plan for interfacing with EBD's systems and any subcontractors. **Our claims system receives, images and processes both automated and manual claims. And it can interface with our plan, member, provider, quality management and utilization management databases. There is no direct interface between the customers and subcontractors. We are responsible for our subcontractor's performance. In addition, we remain liable for contracted services performed by our company, if we subcontract those services to another organization. Therefore, there is no direct interface between EBD's systems and the subcontractors that may be utilized.**	5 points
7.B.3 Describe your plan for screening for excluded or disbarred/debarred entities. **We monitor provider disciplinary actions between credentialing cycles by reviewing state board reports, Office of Inspector General sanction reports and the government-wide List of Parties Excluded from Federal procurement and non-procurement programs (i.e., the Office of Personnel Management Debarment reports). We review these reports as frequently as they are made available to capture any adverse activity that could potentially result in a non-renewal.**	5 points
7.B.4 Describe your plan to meet EBD security requirements. **Our security policies define the fundamental principles for the protection of our information resources and employees. In addition, they define the proper controls needed to ensure compliance with internal and external regulations. They demonstrate effective practices to protect information including sensitive personal information regarding customers and other contracted constituents in addition to employee safety.** **All employees are responsible for ensuring compliance with our security policies. We will work with EBD to meet the security requirements.** **Aetna's Next Generation Authentication** **We continue to invest in digital technology to provide your employees and their families with a simpler, better experience. Our Next Generation Authentication system is an innovative solution to improve security for the users of our apps and digital platforms. Rather than requiring a user ID and password to access the account, the system uses the behavior of the user to determine**	5 points

how much access to provide.

Our Next Generation Authentication system on the Aetna Mobile app, transparently and continuously authenticates the device and the user. The simpler authentication process is more secure and it makes the app more user-friendly. By using FIDO (Fast Identity Online) standards, we're ensuring sensitive information doesn't leave the user's device.

Our Next Generation Authentication process monitors the user's physical location, time of access and thumbprint, as well as a range of 30 to 60 various behaviors, such as:

- **How the phone is held**
- **Keystroke speed**
- **Swipe gesture patterns**
- **How they walk**

When combined, these attributes help us more accurately determine if the user is who they say they are and how much access to provide.

The system uses continuous risk-based authentication that calculates a risk score and determines how much and what type of access to provide to the app. It's added security without impacting the user experience.

Security review for compliance

We comply with the HIPAA (Health Insurance Portability and Accountability Act) Security Rule, which includes the Omnibus Rule.

Internal review

We conduct an annual review of our security program to ensure the necessary controls are in place to meet HIPAA Security requirements and to ensure the program is continually enhanced to address evolving security threats. Our subject matter experts review each HIPAA requirement to confirm our compliance. They are also required to provide supporting evidence of compliance. We completed our most recent security reviews by May 5, 2017. There were no exceptions noted.

External review

IBM Security Services assessed our security program (including HIPAA controls) in May 2017. The results state that our Information Security Program is compliant. An external assessment is performed annually.

Ongoing monitoring

Adherence to our privacy and security policies and procedures is also subject to ongoing monitoring. For example, both our Internal Audit department and Compliance Assessments Team periodically perform assessments of the company's privacy policies and procedures.

Security scorecard

Each month, we are rated against our peers by the Industry Security Scorecard across ten

categories, each assessing the aspects of a company's security infrastructure. And each month, we consistently top the list with the highest overall security score, placing grades above our competitors.	
7.B.5 Describe and provide a copy of your Disaster Recovery Plan as applicable to this RFP. **Our Executive IT Disaster Recovery Plan is the high level plan for recovery of a data center and its critical components. The plan is derived from over 100 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment which are needed to recover data centers** **Application DBAR plans document:** • **Technical and management contacts** • **Application recovery specifics** • **Application dependencies** • **Integrated system synchronization** • **Check-out procedures** **The plans are maintained routinely and utilize automated recovery processes to insure appropriate data resilience. These DBAR Plans are validated semi-annually with the application owners and business users with periodic integrated exercises performed. We have approximately 169 Application DBAR Plans across all recovery tiers.** **All DBAR plans are centrally maintained by our disaster recovery group, stored both locally and offsite, and updated semi-annually or as needed by the respective infrastructure areas.** **Escalation and notification procedures are contained within these Disaster Recovery plans to ensure recovery team members, affected partners and business unit owners are activated in a timely manner.** **We have provided a copy of our Disaster Recovery Plan with our proposal response.** **Please refer to *Disaster Recovery Plan.pdf* located in the Additional Requested Attachments section of our proposal response.**	5 points
7.B.6 Can provider networks be loaded within your system? If a provider is not within a network what is your process for advising the Plan Participant and provider of the out-of-network status? **Yes. Members can check if a provider is in-network or out-of-network by checking DocFind, our online provider directory located at aetnanavigator.com or aetna.com. We update our online provider directory six times per week.**	5 points
8 – IMPLEMENTATION	
8.A Implementation	
8.A.1 Specify, to the greatest extent possible, the activities that are to be undertaken to transition and implement the required services including a step-by-step guide and the names of the persons involved in each step. **We have provided a detailed Implementation Solutions document that outlines the**	5 points

timeline and activities involved in the implementation process. We have also included a timeline for Active health.

Your implementation team includes the following Aetna members:

- **Marcus Duckworth, Sales Vice President**

- **Account Executive/Account Manager**

  - **Primary Aetna contact throughout implementation**
  - **Coordinates open enrollment activities**
  - **Provides ongoing account management after the plan effective date**

- **Mark Sternat, Proposal Director**

Marty Pollard, Strategic Proposal Consultant

  - **Provides initial details of sale, rates, special procedures**
  - **Prepares and documents the Letter of Understanding**

- **Member Service Center**

  - **Provides member services support**
  - **Processes claims**
  - **Coordinates audits**

- **Implementation Manager**

  - **Directs implementation activities**
  - **Oversees activities of all Aetna areas**

- **Plan Benefit Set-Up**

  - **Reviews benefits plans**
  - **Codes benefits and structure into Aetna systems**
  - **Distributes documents to appropriate departments**

- **Contracts/Agreements**

  - **Drafts contracts**
  - **Prepares funding agreements**
  - **Drafts employee Booklets and/or Certificates of Coverage, if applicable**

- **Eligibility**

  - **Maintains member eligibility data**
  - **Coordinates production and ID card mailings**

- **Billing**

  - **Codes billing rates into Aetna systems**

Prepares billing statements

8.A.2 Detail the resource requirements necessary to successfully complete the transition and implementation. Resource requirements should include any required input from EBD Staff and/or the current provider, and an estimated amount of time required from EBD Staff and/or the current provider. **We bring together a team of technical and administration specialists to implement customer plans based on the products and services selected.** **Similarly, we ask EBD to identify a team representing the following areas:** • **Financial** • **Benefits** • **Information technology** • **Human resources** • **Other departments as needed** **Our team concept approach for implementation activities offers the following advantages:** • **Increases accountability** • **Collaboration to identify the best resolution for any challenges** • **Responsiveness** • **High level of customer and member satisfaction** **We will work together with EBD to develop a successful implementation plan.**	5 points
8.A.3 Detail your implementation steps/processes and identify the time requirements for each. **At the start of the process, we identify the technical members needed to implement your benefits program. Our core team includes:** • **Sales** • **Plan sponsor services** • **Member service operations** • **Banking, legal or other internal departments as needed** **The implementation manager and the core team evaluate the products, programs and services you have chosen. They produce a detailed plan that identifies team members and assigns target dates for the completion of each task.** **We also ask you to identify members from your company to work with us to ensure the accuracy of the benefits and plan design. We find that the team concept increases accountability and responsiveness. It also provides the highest level of customer satisfaction.** **<u>Timing</u>** **We recommend a lead-time of 120 days prior to the effective date for a smooth transition. However, the time needed to implement a benefits program varies, depending on your choice of products and services.** **We develop an implementation schedule that outlines the tasks associated with each portion of the project. It provides a scheduled start and completion date for each task and helps keep team members on track.**	5 points

We have provided a detailed Implementation Solutions document that outlines the timeline and activities involved in the implementation process.	
8.A.4 What support, if any, would you require from EBD during implementation? **We ask you to identify a team made up of members from the following departments:** • **Financial** • **Benefits** • **Information technology** • **Human resources** • **Other departments (as needed)**	5 points
8.A.5 What support, if any, would you require from EBD throughout the duration of the contract? **If awarded the business, we would like to sit down and discuss this with EBD.**	5 points
8.A.6 Describe the risks your company anticipates EBD, the Major Service Components, or the Recipients may face during the Implementation Period and your company's plan to mitigate those risks. **We see some common problems during case installation and the first few months of the plan. These may include:** • **Late enrollments - We prompt our customers for the timely submission of enrollment information so we can produce and mail ID cards prior to the effective date.** • **Data errors - We work with our customers to correct data and spelling mistakes.** **Heather Curis, EBD's assigned Account Executive, can help you plan, coordinate and conduct enrollment activities that help employees understand their new benefits plan. We support these efforts with:** • **Enrollment materials such as brochures, flyers and FAQs** • **Provider and network information through our online provider directory** • **Quality, cost of care and health information through our member website** **The assigned eligibility consultant works with you to:** • **Review enrollment options** • **Set dates for the submission of enrollment information** • **Set dates for the production and mailing of member ID cards** **Milliman: We anticipate several types of risks that may Impact the Implementation Period with regard to the Actuarial Service component:** • **Incomplete or inaccurate historical financial information – Developing accurate budgets is**	5 points

dependent on receipt of timely, complete and accurate claims and membership history. To mitigate against delayed receipt of historical information, we use streamlined processes for negotiating data agreements, where our consultants work closely with legal and IT resources to address concerns in data handling, data storage, etc., that may delay the data exchange. To mitigate against the risk of using incomplete or inaccurate data to conduct forecasts, we would conduct various levels of validity and reasonableness checks including comparison to official annual plan statements, trend analyses, benchmarking vs. external data sources, etc. • **Inaccurate member count projections – Developing accurate budgets is also dependent on receipt of timely, complete and accurate enrollment projections. To mitigate against the risk of using inaccurate membership projections, we will review assumptions with applicable EBD personnel and understand likely range of possibilities.** • **To help mitigate against the above risks and other risks that may arise, Milliman is prepared to participate in regular calls (weekly) and in-person meetings (monthly). This process will support timely identification and resolution.**	
8.A.7 Detail your company's experiences with implementing projects of similar size and scope and complexity. Include timelines, goals, results, and other elements necessary to fully communicate your company's implementation experience. **We have over 160 years of experience in providing quality, reliable services to businesses, individuals and the government. The goal of our implementation process is to meet and exceed your expectations for a smooth transition. In order to achieve this, we strive to:** • **Develop a strong partnership with you** • **Anticipate and identify issues that are key to the success of the project** • **Resolve any potential challenges** **We use custom tools, a team approach and survey feedback to keep improving the quality of our implementation process. In this way, we continue to build, improve, support and maintain high performance teams that truly differentiate us in the marketplace. In 2017, our overall post-implementation survey satisfaction results were 4.85 on a 5-point scale (5 being the highest).** **<u>Team members and approach</u>** **Our highly successful approach includes a team of technical experts and specialists. They consult with you to implement the chosen programs and provide ongoing service. Likewise, we ask you to identify a team made up of members from the following departments:** • **Financial** • **Benefits** • **Information technology** • **Human resources** • **Other departments (as needed)** **We find that the team concept increases accountability and responsiveness. It also provides the highest level of customer satisfaction.** **<u>Custom implementation tools</u>** **We use custom project management tools to meet and exceed your expectations for a smooth**	5 points

transition. During the process, we illustrate the chosen products, programs and services on our detailed Implementation Management Plan. This plan identifies members of the implementation team. It also establishes target completion dates for all associated activities. **We also use Project Management Tools to track open items to resolution. We regularly update and distribute this document to the implementation team to keep team members on track and informed of the project's progress.**	