FINAL TECHNICAL PROPOSAL PACKET

SP-18-0059

Note: Updates to this final Technical Proposal Packet are designated by red font.

PROPOSAL SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	HealthSCOPE Benefits				
Address:	27 Corporate Hill Drive				
City:	Little Rock	State:	AR	Zip Code:	72205
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship X Corporation		☐ Public Service Corp ☐ Nonprofit	
Minority Designation: *See Minority Business Policy*	X Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Woman ☐ Service Disabled Veteran	
	AR Minority Certification #: _____		Service Disabled Veteran Certification #: _____		

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	Mike Castleberry	Title:	Senior VP, Network Services & Business Development
Phone:	501-218-7502 (Work)	Alternate Phone:	501-912-2045 (Cell)
Email:	Mike.castleberry@healthscopebenefits.com		

CONFIRMATION OF REDACTED COPY

X YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

X Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's proposal to be disqualified.**

Authorized Signature: Mary Catherine Person **Title: President & CEO**

Use Ink Only.

Printed/Typed Name: Mary Catherine Person **Date: 5-03-18**

SUBMISSION REQUIREMENTS

- *Per the RFP, the below information/documents **must** be submitted with Prospective Contractor's proposal submission.*
- *These items will not be scored as part of the bid evaluation; however, failure to provide the required information/documents **shall** result in disqualification of a Prospective Contractor's bid.*
- ***Do not** include additional information if not pertinent to the itemized requirement.*

1. Proposal Bond

2. Conflict of Interest Affidavit, with any necessary attachments.

3. Copy of the certificate of compliance with SOC -2 Level II and/or SSAE-18

4. Proposed Subcontractors Form

CONFLICT OF INTEREST AFFIDAVIT

- This *Conflict of Interest Affidavit* is for the Prospective Contractor's disclosure of any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) as described and required in the RFP, Section 2.5.

- Per Section 2.5 of the RFP, this *Conflict of Interest Affidavit* will not be scored as part of the RFP evaluation. However, submission of this signed *Conflict of Interest Affidavit* along with the required disclosures if any, as stated in the RFP Section 2.5 is a Proposal Submission Requirement. Should the Contractor fail to submit the *Conflict of Interest Affidavit* with *Technical Proposal Packet* response, the State reserves the right to disqualify the Prospective Contractor's proposal.

- Do not include additional information if not pertinent to the itemized request.

- Should the Prospective Contractor have any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) disclosures to make, the Prospective Contractor **shall** submit an additional document, as an attachment to this *Conflict of Interest Affidavit*, explaining the actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s).

- The Prospective Contractor **shall** include all information necessary to fully communicate the nature of the actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) including proposed mitigation measures.

Check the appropriate box below:

X Per Section 2.5 of the RFP, my company does not have any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) to disclose at this time.

☐ See the attachment to this *Conflict of Interest Affidavit* disclosing my company's actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s).

By signature below, the Prospective Contractor certifies that it meets the disclosure requirements as stated in Section 2.5 of the RFP to the best of its knowledge, and **shall** continue to meet disclosure requirements as stated in Section 2.5 of the RFP throughout the life of the contract.

Authorized Signature: _____
Use Ink Only.

Printed/Typed Name: **Mary Catherine Person, President & CEO** **Date:** **5-03-18**

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP
Mullally Insurance Services	2665 N. Atlantic Ave. Suite 325	Daytona Beach, FL 32118
McAfee & Taft	211 N. Robinson	Oklahoma City, OK 73102
American Health Holding	7400 W Campus Rd F-510	New Albany, OH 43054
Ethicare	22 Route 10 West Suite 201	Succasunna, NJ 07876
Zelis	2 Crossroads Drive	Bedminster, NJ 07921
Cleveland Clinic	1950 Richmond Road	Lyndhurst, OH 44124
HSTechnology	23382 Mill Creek Drive, Suite 200	Laguna Hills, CA 92653
Employers' Health Choice PPO	27 Corporate Hill Drive	Little Rock, AR 72205
Lewis & Ellis, Inc. Actuaries and Consultants	700 Central Expressway South #550	Allen, TX 75013

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

5-03-18

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. **We are well suited to partner with the State of Arkansas as a result of our long history servicing clients and our ability to help customers manage their costs.** **HealthSCOPE Benefits is the leading independent third party administrator of self-funded benefits plans. For over thirty years, we have developed market-leading solutions for many Fortune 500 companies, mid-sized employers, State and Local Governments, and multi-employer plans. HealthSCOPE Benefits administers benefit plans for clients in every time zone in the continental United States. Our client base is diverse, ranging in size and industry from State and Local Governments, manufacturers, and service providers to Taft-Hartley plans and healthcare organizations.** **INNOVATIVE** **For over thirty years, we've delivered the most comprehensive service offerings in the industry, comprised of innovative, high-touch, and custom tailored solutions** • **No shelf products – customized plans to fit your needs** • **Going beyond integration with your vendors to full collaboration (Wellness, Pharmacy, Care, and Population)** • **Health Management + your other service partners** • **A focus on an easy member experience** **CARING & COMMITTED** **We are committed to facilitating timely, appropriate, and effective LOCAL customer care for our members. HealthSCOPE Benefits will establish toll-free access to a team of representatives to respond to member calls and emails. Our Customer Care Team will be responsible for facilitating effective communication, including maintaining established phone standards, timely response to written and phone inquiries, and dialogue with Human Resources regarding all inquiries that may arise. Over the years we have worked to continually improve health plans for companies and state governments like the State of Oklahoma, Whirlpool, Walmart, United Airlines, and the State of Nevada. Our reputation for providing sophisticated flexible claim administration—combined with excellent service—is unmatched in the industry.**	5 points

At HealthSCOPE Benefits, we are on the cutting edge of cost-containment strategies and plan design techniques. And where the market is unable to provide what the State is looking for, HealthSCOPE Benefits is able to develop it from scratch.

LOCAL ACCOUNT MANAGEMENT

Healthcare is local. Through our LOCAL Arkansas account teams, we understand and respond to the needs in local markets. Through our national platform and flexibility, we deliver custom tailored solutions. Our success in managing benefit plans for our clients is due to our holistic view of healthcare, known as- TOTAL HEALTH MANAGEMENT

Resulting in *Healthy People, Healthy Business and Healthy Futures*.

Throughout our journey, we have maintained a focus on providing an exceptional member experience, collaborating across organizations to provide integrated solutions, and leading cost containment capabilities. HealthSCOPE Benefits is fully capable of exceeding all parameters of this Request for Proposal.

HealthSCOPE Benefits goes beyond the offerings of traditional administrators to provide innovative health benefits solutions—a practice we have come to term Total Health Management. This holistic approach allows us to create and manage plans that result in Healthy People, Healthy Business and Healthy Futures. It is not unusual for HSB to take on a new group and see a negative trend in the first year as a result of our cost management programs.

At HealthSCOPE Benefits we do more than talk about innovation, we embody it. The following are just some of the tools and practices we've implemented and the impact for those we serve.

- **HealthSCOPE Benefits is licensed to administer benefits in all 50 states(NAIC 541611)**
- **We've invested in industry-leading technology, including extensive web access for clients, a state of the art IVR phone system for providers, automated benefits administration applications and HSB DataSCOPE™, our sophisticated data warehouse and reporting product.**
- **In-depth review of all claims in excess of $25,000 to include review of implants and appropriateness of charges.**
- **Review of RX in excess of $5,000 to insure appropriateness of charges, FDA approval for submitted diagnosis and appropriate dosing and regime.**
- **Zero dollar threshold for out of network claim negotiation**
- **Care Connect – HSB's outreach program to engage members with total claims payments in excess of $50,000. This program allows us to help members navigate their healthcare plan, answer questions regarding benefit offerings to include case management, disease management and gaps in care. We assist members with the location of network providers to meet their needs and scheduling appointments and work with them to make contact with additional care coordination programs.**

All TPAs are not the same. HealthSCOPE Benefits is different. We back up our claims, guarantee results and maintain long-lasting relationships with our clients. HealthSCOPE Benefits' partnership with you is founded on three tenets. It is our pledge to work with you to develop an attractive, affordable and customer-friendly benefits plan for your employees.

- **Healthy People**

Unlike an insurance company, we are not simply accepting risk on behalf of our clients. Unlike a traditional TPA, we are not simply adjudicating and paying claims for the self-insured. Rather, our company empowers clients to proactively monitor and manage the health of their employee populations.

- **Healthy Business**

It's well documented that a healthier workforce is a more productive workforce. But HealthSCOPE Benefits goes beyond the basics to help deliver a healthier bottom line – by assertively controlling healthcare costs through networks, discounts and utilization management. Furthermore, HealthSCOPE Benefits' flexible, customized plan design means our client companies are delivering exactly the benefit structure they want.

- **Healthy Futures**

HealthSCOPE Benefits is a partner for the long term; the real value of our partnership is unlocked over time. HealthSCOPE Benefits creates sustainable benefit programs. By enabling cost trend management dramatically below the industry's average, HealthSCOPE Benefits helps its clients create healthier futures.

HealthSCOPE Benefits will closely lead in the relationship. All items will go through HealthSCOPE Benefits Account Management.

HealthSCOPE Benefits forms partnerships with the best vendors in the business. We currently manage our partnerships by ensuring continuous due diligence by maintaining constant involvement in day to day processes and procedures regarding vendor integration into the daily activities of HealthSCOPE Benefits' groups. Regular meetings, quality checks, and various internal processes are imposed to ensure all requirements are met and continued improvement is ensured relating to all aspects of our vendor partnerships and processes.

1.A.2	Describe your experience in providing multiple health services in a "bundled" capacity.	5 points

We administer services in this capacity for many of our clients.

HealthSCOPE Benefits is a leader in managing medical trend for self-funded employers. Our client's average annual medical trend has been 2.66% for the past 13 years – two to three times lower than our competitors. We have developed an innovative suite of solutions to aggressively manage medical claim. We maintain a highly efficient, cost-effective and high-touch claims management platform for our clients. We have a +30 year track record of operational excellence and continuous quality improvement.

HealthSCOPE Benefits is one of the fastest-growing independent TPAs in the industry. We have achieved high client retention rates through an unyielding commitment to open communication and independence. We listen to our clients so that we can help them identify their needs and deliver solutions that meet those needs most effectively. Our attention to detail begins during the proposal process with a thorough review of your current plan and understanding your objectives. Once you become a client, that detail continues with high-quality management information and regularly scheduled account management communication. HealthSCOPE Benefits has experienced double-digit growth each of the last four years as prospective clients appreciate the cost management techniques we can provide.

We are constantly looking for innovative ways to help our clients and their employees. We accomplish this through innovative solutions centered on Total Health Management®, resulting in Healthy People, Healthy Business, and Healthy Futures. HealthSCOPE Benefits provides some of the most comprehensive service offerings in the industry, comprised of unique, high-touch and highly customized services. We provide the strength of a national platform and the flexibility of an independent administrator.

• INDEPENDENT
Largest Independent TPA
800 Associates

• NATIONAL PLATFORM
Over 700,000 Members
$1.6 Billion Paid Claims

• RESULTS
2.66% Medical Trend
96% Client Retention

• DIVERSIFIED
Fortune 500 and State Government Clients to Middle Market Employers

• NETWORKS
Deep Roots Developing Custom Networks

• VALUE-BASED CARE
ACOs, Bundled Payments, Capitation & Creative Solutions

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.

5 points

We are well suited to partner with the State of Arkansas as a result of our long history servicing clients and our ability to help customers manage their costs. We have partnered with the State of Nevada since July 2011 and have helped them have negative trend since that year—meaning they pay less fees PEPY today than they did in 2011 and have increased benefits. We use many of the below subcontractors with them.

Specifically for the State of Arkansas, we will utilize the following subcontractors for each of the services described below.

A complete description of these services has also been provided within question 2.A.5.

Subcontractor's Company Name	Service Provided
Mullally Insurance Services	MIS, Inc. provides claims auditing services based on industry standards and client specific benefits as outlined in client's summary plan document.
McAfee & Taft	For subrogation recovery services, we partner with McAfee & Taft, the largest law firm in the country that handles day-to-day health care subrogation services. They have clients/participants located in all 50 states and their recovery rates are at the very top of the industry.
American Health Holding	Medical Management & Oncology Management Services
Ethicare	Medical Bill Review to ensure clients are not overpaying for services.
Zelis Health	Claims Cost Management
Cleveland Clinic	Employee Assistance Program Provider
HSTechnology	Provider of Reference Based Pricing technologies that reduces healthcare claims costs.
Employers' Health Choice PPO	Wrap Network for Physician Reference Based Pricing

Lewis & Ellis, Inc. Actuaries and Consultants	**Actuarial Services to include** • **Financial monitoring and claims experience analysis, which will include maintaining models** • **Renewal evaluation and rate projections based on various funding scenarios** • **Claim forecasting** • **Monitoring and analysis of network pricing** • **Analysis of the financial impact of proposed benefit changes** • **Analysis of the impact of future regulatory changes** • **Development of IBNR liabilities** • **Budgeting and trend forecasting** • **Retiree Drug Subsidy actuarial attestation** • **OPEB valuations under GASB 74 and 75** • **Consultation and advisory services related to the administration of the program and the benefits** • **Attendance at meeting, as requested by EBD**
Renalogic	**Management of Dialysis & Renal Spend**

HealthSCOPE Benefits goes beyond the offerings of traditional administrators to provide innovative health benefits solutions—a practice we have come to term Total Health Management. This holistic approach allows us to create and manage plans that result in Healthy People, Healthy Business and Healthy Futures. It is not unusual for HSB to take on a new group and see a negative trend in the first year as a result of our cost management programs.

We provide these exact services for other clients today. We would work with the EBD and its partners who coordinate care to make sure members are being managed in the most efficient manner possible. Our data warehouse allows us to review coordination of care and site of care appropriateness within once day of claim payment to allow for intervention when it is still relevant.

We also drive site of care and care coordination through our customer care team and the ability to redirect members to the most effective providers.

We would expect to have monthly meetings with the Account Management team and quarterly meetings to include the Account Management team and our Executive Team. Our proactive Account Management team can help the client meet all desired objectives. Our Account Managers are experienced and skilled in providing this level of service. Our Account Managers and Executive team assembled for each client is highly committed to providing exactly what our customers want when they want it.

We want to be very hands-on, with orientation meetings with group employees, followed by a very visible and positive presence. Therefore, we will provide on-site assistance with meetings, materials for the meetings, as well as any additional training needed for the HR staff.

Because of our independent status, we are able to constantly review new opportunities and build relationships with world class partners in designing what our clients need and desire as part of their strategic planning. Our relationships with respected industry partners will not be apparent to your employees, but they do provide tremendous value to your health plan. We are committed to working with vendors our clients already have in place or choose to make sure the strategy is supportive of the overall goal, whether it is related to health and wellness, network expansion and management, new health plan options for employees, or bringing new products and services to the general marketplace. HealthSCOPE Benefits can deliver the necessary expertise and tools to make any plan a reality.

HealthSCOPE Benefits forms partnerships with the best vendors in the business. We currently manage our partnerships by ensuring continuous due diligence by maintaining constant involvement in day to day processes and procedures regarding vendor integration into the daily activities of HealthSCOPE Benefits' groups. Regular meetings, quality checks, and various internal audit processes are imposed to ensure all requirements are met and continued improvement is ensured relating to all aspects of our vendor partnerships and processes. Audit processes and schedules vary based on the provider.

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.	5 points

HealthSCOPE Benefits (HSB) has been building and maintaining provider networks for large employers since 1985. We are ranked by Business Insurance Magazine as the largest Independent Third Party Administrator (not owned by an insurance carrier). Before we entered the TPA business in 1992, we built and maintained provider networks for some of the largest employers in the Country. Originally incorporated in 1985, our initial focus was on developing and managing provider networks for Fortune 500 manufacturing companies. Throughout our evolution as a company, HealthSCOPE Benefits has built over 130 custom Point of Service (POS) gatekeeper and PPO networks in more than 30 states.

HealthSCOPE Benefits Network Administration Services supports provider or employer sponsored networks through turnkey management services. HSB provides network solutions in network design, structure, data review, contracting, credentialing, utilization review and benefit design. This process maximizes network access, steerage and cost management. We have dedicated business unit that handles network development in regional markets as an end-to-end solution.

In addition to networks that we design, build, and maintain for our clients, we provide our clients access to 140 provider networks nationwide (CIGNA, Aetna, etc.). In order to meet the RFP's request for innovation and creative ideas, we have proposed the following network option:

HST Facility Reference Based Pricing wrapped with the Employers' Health Choice Network for Network Practitioner and Ancillary Only Access

We are committed to embark on a journey with the State of Arkansas to a collaborative care delivery model with value-based reimbursement and a cost-plus reimbursement methodology.

HSB has saved our clients millions of dollars through improved network utilization, expanded provider networks and improved fee schedules. HSB has managed PPO transition, improved out-of-network utilization, defined network alternatives and facilitated transitions to new TPAs. Additionally, we have maximized network contract and credentialing compliance avoiding potential legal pitfalls.

Just as important as our technical capabilities, we are a leader in developing easy to understand member communications to introduce new plans and networks to members that are accustomed to broad PPOs. Our marketing and communications team will work with the State to create a custom member communications strategy to introduce the new network as a positive enhancement focused on providing the State's members with access to the highest quality care.

We use our network development expertise to provide access management through customized provider recruitment initiatives in specific geographical areas where the clients' needs are most evident.

Utilizing insight from our Network Analytics team, we can put together a family of network products and services as well as establish and maintain networks based on experience and research, which can lead to greater efficiencies and more affordable care.

As an example we have built custom networks in multiple markets for a Fortune 100 client. We utilized reference based reimbursement programs as well as developed and maintained high performance networks that have provided improved efficiencies and member satisfaction. The Plans utilizing a custom network that we have built and maintained, on average have a medical trend under 2.0%;out-performing industry benchmarks by more than two times and improving member satisfaction and clinical results.

	In an effort to provide a successful RBR program, we have developed robust policies and procedures for handling pre-admission advocacy and support, balance bill negotiations, and final negotiation, resolution and indemnification. Our experience as the largest independent TPA in the Nation, provides the State with assurances that we offer the safeguards in place to ensure members have a positive experience and are not pressured by providers.	
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 Section III to reference these sample materials – located on CD.**	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: **As with any company our size, litigation is part of the current business landscape. While HealthSCOPE Benefits has had proposed litigation in the past, HSB does not have a single pending action. HealthSCOPE Benefits has not filed bankruptcy, insolvency proceedings, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.** • 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. **HealthSCOPE Benefits has not had any pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in the RFP.** • List all of insurance Market Conduct examinations and findings. **None.** • 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. **HealthSCOPE Benefits has not had any of its contracts terminated prior to the 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. **None.**	5 points

- List any damages, 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.

None.

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

Ed Grooms serves as Vice President, Project Management Office responsible for formalizing and implementing structures around key strategic initiatives. Mr. Grooms' leadership and project management skills enable HealthSCOPE Benefits to efficiently execute on the top strategic initiatives of the organization thereby enabling company growth and service excellence to our customers.

HealthSCOPE Benefits goes beyond integration to full scale collaboration with our client's other vendors and in-house resources. A large part of our value for health systems is our flexibility to drive collaboration to deliver custom tailored solutions. In other words, we are not just sharing eligibility with other vendors. We are sitting down at the same table to develop and administer creative solutions without competing priorities.

Clients and consultants often compare HealthSCOPE Benefits to Switzerland. Independence drives us to always put the client first and collaborate across organizations. Our focus is on the client – no ownership in networks, services or other vendors and no conflicting allegiances. Our unique profile makes HealthSCOPE Benefits the right choice to support health systems ACOs looking to leverage their internal resources and affiliations with other best in class partners.

HealthSCOPE Benefits forms partnerships with the best vendors in the business. We currently manage our partnerships by ensuring continuous due diligence by maintaining constant involvement in day to day processes and procedures regarding vendor integration into the daily activities of HealthSCOPE Benefits' groups. Regular meetings, quality checks, and various internal processes are imposed to ensure all requirements are met and continued improvement is ensured relating to all aspects of our vendor partnerships and processes.

Claims, eligibility, medical management and provider application functions are all fully integrated into one highly functioning platform. We utilize the Insur-Claims System through Healthaxis; this system is leased and accessed on an ASP basis with the system hosted in an IBM Data Center in Pearl River, New York. Healthaxis is SSAE 18 accredited and undergoes annual review.

This is a highly automated platform featuring fully integrated enrollment processing, medical management records, claims adjudication, provider record management, and Internet self-service. This system is "paperless" in that all documents received in our office are imaged and indexed to a sophisticated workflow.

There is an electronic link between our claims system and our utilization review program, large case management program, HRA claims processing, HSA claims processing, and FSA claims processing.

To ensure seamless data integration between claims processing and utilization review/medical management, we transmit encrypted eligibility and review determination data on a nightly basis via secure FTP site in a HIPAA compliant format. Transmissions are validated for accuracy using error checking routines for all data received.

During the notification review process, cases are analyzed for a number of criteria used to trigger cases to Case Management for review. These triggers include ICD-10 diagnosis codes, CPT codes, length-of-stay criteria and claims dollar thresholds, as well as specific criteria requested by our customers. Information is easily passed from Utilization Management to Case Management through our fully-integrated care management software system. All notification requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.	
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. **Please refer to Section I to review our Certificate of Insurance letter of Intent and our Errors & Omissions/Cyber Security Certificate of Insurance. HealthSCOPE Benefits agrees to maintain for the life of the contract, general liability, professional liability, and cyber liability insurance, including data breach insurance, naming EBD as an additionally insured in the amount set in the RFP. HealthSCOPE Benefits will also agree to maintain an errors and omissions policy, acceptable to EBD.**	5 points
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 Section IV to reference our confidential audited financial statements within the TECHNICAL PROPOSAL PACKET. We have provided statements for 2015, 2016 and our unaudited 2017 statement, in additional to financial reference letters. We will be happy to provide audited 2017 financial statements once complete.**	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. **We are not a qualified heath plan because we are a third party administrator servicing self-funded clients. We do not have marketplace plans because we do not offer fully insured plans.**	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. **We propose to staff the call center 1 rep for every 1,850 insureds and 1 claims analyst for every 2,500 insureds. Staffing for the State would consist of 50% tenured staff and 50% newly hired staff with a minimum of 3-5 years in our industry. In an effort to insure we maintain proper staffing levels of high quality employees, HealthSCOPE conducts a recruiting and training initiative every quarter regardless of new business needs. This insures we always have adequate staffing that is thoroughly trained to administer our business.**	5 points

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. **Upon notification of being awarded the contract HealthSCOPE would immediately begin recruiting staff to backfill the 50% tenured staff that will be assigned to the State plan. This will insure a solid foundation of staff upon which to continue to build out the team dedicated to the State plan.** **HealthSCOPE Benefits offers its employees competitive salary in a positive work environment with opportunity for growth. Our continued focus on Learning and Development positions our employees for continued success.**	5 points

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.

5 points

Please refer to the biographies below for the key personnel who will be involved with the administration of the State's Plan.

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.

HealthSCOPE Benefits has an extensive account management staff with more than 40 current members. For the State of Arkansas, we would involve some of our most experienced staff.

The State of Arkansas will be assigned a dedicated Account Manager for day-to-day Plan administration along with a dedicated claims administration and designated customer service team. As requested, the dedicated Account Manager would provide the following:

- **Overseeing and supporting all day-to-day matters arising from the administration and management of the services listed within this RFP.**
- **Working with EBD on the administration and management of the Major Service Components as necessary (i.e., interpreting the Contractor's policies, providing coverage criteria information, resource for outreach and education of our staff/Recipients as needed) to fulfill the requirements of this RFP and as requested by EBD.**
- **Making all final decisions regarding claims, administrative, and/or programmatic issues arising from the operation of the Services and possessing the final decision-making authority necessary to implement changes presented and approved by EBD.**
- **Meeting weekly with EBD regarding topics such as the status of the operation of the Services, escalated issues, and other topics as determined necessary and requested by EBD.**
- **Facilitate the development of report(s) and creation of data files.**
- **Responding to EBD requests for data as needed.**

We will work with the State to determine the number of employees that will need to be assigned for day-to-day Plan administration. HealthSCOPE Benefits will also provide a local customer service office for the State's members.

Each client receives a highly experienced account manager to lead an expert team of individuals all dedicated to exceeding client expectations. Our account managers proactively manage clients through providing ongoing information about national and local issues that impact service delivery, and meet at least quarterly with each customer to review not just utilization data, but overall service quality and future planning. Each HealthSCOPE account team assists in the development and distribution of any training or communication materials that keep members informed of the value of the benefits, of new services available, and reminders for benefits already in place. Again, our methods for working with each client are designed specifically for what that client needs.

HealthSCOPE Benefits believes strongly in the adage, "There is only one chance to make a first impression," and that lasting partnerships begin with starting and staying on the same page. Our philosophy is One Team from the onset of the implementation to servicing your account. As such, the same team responsible for working with you through the proposal and decision making process, is the same team who will be working with you through and beyond implementation. There is no "hand off" to a separate team. Our goal is continuity of service, and our clients appreciate the fact we are consistent in who is involved at every level of service. HealthSCOPE Benefits is willing to place fees at risk towards Account Management satisfaction.

Our proactive Account Management team can help the client meet all desired objectives. Our Account Managers are experienced and skilled in providing this level of service. Our Account Managers and Executive team assembled for each client is highly committed to providing exactly what our customers want when they want it.

HealthSCOPE Benefits takes a great deal of care in selecting the right fit for each client, as the complexities, strategies, overall goals vary and differ among each individual customer. Level of expertise, background history in the service of various industries and capacity to provide the highest levels of service all are taken into account when choosing a team who will represent HealthSCOPE Benefits in any such assignment.

State of Arkansas
Executive Team Biographies

Mary Catherine Person, President
Role: Executive Sponsor

HealthSCOPE Benefits
27 Corporate Hill Drive
Little Rock, AR 72205

Mary Catherine Person serves as President for HealthSCOPE Benefits and has been employed by HealthSCOPE Benefits for 24 years. In this capacity Ms. Person is responsible for claims administration, customer service, sales and account management for the organization. Previously, she served as Executive Vice President for CenBen USA focusing on operations and account management. For many years, Ms. Person's role was that of Vice President of Managed Care Services for CNA Health Partners, overseeing the company's network development and medical management efforts. Prior to her employment with HealthSCOPE Benefits and its predecessor companies, Ms. Person worked for the Federal Office of Rural Health Policy where she gained extensive background in the issues of rural health and the problems employers and providers face in those areas.

Ms. Person received a Bachelor of Arts degree, Cum Laude from Princeton University in Princeton, New Jersey.

Todd Archer **Role: Senior Vice President, Account Management** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Todd Archer serves as Senior Vice President of Account Management for HealthSCOPE Benefits. With over 35 years experience, Todd has a rich history of success in the third party administration of health benefits. Prior to joining HealthSCOPE Benefits, Todd was with Mutual Assurance Administrators/HealthSmart for 26 years where he served in various executive management roles.** **Todd earned a Bachelor of Science degree in Business Administration from the University of Tennessee, Knoxville. He is involved in numerous industry and community leadership boards and activities including: Healthcare Administrators Association (HCAA) – Past Presidents; Self Insurance Institute of America (SIIA) – SIPAC Trustee; QUBIC, Inc. – Past Board Member; Rebuilding Together OKC – Past Board President and Current Advisory Board Member; OKC All-Sports Association – Current Board Member.**	
Mike Castleberry **Role: Senior Vice President, Network Services & Business Development** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Mike Castleberry serves as Senior Vice President of Network Services and Business Development for HealthSCOPE Benefits. With more than 20 years experience in the health care industry, Mike has been instrumental in leading highly successful sales and marketing efforts across the health care industry. Prior to joining HealthSCOPE Benefits, Mike served as Director of Sales and Marketing for WellPoint. There, he was responsible for creating alliances with health plans, self-funded employers, and Third Party Administrators to achieve cost efficiency and improve the health of these organizations.** **Mike was recently appointed to the new Arkansas Health Insurance Marketplace Board of Directors by Governor Mike Beebe, and serves on the board of the Arkansas Comprehensive Health Insurance Pool as Secretary/Treasurer. He also serves on the Federal Pre-Existing Condition Insurance Plan. Mike is President of The Arkansas Association of Health Underwriters, in addition to serving as an adjunct professor at the University of Arkansas at Little Rock within the Economic and Finance department. Mike is also very involved in the community. He is a graduate of the Greater Little Rock Leadership Program and serves on the Riverfest board and committee.**	

Brett Edwards **Role: Senior VP of Solutions and General Counsel** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Brett Edwards serves as Senior Vice President Legal and Compliance for HealthSCOPE Benefits. In this capacity, Brett is responsible for all legal and compliance matters for the organization. He oversees the Legal and Compliance departments, the Appeals, Benefits Administration, Eligibility, and Billing departments as well as Human Resources. Brett has been with HealthSCOPE Benefits since 2009 and has a background in employee benefits, employment law, and litigation. In addition to his work at HealthSCOPE Benefits, Brett sits on various state and national legal committees related to health care.** **Brett received a Bachelor of Science degree from Georgetown University and a Juris Doctor degree, Cum Laude, from the American University Washington College of Law. He is licensed to practice law in New York.**	
Stephanie W. Harris **Regional Vice President of Account Manager** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Stephanie Willbanks Harris serves as a Regional Vice President of Account Management for HealthSCOPE Benefits. Before this, Stephanie served as Director of Account Management for 4 years. Ms. Harris is responsible for several Account and Client Relations Managers; assisting with daily operations including special client projects across the region. She began her insurance career in 1995 in Customer Service with a national carrier, and then moved on to manage the customer service unit for several years. Ms. Harris transferred to sales and marketing and led the Provider Relations team and Appeals Unit for that carrier over the course of her 10 years with the company. She then spent 7 years as an insurance broker in a small firm in Little Rock before joining HealthSCOPE Benefits in late 2014.** **Ms. Harris received her B.S. in Journalism from the University of Central Arkansas and currently serves as a board member for the Arkansas Association of Health Underwriters. She is active in the community as a volunteer for various organizations, and she is a licensed life and health agent for over 15 years.**	
Mary Manriquez **Role: Clinical Program Director** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Mary Manriquez is Client Program Manager for HealthSCOPE Benefits. Ms. Manriquez is responsible for managing specific benefits programs and acts as a direct liaison between the client, HealthSCOPE Benefits, and account management.** **Prior to joining HealthSCOPE Benefits, Ms. Manriquez worked in Public Health Administration and various hospital settings. Ms. Manriquez has a Bachelor of Science in Nursing from the University of Arkansas for Medical Sciences and is a Registered Nurse in the state of Arkansas.**	

Patty Kelly **Role: Implementation Manager** **HealthSCOPE Benefits** **2350 South 7th Street, Suite 100** **St. Louis, MO 63104** **Patty Kelly, Implementation Manager, has been with HealthSCOPE Benefits for 15 years. She is responsible for overseeing the entire implementation process of new clients from contract signing through product go-live which requires close coordination among all the designated personnel for this process.** **Prior to this position, Ms. Kelly served as a Network Services Administrator for HealthSCOPE Benefits. She was responsible for implementing the PPO Networks and Vendors for all new and existing clients. She also maintained our provider database, updated directories for all contracted organizations, and built fee schedules for our contracted partners.**	
Kimberly Hayes **Role: Director, Eligibility** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Kimberly Hayes serves as Eligibility Director for HealthSCOPE Benefits. In this capacity Mrs. Hayes is responsible for setting, managing, and coordinating the policies, procedures, and activities of the Eligibility Department. Though only joining HealthSCOPE Benefits' team in January 2013, she has over 20 years of experience in Benefits, Administration, Government Compliance, Human Resources, COBRA and Eligibility administration.** **Prior to HealthSCOPE Benefits, Mrs. Hayes served as the Eligibility Manager for a Northwest Louisiana TPA for 15 years. There she was responsible for Eligibility, COBRA, Group & Individual Billings, System & Plan Building, Government Compliance, and Benefit Contracts & Administration. She is a graduate of Louisiana State University-Shreveport with a degree in Business Management. She is highly motivated and demonstrates effective Leadership and Management skills with excellence and continues to strive for innovative, efficient new procedures and processes to benefit the company and its clients.**	
Ms. Cathy Gantt **Role: Senior Manager, Claims Administration** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Cathy Gantt serves as Senior Claims Manager for HealthSCOPE Benefits. In this capacity, Ms. Gantt is responsible for monitoring of day to day operations of the Claims Administration Department. This also includes specific management functions for a major large medical/dental group. Her responsibilities include monitoring of inventory, turn around time, quality, training assessment, reports and providing assistance to individual supervisors.** **Ms. Gantt began her career as a certified Medical Assistant, focusing on health insurance. She has worked in multiple aspects of the field, including billing, claims adjudication, medical review, audit, customer service, eligibility, training and benefit programming. She attended Parks College in Denver, Colorado.**	

Ms. Norma Campbell **Role: Senior Supervisor, Claims Administration** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Norma Campbell has been with HealthSCOPE Benefits, Inc, since September of 1997 and serves as a Claims Administration Senior Supervisor. Ms. Campbell is responsible for supervising claims analysts to ensure claims are processed in an accurate and timely manner. She also works with Client Relations Mangers on benefit changes and group questions.** **Prior to joining HealthSCOPE Benefits, Ms. Campbell worked in the insurance industry for more than 29 years with a back ground in eligibility , customer service and claims supervision.**	
Ms. Lowana Hudson **Role: Customer Care Manager** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Lowana Hudson serves as Customer Care Manager for HealthSCOPE Benefits. Lowana is an experienced professional dedicated to meeting/exceeding call center guidelines; including service levels and productivity goals. She is skilled in call center operations, change management, problem solving and Key Performance Indicators (KPI's). Lowana coaches and develops team by leading training sessions as well as providing one on one development to CSRs. She possesses strong leadership abilities as well as excellent verbal and written communication skills needed in order to lead staff to achieve required metrics.**	
Wanda Elmore **Role: Customer Care Director** **HealthSCOPE Benefits** **5150 Dublin-Granville Rd., Suite 300** **Columbus, OH 43081** **Wanda Elmore serves as Customer Care Director for HealthSCOPE Benefits. In this capacity, she is responsible for managing all aspects of the Customer Care Department.** **Ms. Elmore has over 20 years experience in benefits and claims administration.**	
Darren Ashby **Role: Senior Vice President of Operations** **HealthSCOPE Benefits** **5150 Dublin-Granville Rd., Suite 300** **Columbus, OH 43081** **Darren Ashby, Senior Vice President of Operations brings over 22 years of experience in the insurance and benefits administration industry. His responsibilities include maintaining HealthSCOPE Benefits' claims and customer service technology and managing the company's highly experienced staff to deliver the very best in claims administration.** **Mr. Ashby has been with HealthSCOPE Benefits for fourteen years.**	

Cathleen Armstrong **Role: Vice President of Quality Assurance** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Cathleen Armstrong serves as the Vice President of Quality Assurance for HealthSCOPE Benefits. In this capacity, Cathleen is responsible for managing and monitoring claims processes to meet and exceed industry standards. She is also responsible for all external audits and the recovery unit. She served as Manager of the Employee Benefits Division for CNA Health Partners, HealthSCOPE Benefits' predecessor company. Prior to employment with CNA Health Partners in 1994, Cathleen was in the property, casualty, health and workers compensation claims areas.** **Her claims experience spans over the last 30 years.**	
Tim Beasley **Role: Chief Information Officer** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Tim Beasley is Chief Information Officer for HealthSCOPE Benefits. In this capacity, Mr. Beasley is responsible for overseeing the Information Services Department and all things technical. He provides a dedicated resource to better support some key departments.** **Prior to joining HealthSCOPE, Mr. Beasley held executive management positions at Surgical Care Affiliates, Diagnostic Health Corporation, and Ardent Health Services. With over 25 years in the Information Technology industry, he has gained valuable experience with developing and executing IT strategies, outsourcing and vendor management, Security and Compliance along with audit preparation, implementation of multiple software systems, and has built Data Center Infrastructures.** **Mr. Beasley is originally from Alabama and holds a Bachelor of Science in Computer Science from the University of Alabama at Birmingham.**	

Susan Hayworth **Role: Vice President of Strategic Consulting** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Susan serves as the Vice President of Strategic Consulting for HealthSCOPE Benefits. In this capacity, Susan supports the Account Management and Sales teams with client initiatives and broker/consultant relationships, and also leads innovation projects for the company.** **Susan's experience spans 30 years in the benefits consulting, carrier, and corporate benefits fields. The majority of her experience has been in health and benefits consulting while with Aon, Hewitt and Mercer; and working for two carriers in national account management. Just prior to joining HealthSCOPE Benefits in early 2017, Susan spent 4 years in human resources leadership roles, working for a global IT company, and for a large regional health care system.** **Susan earned a BS in Business Administration from the University of North Carolina-Chapel Hill, and a Master's degree in Legal Studies from the University of Baltimore. She is a Certified Employee Benefit Specialist (CEBS) and a Certified Compensation Specialist (CCP).**	
Carol Montgomery, R.N. **Role: Senior Vice President of Continuous Improvement** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205** **Carol serves as the Senior Vice President of Continuous Improvement for HealthSCOPE Benefits. In this capacity, Carol works with senior HealthSCOPE leadership to determine, develop and deliver innovative strategies and tools for clients. Carol also works closely with Account Management, Benefit Programming, Claims, PBM team, Customer Care and IT Departments to accommodate client specific benefit plans, as needed.** **Carol's experience spans 40 years in the Healthcare space beginning with her career as a Registered Nurse. Her experience includes nursing in Surgery, ICU and the Burn Unit, Medical Sales, Utilization Review, Case Management, Director of Medical Management unit, Claims experience as Director of Client Service Unit, Stop Loss experience, worked with most major Stop Loss carriers, as well as, worked extensively with Brokers, Consultants and Clients.** **Carol earned her RN degree in St Louis, Mo at O'Fallon School of Nursing. As well, Carol is a licensed insurance product in Life and Health.**	

Laura Knight **Role: Director, Client Services** **HealthSCOPE Benefits** **27 Corporate Hill Dr.** **Little Rock, AR 72205** **Laura Knight serves as Director, Client Services within Account Management. Laura began her tenure with HealthSCOPE in 2017 is responsible for the implementation of new client business and vendor integration. Laura's career spans 20+ years in employee benefits.** **Prior to joining HealthSCOPE, Laura managed new business operations teams at Transamerica Employee Benefits as well as serving in national and core account management roles. Prior to that Laura managed large scale partner implementations, implementation of large blocks of business purchased from other carriers, conducted product and service implementations and served in various account management roles with USAble Life.**	
2.A.4 Describe your plan for substitution or replacement of Key Personnel. **HealthSCOPE Benefits' leadership is charged with developing and maintaining a succession plan for key personnel. The plan is reviewed by Senior Management on a bi-annual basis. HealthSCOPE Benefits has more than 800 associates. If a team member is not the right fit for the State, we would review our options with the State to meet its satisfaction.**	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

We do not plan to subcontract any essential portion of our services. We will take responsibility for the quality, timeliness, and accuracy of all subcontracted services.

HealthSCOPE Benefits forms partnerships with the best vendors in the business. We currently manage our partnerships by ensuring continuous due diligence by maintaining constant involvement in day to day processes and procedures regarding vendor integration into the daily activities of HealthSCOPE Benefits' groups. Regular meetings, quality checks, and various internal audit processes are imposed to ensure all requirements are met and continued improvement is ensured relating to all aspects of our vendor partnerships and processes. Audit processes and schedules vary based on the provider.

Preferred Subcontractor Partners to Include:

Mullally Insurance Services - Claims Auditing

Mary Jean Mullally
President
Mullally Insurance Services, Inc.
2665 N. Atlantic Ave., Suite 325
Daytona Beach, FL 32118
813.973.8700 (office)
813.994.6353 (direct)
813.787.5191 (cell)
832.550.0401 (fax)
maryjean@misaudit.com
www.misaudit.com
Tax ID: 05-0548792

PROJECT DATES:
1997 to present

DESCRIPTION:
MIS, Inc. provides claims auditing services based on industry standards and client specific benefits as outlined in client's summary plan document.

The rising cost of medical care is forcing more employers and their consultants to become involved in their own employee benefit programs. That involvement is changing both the patterns of obtaining benefits and the methods of funding them.

Information has become the most powerful weapon in the war on escalating medical costs. Utilization review programs, catastrophic case management, and data analysis packages all attempt to generate reports to help identify and analyze utilization patterns.

Employers and their consultants are relying on these reports to make crucial decisions about plan designs and cost containment measures. The astonishing truth is that most of these decisions are made without ever questioning the integrity of the basic information used to generate the reports Millions of dollars are spent each year for the purchase of managed care programs. Nothing is spent on auditing the credibility of the most basic source of information

If your insurance company or third party administrator is not adjudicating claims accurately and according to the plan design, all other information that follows is useless.

MULLALLY INSURANCE SERVICES, INC. emerged from the experience of professionals with both health insurance and claims administration backgrounds. They realized that the accuracy of claims administration increased dramatically when the claims examiners are subject to independent audits.

McAfee & Taft – Subrogation Services

Richard Nix, Attorney
McAfee & Taft
Subrogation Services
211 N. Robinson
Oklahoma City, OK 73102405.552.2219 (office)
405.228.7419 (fax)
Richard.nix@mcafeetaft.com

PROJECT DATES:
2015 to present

DESCRIPTION:
For subrogation recovery services, we partner with McAfee & Taft, the largest law firm in the country that handles day-to-day health care subrogation services. They have clients/participants located in all 50 states and their recovery rates are at the very top of the industry.

Oklahoma City-based McAfee & Taft was organized as a professional corporation in the state of Oklahoma in 1952 and is privately owned by the attorney shareholders of the firm, all of whom reside in Oklahoma.

The senior management team is led by Michael F. Lauderdale, the firm's managing director, and a six-member board of directors, which consists of Timothy J. Bomhoff, Jennifer H. Callahan, Stephen M. Hetrick, Henry D. Hoss, Michael J. LaBrie, and Scott D. McCreary. Additional firm leadership is provided at the practice group level. Practice group leaders include Richard D. Nix (Subrogation Recovery Services Group), Brandon P. Long (Employee Benefits and Executive Compensation), and Mary Quinn Cooper and Michael D. McClintock (Litigation).

The firm's top administrative executives are Chief Operating Officer Matthew D. Bown and Chief Financial Officer John C. Litke.

AHH – Medical Management Services & Oncology Services
PROJECT DATES: 2009 to Present

Kathy Diaz
Account Executive
American Health Holding
7400 West Campus Road
New Albany, OH 43054
614.933.7573
kdiaz@ahhinc.com
www. Ahh.inc.com

DESCRIPTION:
Since its founding more than 20 years ago, American Health has evolved to become one of the nation's leading medical management companies. Recognized for its URAC-accredited programs, flexible solutions, clinical expertise, and leading proprietary technology, American Health provides health care cost savings and customized solutions at a price lower than the competition.

Some key facts about the company include:

- **Serving approximately 2.5 million lives across all 50 states, the Caribbean and Bermuda**
- **98% client satisfaction rate**
- **91% retention rate**
- **16 onsite locations**
- **More than 20 years of experience with medical management and cost management solutions**
- **URAC-accredited, integrated Utilization Management, Case Management and Disease Management programs**
- **Licensed in all required states**

The mission of American Health is straightforward: to deliver flexible medical management services that support cost-effective quality care for members. Today, American Health's relationships encompass a wide variety of organizations including:

- **Third party administrators**
- **State and local governments**
- **Taft-Hartley/health and welfare funds**
- **Self-insured companies**
- **Reinsurance carriers and MGUs**
- **Health care/business coalitions**
- **Health insurance carriers**
- **PPOs, HMOs, and MCOs**
- **Independent practice associations**

HealthSCOPE Benefits, Inc. has partnered with AHH, Incorporated ("AHH"), in order to bring its customers a world-class cancer management process, known as the Oncology Management Solution ("OMS Program").

AHH is a company with over 30 years of experience in the manufacturing of laboratory and medical instrumentation for the clinical, research, chemical, environmental, industrial and pharmaceutical laboratories throughout the world.

AHH's OMS Program will minimize the plan's vulnerability to excessive financial risks in connection with the payment for chemotherapy charges associated with cancer care.

Under the OMS Program, participating employers will be provided with a comprehensive oncology-specific strategy for patient management, medication management, provider management and claims management that results in:

- **Intense clinical support to help members have a safe and successful therapy cycle, resulting in improved patient outcomes.**
- **Side effect mitigation through early intervention that could otherwise result in costly emergency and inpatient care.**
- **Cost avoidance for unnecessary and inappropriate chemotherapy treatment through proactive medication management.**

When a member is referred to the OMS Program, a certified oncology nurse coordinator and pharmacist are assigned as the key resource to both the member and treating physician during the course of the treatment. The nurse coordinator and pharmacist will be responsible for guiding members through the entire treatment process as they maintain ongoing communication with the patient's physician concerning the patient's therapy compliance, side effects management and general well-being.

Statistics show that the cost of cancer treatment and chemotherapy will only continue to rise; therefore, AHH and HealthSCOPE Benefits, Inc. are pleased to make this cancer management program available to help defer these escalating costs.

Renalogic – Management of Dialysis & Renal Spend
PROJECT DATES: 2007 to Present

Shelly McKown
Senior Account Representative
22601 N 19th Avenue, Suite 230
Phoenix, AZ 85027
623-594-3126 (p)
602-526-5164 (c)
602-714-8853 (f)
smckown@renalogic.com

DESCRIPTION:
HealthSCOPE Benefits has partnered with Renalogic for customized cost containment options for managing dialysis and renal spend. Renalogic's consulting services include programs that provide quality care options tailored to meet plan fiduciaries' specific needs. These programs are described below:

***Payment Based Usual & Reasonable (U&R) Program*. This program allows Plans to apply U&R payment methodology to the dialysis claim. This U&R methodology is non-arbitrary and is based in part on providers' own payment reporting, combined with proprietary database dialysis claims analysis. Proprietary plan language allows U&R re-pricing for in-network as well as out- of-network claims. Our process allows us to review all aspects of each case including, but not limited to plan language, treatment costs, location, risk tolerance, and other financial and case-specific considerations.**

***Home Modalities Education*. This program helps identify members with chronic kidney disease, and where feasible and by working through active case management for the member (if the member is willing), direct patient contact before they begin dialysis to increase knowledge of this alternative treatment. The hope is to accomplish this education before the decision is made to utilize traditional dialysis in- center methods and to promote a lifestyle of independence. The patient's participation in the program not only enhances the quality of the patient's life with improved outcomes, but also results in a reduction of the patient's medical costs. Experts negotiate rates, if appropriate, to provide direct savings to the member and their plan. Home dialysis options include continuous ambulatory peritoneal dialysis (CAPD), using the member's own body without need for a machine, continuous cycling peritoneal dialysis (CCPD), and home hemodialysis (HHD).**

***Medicare Education*. When a member has started dialysis and has not applied for Medicare, or for members that may have come on the plan that were already in dialysis but have not applied for Medicare an educational letter can be sent to appropriately inform the member on the importance of Medicare as secondary coverage for ESRD.**

***Single Patient Agreement (SPA) and Network Access Services*. Under this program, we will negotiate directly with networks and providers for purposes of securing a better discount than would normally be available under a traditional network arrangement. We leverage our established relationships with certain providers in key geographic locations with our own regional network arrangement to procure the best rate available in each regional market.**

***Renal Data Management and Cost Analysis Program*. Through this program, we can help an employer be pre-emptive so that the plan can avoid excessive monthly dialysis expenditures- starting from the employee's first date of dialysis. Two data-focused services are offered, enabling clients to better understand the unique dialysis market dynamics and proactively implement the appropriate cost containment measures pre-onset of dialysis to support members and reduce costs.**

***Chronic Kidney Disease (CKD) Management Program*. What is often overlooked is that long before dialysis, there is a hidden cost when members develop CKD. Typically, CKD is caused by one or more expensive chronic conditions. CKD is a complex illness, which often increases the severity and cost of the underlying chronic conditions, and these conditions lead to progression of CKD. There is much employers can do to control the cost and health impact of CKD. Recent research indicates that with proper management, progression of CKD can be slowed or "put in remission" saving money today and potentially avoiding future dialysis costs. We offer an innovative telephonic case management approach targeted to patients with CKD. The program coordinates with the employer to identify CKD members and establish a point to begin interventions. After identification, a team of wellness, disease management and case management professionals contact members and begin the engagement process. In those cases where CKD progresses to end-stage renal disease (ESRD) and dialysis early education can direct members to more cost effective dialysis treatment options, many of which improve overall health and may increase life expectancy.**

Employers' Health Choice PPO – Network Access
PROJECT DATES: 2010 to Present

Pamela Waters
Provider Relations/Network Development Manager
HealthSCOPE Benefits
Manager – Provider Relations
27 Corporate Hill Drive
Little Rock, AR 72205
501-218-7764 (p)
501-225-9182 (f)
Pamela.waters@healthscopebenefits.com

DESCRIPTION:

Employers Health Choice PPO (EHCPPO), is Arkansas' only statewide employer owned PPO network. With strong roots in the community and a growing network of providers wherever you live and work, EHCPPO represents over 5500 physicians and hospitals. EHCPPO is the choice of many employers throughout Arkansas.

Employers Health Choice PPO's partnership with healthcare service providers, employers and employees provides comprehensive, high-quality healthcare at reduced prices. EHCPPO works with physicians and hospitals to negotiate discounts for participating employers. We provide a superior healthcare experience through medical management programs, educational and support service, and coordinated care.

Our goal is to continually develop and maintain the highest quality, cost effective network of choice. Some of our strengths are categorized as:

- **Outstanding Customer Satisfaction: We realize that in our industry it is service that sets us apart from our competition. We are committed to maintaining our reputation as a leader in customer satisfaction. We welcome your calls for information, questions or suggestions.**
- **Local Presence: Our local presence and market knowledge allows us to respond to the immediate needs of our providers and members in Arkansas.**
- **Our People: At EHCPPO, we believe an organization is only as strong as the capabilities, experience and desire for excellence demonstrated by its staff. The combined experience of our staff brings over 20 years of expertise in the managed care field. This level of dedication and experience underscores our philosophy that a company is defined by its representatives.**

Ethicare – Claims Review
PROJECT DATES: 2014 to Present

Mark S. Hartmann, Jr. MS
22 Route 10 West, Suite 201
Succasunna, NJ 07876
888.838.4422 (office)
www.ethicareadvisors.com

DESCRIPTION:

Our three-tiered approach to saving claim payors money ensures a comprehensive effort is made on every referral to secure the most savings possible.

Our most effective approach is to negotiate settlements directly with providers. We've never had a settlement rescinded!

We save claim payors money. Our expertise and experience settling high-dollar and dialysis claims through negotiated sign-offs, medical bill review and U&C pricing has positioned us as a trusted partner for employers, labor funds, TPA's and carriers. We have a long record of success in negotiating high-dollar, in-network and out-of-network claims and can proudly state that no EthiCare Advisors negotiated settlement has ever been rescinded by any provider. It's our mission to save claim payors money and our hands-on approach to each referral is the key to our success.

Zelis Health – Claims Review
PROJECT DATES:
Premier Healthcare Exchange, Inc. – June 1, 2010; Stratose, Inc. – June 11, 2015; Zelis – January 1, 2017

Lori Sempervive
President
2 Crossroads Drive
Bedminster, NJ 07921
888.311.3505 (office)
www.zelis.com

DESCRIPTION:

Zelis Healthcare is a healthcare information technology company and market-leading provider of integrated healthcare cost management and payments solutions including network analytics and design, network access and cost management, claims cost management and electronic payments to payers, healthcare providers and consumers in the medical, dental and workers' compensation markets nationwide.

Cleveland Clinic – Employee Assistance Program
PROJECT DATES: 2015 to Present

Eva Steinel, PCC-S
Cleveland Clinic
Program Manager – Cleveland Clinic Wellness
1950 Richmond Road
Lyndhurst, PH 44124
216-448-8171 (p)
Steinee@ccf.org
Clevelandclinicwellness.com

DESCRIPTION:

EAP/Caring for Caregivers Services

There are times we all need a little help with life's challenges. Cleveland Clinic understands this and provides resources and support through the Caring for Caregivers Program, (Professional Staff Assistance, Licensed Professionals Health, Employee Assistance Program and the Wellbeing Resource and Referral Service). Through these programs and services expert, confidential and free support is available.

The confidential EAP is here to help. No issue is too big or too small for the EAP, including:

Work problems
Family issues
Emotional problems
Alcohol and drug use
Legal matters

Marital problems
Parenting issues
Loss/bereavement
Financial pressures

HSTechnology – Reference Based Pricing
PROJECT DATES: 2016 to Present

Michael Ward
Vice President Business Development
HSTechnology
9551 Irvine Center Drive
Irvine, CA 92618 602.828.1166 (Mobile)
mward@hstechnology.com
www.hstechnology.com

DESCRIPTION:

Since 2009, HST has been at the forefront of providing referenced-based pricing (RBP) technologies that reduces healthcare claims cost.

We believe that combing pricing and quality can effect meaningful change in purchasing medical services and containing costs. Timely access to reliable cost and quality information is indispensable in determining the economic price of reimbursements. We are dedicated to providing transparency to payers so we can design effective reimbursement strategies.

Our Mission is clear...

Providing our clients with meaningful, timely, and accurate information as it pertains to price, cost and quality of medical services resulting in increased cost savings.

HST's clients consist of Health Plans, TPAs, Trust Funds, Stop Loss Carriers, MGUs, Specialty Risk Insurers, and Self-Administered Group Health Plans, Self-Funded Employer Groups.

Reference-Based Pricing technologies and Claim Surveillance

Our proven innovative pricing technologies allow healthcare payers to optimize reimbursements for all healthcare transactions by benchmarking claims. The pricing engine utilizes extensive data sets to determine the prevailing price, cost and value for all medical services. Claim surveillance examines every claim automatically and benchmarks results against Medicare pricing, cost, average reimbursements, commercial claim payment, reasonable and customary databases and proprietary data bases. This is our Turn-key claims cost management solution.

Once the prevailing price is established, our seasoned negotiators present the findings to the provider and secure a negotiated sign-off agreement based on the reduced amount. This ensures payment-in- full with no balance billing to the member.

HST provides pricing data services to support your cost containment solutions. Our pricing and cost data allows you to benchmark against Medicare pricing, costs and our proprietary databases with tailored results based on your risk tolerance. We can customize our solution to meet your needs and turn-around times.

Our medical appropriateness looks for redundant & duplicate charges, unbundling, experimental drugs, capital equipment, routine nursing, inappropriate charges, unidentified and incomplete charges. Claims requiring further investigation are flagged for specialist review.

Lewis & Ellis – Actuarial Services
PROJECT DATES: May 2018 to Present

Bonnie Albritton, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc. Actuaries and Consultants
700 Central Expressway South #550
Allen, TX 75013 Phone – (972) 850-0850
Email – balbritton@lewisellis.com

DESCRIPTION:

- **Financial monitoring and claims experience analysis, which will include maintaining models**
- **Renewal evaluation and rate projections based on various funding scenarios**
- **Claim forecasting**
- **Monitoring and analysis of network pricing**
- **Analysis of the financial impact of proposed benefit changes**
- **Analysis of the impact of future regulatory changes**
- **Development of IBNR liabilities**
- **Budgeting and trend forecasting**
- **Retiree Drug Subsidy actuarial attestation**
- **OPEB valuations under GASB 74 and 75**
- **Consultation and advisory services related to the administration of the program and the benefits**
- **Attendance at meeting, as requested by EBD**

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

5 points

HealthSCOPE Benefits will notify the claimant of the final decision on our client's behalf. In certain cases, pursuant to PPACA's requirements, the claimant may be able to request an external review of the plan's final internal appeal decision. HealthSCOPE Benefits maintains relationships with a number of external review organizations and will administer the external review process, including notifying our client and the claimant of the external reviewer's decision. Finally, HealthSCOPE Benefits maintains documentation throughout the entire process for stop loss purposes.

Dan Honey is Assistant General Counsel for HealthSCOPE Benefits. In this role he relies on his extensive background in insurance regulatory law and government administration to manage the Appeals Division and handle various legal and compliance matters for the organization.

Dan works directly with our staff to continually train and work with our staff to identify, investigate, and resolve reviews and appeals.

Our appeals specialists team also includes the following individuals who work, and/or are supervised out of the Little Rock headquarters: • **Trudi Drinkwater** • **Shelia Apple** • **Ebonie Hughes** • **Pat Jackson** • **April Rogers** • **Gwynn Guinn** • **Ayanna Edwards** • **Audrey Gooden** • **Gloria Nelson** • **Christina Hurtt** • **Dawn Marshall**	
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. **Any problems with work under the contract will be escalated to our senior leadership team immediately for resolution. The EBD staff would have their cell phone numbers for urgent or emergent issues.**	5 points
2.A.8 Describe your plan for developing and implementing training material for all staff, including subcontractors. **HealthSCOPE Benefits has a robust training program for Claims Specialists, Customer Care Representatives, and Account Managers. Our Learning & Development department has four dedicated trainers (two each for Customer Care Representatives and Claims Specialists) and one trainer dedicated to Account Managers. We have four office locations with dedicated training rooms (Columbus, OH, Little Rock, AK, Nashville, TN, El Paso TX).** **Claims Specialists Training is an eight week endeavor, consisting of five weeks of comprehensive training and three weeks with a mentor. We will run a claims training course every six weeks, with an average of 15 people and a maximum capacity of 30 people per cohort.**	5 points

Table 1. Claims Specialists Training

Learning & Development Program	Curriculum Content	Length	Amount Frequency
Claims Specialists Training	**Claims analysis and processing**	**5 weeks**	**1 class of 15-30 every 6 weeks**
	HIPAA Privacy & Security Intro to HealthAxis & PC View HCFA Quick Claims UB04 Quick Claims Dental Quick Claims Vision Quick Claims Providers & Networks Coordination of Benefits Corrections, basic adjustments, and troubleshooting Researching Information Complex Claims DME Open Call "Tracks" and DocTrax	1/2 day 1 day 2 days *3 days* *2 days* *2 days* *2 days* *3 days* *3 days* *2 days* *1/2 day* *2 days* *2 days*	

Customer Care Representative Training is a five week endeavor, with three weeks of comprehensive training and two weeks with a mentor. We will run a claims training course every four weeks, with an average of 15 people and a maximum capacity of 30 people per cohort.

Table 2. Customer Care Representative Training

Learning & Development Program	Curriculum Content	Length	Amount Frequency
Customer Care Representative Training	**Claims analysis and processing**	**5 weeks**	**1 class of 15-30 every 4 weeks**
	HIPAA Privacy & Security Intro to HealthAxis & PC View Selection Criteria & Eligibility Claim History Claim Options HRA, HSA, & Adjustments Benefits Telephone System Open Calls Vendors & Websites	½ day 2 ½ days 2 days 1 day 2 days 2 days 2 days 1 day 1 day 1 day	

Account Manger Training is two day training. This training is customized to each clients needs, plan requirements and service agreement, and is delivered as needed.

Table 3. Account Manager Training

Learning & Development Program	Curriculum Content	Length	Amount Frequency
Account Manager Training	**Client and service agreement**	**2 Days**	**1 class of 3-5 as needed**
	Client overview Service agreement	½ day 1 ½ days	

We deliver instructor led and remote instructor led training at any of our four service offices. We also deliver compliance training and refresher training via our Litmos LMS.

Table 4. Learning Mode and Locations

Delivery Format	Locations	Training Rooms/capacity	Location Capacity	Total Capacity
Instructor Led Training	Columbus, OH Little Rock, AK Nashville, TN El Paso, TX	2 rooms, 15 & 10 2 rooms, 15 & 15 1 room, 10 1 room, 10	25 30 10 10	75
Asynchronous Self-learning (Litmos)	All locations	Any computer	Unlimited	Unlimited
Remote Instructor Led (GoToTraining)	Columbus, OH Little Rock, AK Nashville, TN El Paso, TX Any computer	2 rooms, 15 & 10 2 rooms, 15 & 15 1 room, 10 1 room, 10 unlimited	25 30 10 10 unlimited	75+

2.A.9 Describe your plan for ensuring adequate resources to investigate unusual incidents and develop corrective action plans. **Our dedicated project manager will ensure adequate resources and investigate unusual incidents and develop corrective action plans. A significant part of HealthSCOPE's implementation project planning and discovery calls is the investigation of scope of work and the ability to identify resources needed to meet established timelines.** **We have successfully implemented many large plans with complicated benefits offerings. HealthSCOPE includes our executive team and senior management team in the implementation process so if unusual events occur, we have the decision makers already involved. Immediate action and strategic planning are put into action to solve for the event.** **At the outset of the project, we would create a statement of work and document staffing needs. The team would include multiple levels of individuals and would provide more than adequate resources to investigate unusual incidents and develop correction action plans.**	5 points
2.A.10 Describe your plan to complete all the duties required for transition at end-of-contract. **A project plan will be developed in PMWare by our implementation team.** **PMWare is our project management software. It will be used to establish and document all relative tasks and duties as well as establish due dates or timelines for completion.** **The implementation team will meet with the client at the frequency needed to ensure success.**	5 points
2.A.11 Provide a general end-of-contract transition plan which addresses the key components outlined in the RFP **Planning for end of contract transition items will be handled several ways:** **1-When HealthSCOPE Benefits is awarded the bid, we will work with the outgoing administrator to identify all components of the transition and include these items on the implementation plan. Run out components or tasks, such as, run-out claims, will be identified and mapped into our implementation plan. A discovery call will be held with the prior administrator and EBD to identify the scope of work and to establish timelines for the successful delivery of each item.** **Implementation calls will be set at the frequency needed to ensure a successful transition of the business to HealthSCOPE Benefits.** **2- Should the State subsequently terminate the contract with HealthSCOPE Benefits, we will commit to full cooperation with the new administrator and EBD to successfully transition all run-out items and to participate in transitions calls, as needed.**	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. **We offer access to our data warehouse and analytics product called HSB DataSCOPE™, a powerful information reporting system developed by HealthSCOPE Benefits to help our clients understand and manage the factors that drive cost and quality of healthcare delivery. HSB DataSCOPE™ compiles data from the client's health plan into valuable reports on factors such as provider performance, employee health status, and disease management.** **HSB DataSCOPE™ surpasses other information systems in its ability to apply advanced Clinical methodologies to healthcare claim data. Where other systems monitor only cost and utilization, HSB DataSCOPE™ considers the data from a clinical perspective. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan and provider performance. Therefore, HSB DataSCOPE™ is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan-management activities.** **HSB DataSCOPE™ is our internal data warehousing product made available to all of our clients, which includes:** **Pharmacy Claims Analysis Integrated with Medical** **Data Management and Warehousing** **Health Care Information Reporting and Analysis** **Benefit Plan Design Modeling & Evaluation**	5 points

Provider Quality & Cost Analysis
Clinical Predictive Modeling
Cost and Care Management Analysis
Ongoing Support Activities

The HSB DataSCOPE™ information reporting system can positively impact your medical plan by providing benchmarking data and analysis to identify specific drivers behind increasing health care costs.

HealthSCOPE Benefits produces a robust set of monthly reports to its clients. These reports include both clinical and financial data which include: Top Providers; Top Procedures, Top Diagnosis, Monthly Lag Summaries, Utilization and Cost Comparisons to National Benchmarks as well as Clinical Usage information. These reports are available to our clients online on the 15th every month.

Aside from the above detailed reports we also provide monthly check register logs for a client to keep in their records. For those clients who are heavier utilizers of their claims data, we offer the ability to run your own reports above and beyond normal month-end reports. HSB DataSCOPE™'s number one goal is to provide actionable information in a timely manner to impact health care costs and utilization as they are happening, not years later.

Distinctive Advantages:

Clinically Adjusted Claim Data: DRGs, MDCs
Data Capture and Analysis System aggregates Multiple Vendor Data Feeds
Mapping and Editing Expertise
Data Analytic Staff produces actionable information
Integration = One Source Reporting

Lab Values
Health Assessments
Pharmacy Benefit Managers
Medical Management
Mental Health / Chemical Dependency Management
Disability Managers
Dental Claims Data
Workers Compensation
Biometric Screening Data

Analytic and Support Services:

Predictive Modeling
Physician, Plan and Network Data
Identify, Drill-down and Research Area of Concern
Provide Solutions-oriented Recommendations
Cost Benefit Analysis
Blend Technology with Health Care Expertise
Chronic Illness Compliance

Please refer to Section III to review our Sample HSB DataSCOPE Reporting Package on CD as requested within question 2.B.7 below.

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. **An email is sent to the dedicated email box of EBD with the request along with the details. Average turnaround time is less than 24 hours with more complicated requests taking up to 72 hours.**	5 points
2.B.3	Provide a detailed description of the process to generate reports from currently available portal/web-based applications. **All reporting is available on-line as well as in electronic format (unless requested in hard copy) and downloadable into standard database (Access) or spreadsheet (Excel) format for manipulation or graphic presentation. Turnaround time to receive ad hoc or customized reports is generally 24-48 hours.** **With proven web-based technology, our reporting capabilities transform daily claim data into actionable management information to help employers understand, predict and lower benefit costs.** **Employer Benefits:** • **View daily, weekly, monthly or other specified periods of claim activity** • **Produce scheduled and ad-hoc reports which detail benefit utilization** • **View large claims (shock claims) immediately and take action** • **Compare benefit plan performance based on national databases** **Benefit and claim data is still only data until it can become helpful information in making employee benefit decisions. Utilizing HealthSCOPE Benefits' online reporting tools, preparing comprehensive reports and analysis that capture benefit utilization statistics and trends has never been simpler. Utilization, comparable data and cost summary information is compiled in user friendly reports that provide a detailed view of your benefit utilization and costs.**	5 points

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. **Our diligence in providing relevant data, when you need it, ensures that all of your reporting needs are met. A Reporting Analyst will collaborate with your dedicated Account Management Team to provide concise data for analysis. Data will be segregated as specified during implementation and will be distributed within 15 days from the end of the month. Statistical (utilization) reports will be provided in a format and that time frame specified by EBD. We have monthly and quarterly statistical reporting available on our website and conduct quarterly onsite meetings to review our HSB DataSCOPE™ reporting. We can also provide the ability to conduct online queries of your data** **Our data analytics team and systems capabilities allow us to tie the services of multiple cutting-edge, forward-thinking vendors into a seamless, single delivery format for the products and services meaningful to your vision.** **Predictive modeling is a core element in HSB's ability to manage its customer's costs. We utilize artificial intelligence to identify potential "at risk" members and to isolate the related health factors. Detailed pharmacy experience also serves as an important data input to our cost management programs. By combining pharmacy data with medical experience, a comprehensive picture is drawn to providing the basis for the plan of care. This knowledge enables the program to effectively focus medical management resources on specific patients and diseases by developing a comprehensive plan of care for the individual. The customer has full access to reports. Our Wellness, Disease Management, and HSB DataSCOPE™ programs are based off of the data. We can provide EBD with access if desired. HSB DataSCOPE™ is a powerful information reporting system developed by HealthSCOPE Benefits to help our clients understand and manage the factors that drive cost and quality of healthcare delivery. HSB DataSCOPE™ compiles data from the client's health plan into valuable reports on factors such as provider performance, employee health status, and disease management.** **HSB DataSCOPE™ surpasses other information systems in its ability to apply advanced Clinical methodologies to healthcare claim data. Where other systems monitor only cost and utilization, HSB DataSCOPE™ considers the data from a clinical perspective. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan and provider performance.**	5 points

Therefore, HSB DataSCOPE™ is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan-management activities. **HSB DataSCOPE™ is our internal data warehousing product made available to all of our clients, which includes:** **• Data Management and Warehousing** **• Health Care Information Reporting and Analysis** **• Benefit Plan Design Modeling & Evaluation** **• Provider Quality & Cost Analysis** **• Clinical Predictive Modeling** **• Cost and Care Management Analysis** **• Ongoing Support Activities** **• Pharmacy Claims Analysis Integrated with Medical**	

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 f. In-Pt/Observation Discharge g. 30-day re-admission h. Claims adjudication cycle, including pended claims i. Network savings reports **As referenced earlier in this section HealthSCOPE Benefits integrates information from numerous platforms and vendors to present a holistic view of the health and wellness of a client's membership. This collection of data requires a rigorous set of quality control processes to ensure clinical and financial reporting remains accurate, complete and consistent. Verification of industry standard codes such as bill type, diagnosis, place of service, etc. is one example of a quality control methods used. Maintaining the integrity of the data is key for delivering actionable information that instills confidence with our clients they have selected the right health and wellness partner.** **a. Claims by ICD-10 category, as requested** **HealthSCOPE Benefits provides extensive diagnosis reporting to our clients at the detail (individual code) level and aggregated at a grouper or super grouper level based upon the paid and/or incurred period desired. Our online DataSCOPE reporting system allows clients to generate reports like the Top 20 Diagnosis Groups report which lists the diagnosis groupers by total paid amount with a per member per month cost allocation for the client and the Truven Health benchmark cost allocation to see how the client's per member cost compares nationally. This report also shows our book of business (BoB) sequence number for comparison purposes. This is just one example of the diagnosis code reporting options built-in to our reporting solution.** **b. Age/gender claim reports** **Our online reporting system captures age and gender information for each claim based on the date the claim was finalized/paid. The system allows our clients to summarize claim counts and amounts by age or gender within the reporting period selected.** **c. Claims by CPT-4 procedure code, as requested** **HealthSCOPE Benefits provides extensive procedure code reporting to our clients at the detail (individual code) level and aggregated at a grouper level. Our online reporting system allows clients to generate reports like the Top 20 Procedure Groups report which lists the procedure groupers by total paid amount with a per member per month cost allocation for the client and the Truven Health benchmark cost allocation to see how the client's per member cost compares nationally. This report also shows our book of business (BoB) sequence number for comparison purposes. This is just one example of the procedure code reporting options built-in to our reporting solution.**	5 points

d. Hospital claims data (admissions, number of days)

Our online reporting system allows easy access to the number of inpatient days and admissions with averages for plan paid and member paid amounts. Drilldown links included in the reports allow clients to quickly view details behind the summarized data such as admitting diagnosis, provider information, etc.

e. ER services

Our online reporting system contains an ER Visit Analysis report which presents the number of visits, average paid per visit and potentially avoidable visits based on category, diagnosis and frequency (frequent flyers). The category breaks the information into severity levels. The diagnosis summaries the information by diagnosis super groupers. The frequency counts the number of visits for individuals with two or visits during the reporting period. The percentage of admissions from ER visits is also captured.

f. In-Pt/Observation Discharge

Our online reporting system captures the required data elements like revenue code, discharge status and discharge date for generating reports for inpatient / observation services.

g. 30-day re-admission

The Utilization Metrics report within our reporting system provides the total count and average paid amount for 30 day re-admissions identified during the reporting period. Benchmark information is also provided for comparison purposes.

h. Claims adjudication cycle, including pended claims

Claims adjudication rates along with pended claim counts and reason codes are reported directly from our claims processing system. These details are tracked by our Claims Department on a daily basis to manage workforce allocations.

i. Network savings reports

Our online reporting system contains a Network Analyst report which compares network performance based upon total savings recorded during the reporting period. This report also includes the number of member, number of claims, total billed, total allowed and total paid for each network listed.

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 **HealthSCOPE Benefits normally provides a monthly reporting package that includes the total number of paid claims, total billed, total allowed, total deductible, total copay, total coinsurance and total paid summarized by the plan structure defined by the client. This package also includes year to date totals for each item referenced above.** b. Coordination of benefits savings **When coordination of benefits is involved with a client's claim, HealthSCOPE Benefits captures the savings associated for reporting. The frequency and reporting period utilized is outlined by the client.** c. Claims payment analysis of payments to providers, separately and combined **HealthSCOPE Benefits is able to produce payment reporting based on the requirements of the client. This normally occurs at the Tax ID (facility/vendor) level, but is also available at the practitioner level.** d. Incurred date lag reporting **HealthSCOPE Benefits provides lag matrix reporting by benefit type (medical, dental, vision, pharmacy) within our online reporting system** e. Premiums to claims ration reporting **HealthSCOPE Benefits is able to provide premiums to claims ratio reporting when premium information is shared by the client.**	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 the Section III to review examples of all available reports requested provided on the enclosed CD.**	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. **The following standard reports are delivered showing a breakdown of cost in the account structure, subtotals and totals requested by the client. All reporting is available on-line as well as in electronic format (unless hard copy is requested) and downloadable into standard database (Access) or spreadsheet (Excel) format for manipulation.** **Standard Reports (Frequency)** **Detailed monthly claims report, including in and out-of-network claims broken out (Monthly)** **Quarterly claims detail reports, including utilization data and network analysis (Quarterly)** **Copies of current aggregate/specific reports (Monthly)** **Lag report (Monthly)** **Case management reports (Quarterly)** **50% of the specific report: all claims paid @ 50% of the groups specific deductible (with claim amounts listed) (Monthly)** **Diagnosis and prognosis for any claimants listed on the 50% report (Monthly)** **Copies of paid stop loss reimbursements (i.e. copies of the letter and check showing that the claim has been settled) (Monthly)** **Percentage of in-network savings amounts (Monthly)** **Subrogation activity reports (Quarterly)** **Summary reports - showing admits (broken out by type), average length of stay (Quarterly)** **Inpatient utilization by diagnostic category – showing experience by major diagnostic category. (Quarterly)** **Physician experience – broken out by in-network and out-of-network (Quarterly)** **Utilization reports for the current month and year to date indicating claims by age, sex, and claims by location (Monthly)** **Financial accuracy report (Quarterly)** **Non-payment accuracy report (Quarterly)** **Claims turnaround time report (Quarterly)** **Please refer to the Section III to review examples of all available reports requested provided on the enclosed CD – Standard Reporting Package.**	5 points
2.B.10	Describe your plan for completing each of the audits required in this FINAL RFP. **We welcome additional independent analysis of our quality results and will fully cooperate with representatives of the State of Arkansas (and/or independent third-party auditors hired) to conduct any such inspection or audit. An annual audit using standard industry audit practices will be at no cost to the State. We have extensive experience working with outside auditors.** **HealthSCOPE Benefits agrees to the Audit requirements set forth in Section 3.9 of the 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 work with the State to confirm definitions and expectations under the performance guarantees. Guarantees with such expectations do require overstaffing. We will work with the State to comply with changes over time. HealthSCOPE Benefits is willing to place fees at risk towards meeting these performance standards.**	5 points
2.C.2 Describe how you will develop an administrative procedure for detecting fraud and abuse. **Our analysts go through annual training to identify fraud, waste and abuse situations, and we review our data quarterly for potential issues at an enterprise level. Our system is set up to recognize possible workers compensation diagnoses. We receive possible high dollar alerts from our UR/CM vendors on possible large cases. We would typically stop claims in the above categories for review prior to payment. We would like to discuss the ability to have our analysts review and investigate these claims prior to payment with the State.** **We have a full-time staff of Fraud Investigators that continually look for provider billing and participant eligibility fraud. This is done through a series of sophisticated databases and complex queries of the claim system and our data warehouse. When we receive a tip or suspect a provider, we research it and can provide all supporting documentation to the State.** **We have our in-house quality assurance team supported by external resources. We also have a quarterly full review of all claims conducted to review for longitudinal issues.** **We audit 2% of all claims on a monthly basis through an outside audit firm so as to keep the highest integrity and avoid the "fox watching the hen house" comparison. We want all of our clients to know and trust that someone other than our own internal staff has been reviewing and reporting on the statistics. We are confident that this process sets us apart from the majority of our competitors.** **The Healthaxis claim processing system has functionality built in that assists with detecting questionable claim situations. The scenarios that the system prompts with could contain indicators of fraud and should not be bypassed or overridden without this thought in mind. Many of our daily claim practices are ways to combat "soft" fraud where the intent was not to commit fraud. They can also detect "hard" fraud where the intent was to commit fraud.**	5 points

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. **We have many controls in place to ensure claims payments are accurate, such as, audit limits and release authority limits.** **For example, claims analysts have specific audit limits in place based on their claims processing level and expertise. The audit limits are increased based on audit results and based on the analyst meeting HealthSCOPE's quality standards. These limits also apply to claims team leader, supervisors and managers.** **Other processes in places are claim editing software to review appropriateness of provider billing practices, up coding reductions and other such edits.** **Once claims are loaded into the claims system, claims are reviewed for appropriate billing, medical necessity of services and routed for additional review processes. Copies of the actual claim can be reviewed in the claim system when necessary to ensure that services were applied to the appropriate member on the plan. Other processes in the claims system allow for correct provider matching, correct eligibility matching and confirmation that benefits are eligible under the plan.** **HealthSCOPE also carefully monitors claims for potential fraudulent activities by having internal fraud prevention processes in place:** • **Any department within HealthSCOPE can send referral to our Special Investigation Unit (SIU) for review by sending the claims or claim situation to Fraud.Referals@healthscopebenefits.com** • **Internal reports have been created to identify potential fraud indicators, such as, when Providers and Members share the same name, Member resident state is different than the Provider's rendering state, Provider and Member share the same address** • **Sources HealthSCOPE works with to monitor the list of known Fraudulent Provider are; State agencies, Licensing boards, other similar industry task forces, Law Enforcement agencies, FBI, Attorney General, Federal Trade Commission** • **HealthSCOPE provides a toll-free Fraud Hotline – 800-333-4585.This number and a message regarding fraud identification and prevention, is provided on each Explanation of Benefits.**	5 points

Internally, there is an authority level hierarchy in place with established dollar limits for Claims Analysts, Supervisors, Managers and Directors; this will ensure the claim (depending on dollar amount) has several levels of review before release. We also have various reports available through our claims system to ensure timeliness and accuracy of processing.

1. Scan Track Report. This is a daily report and gives a high level view of how many claims are in our system for a given client.

2. Duplicate Report. This report is produced daily and reviewed by the account supervisors to validate claims that are possible duplicates.

3. Over 25,000 Report. This report is produced daily for tracking of high dollar claims with billed charges over $25,000. These claims require additional review and are prioritized to move them through our system in a timely manner.

4. DS Report. This is a daily report that shows every claim in our system that had not been routed or touched.

5. DS.ES Report. This is an on demand report that shows every claim for a specific group and its current status in our system. This contains more detail than the Scan Track report.

6. Reversed not Copied. This is a daily report that tracks adjustments that have not been finalized.

7. Draft Held Report. This is a daily report for claims that require an additional level of review before a check can be released. This could be for a dollar authority limit or for reinsurance purposes.

8. Daily ADB Report. This report tracks any claim that the analyst has manually calculated benefits and overrode the system to pay. This is usually done for client exceptions.

9. COB Audit. Tracks claims processed as primary with secondary indicator on eligibility file.

10. Inventory Sum and Inventory Total. These reports track total inventory by client with total only or by date with total only.

We utilize the most comprehensive clinical editing in the industry. We currently use Advanced Clinical Editing software pre-adjudication to review and accept or reject claims not meeting editing criteria. These claims are rejected back to the provider with explanation to allow them to correct and resubmit the claim. This process allows for educating the providers on correct coding and increases the claims processing.

HealthSCOPE Benefits goes above & beyond to help manage our customer's costs. We have the McKesson edits built into our system with looks for bundling and unbundling. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur. We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm. Mullally Associates reviews 2% of all claims processed on an ongoing basis. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors. All claims over $50,000 are reviewed in detail by the Senior Vice President of Operations.

External review mechanisms include outsourcing of random claims and high dollar claims to a professional audit firm. Two percent of all claims processed are reviewed on an ongoing basis. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors.

We are committed to protecting your plan from any unwarranted costs, and to ensure the accuracy of each and every claim that we adjudicate. How do we do this exactly?

One key factor of cost management is managing the claim itself. This includes monitoring of the accuracy of the billing, as well as a safe guard of the processing and the final adjudication of the claim. We manage the claims on several fronts using our claims system's internal features, our quality assurance procedures, and by sending some claims out for vendors to review.

Built-in Review - We have McKesson Clinical Edits Software built into our system which looks for bundling and unbundling of coding. Additionally McKesson incorporates information from Center of Medicare Services (CMS), the American Medical Association (AMA) and various specialty societies into the edits development and validation process. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur.

Audits – We engage Zelis Health, Ethicare, & Ceris to review all facility claims exceeding $50,000 for coding and clinical review, and all claims with more than 50% of the charge for implants. All claims over $50,000 are reviewed in detail by the Vice President of Quality Assurance and the President of HealthSCOPE Benefits. Internally, there is an authority hierarchy in place with established dollar limits for claims.

Analysts, Supervisors, Managers and Directors; this will ensure the claim (depending on dollar amount) has several levels of review before release.

More Audits - We have outsourced our audit functions of random claims auditing and high dollar claims review to a professional audit firm, Mullally & Associates. We have made this shift in responsibility, so that our audits are fully independent. Mullally & Associates reviews 2% of all claims processed on an ongoing basis. HealthSCOPE Benefits receives daily and monthly reports regarding overall performance, as well as the performance of individual processors.

In an effort to better streamline electronic claims processing, HealthSCOPE Benefits implemented an Advanced Clinical Editing (ACE) system. Each pre-adjudicated claim submitted to us is automatically evaluated by the ACE system. This system scans claim information to detect potential errors. Claims identified as having a definite or potential Edit error will be returned to the submitter along with a 277CA report. This report contains a clear message explaining the error so that providers can quickly and easily identify the problem and resolve it; then resubmit the claim for quick and reliable electronic processing.

The report is based on the Medicare 277CA Healthcare Claim Acknowledgement report. Claims listed on this report are not submitted to our claims adjudication system until they are returned to HealthSCOPE Benefits from the submitter. Upon return, they will enter the adjudication system, whether they have been corrected or not.

When a provider receives a returned claim with its accompanying explanation for return, it is their choice to correct and resubmit, or resubmit without corrections. If they return these claims without requested corrections may result in denial of the claim or a request for additional information.

The combination of all of our clinical edits means the most sophisticated editing available is applied to every HealthSCOPE Benefits claim.

Nearly all administrators talk about clinical editing, many of these lack the breadth, depth and flexibility to prevent significant claim overpayments. Our Medicare edits include multi-factor analyses of age, gender, diagnosis, diagnosis sequencing procedure, procedure combinations, modifier, place of service, and provider specialty. We have ten different edits and nine sources for that data. In addition, we include every state's Medicaid edit for review. We include commercial edits to evaluate professional and institutional claims based on policies established by more than 80 national sources including every major clinical association. Knowledgebase development and maintenance are critical to ensuring alignment with state and national coding policies. Based on our national scope, we review these on a bi-weekly basis within our claims team to determine updates needed based on the claims we are seeing. In addition, we utilize the latest version of McKesson Clinical Edits Software, which incorporates information from CMS, the AMA and various specialty societies into the edits development and validation process. This multi-step approach enables stronger edit rationale backed by industry accepted standards and common clinical practice.

2.C.4 Describe your process for performing preliminary investigations of suspected or confirmed wasted, fraud, or abuse. **Our claims processing system has functionality built in that assists with detecting questionable claims situations. Insur-Claims is a highly automated, fully-integrated claims adjudication system that allows for validation of eligibility, verification of provider network participation status, calculation of contracted reimbursement and benefits, and application of overall plan limitations. The most significant and advantageous feature of the system is its ability to apply benefit-eligible rules and limitations, as well as global rules for processing. This affords controls regarding: patient age, additional insurance coverage, third-party liability, diagnosis-based limitations, etc. Depending on the situation, we may call providers and get clarification on bill and document calls, or we may deny the claim and request clarification or correction in writing. Some edits advise to bundle codes together or deny completely so we would follow those edits. The analyst can correct them as they are processing the claim.** **Reporting Fraud** **A. Referral to State Licensing Board - In most states where HealthSCOPE Benefits is licensed there are state licensing boards for chiropractors, nurses, dentists and medical doctors. The entities have better resources and are usually interested in becoming involved in investigating any legitimate allegations against providers within their jurisdiction of discipline. Any investigation which has developed to the stage of recognizing wrongdoing by a provider should be communicated to the appropriate state licensing board, regardless of any other action taken.** **B. State Requirements – In order to be compliant, it is critical to be aware of any reporting requirements set by the state in which the fraud has been detected.** **C. Prosecution - If the amount of loss is $10,000 or more, the case should be referred to the Corporate Legal Department to determine if the case will be prosecuted. The case may be referred to a federal investigator such as U.S. Attorney, FTC or the FBI. Otherwise, an attempt to get the case accepted at a local or state level is made.**	5 points
2.C.5 Describe your process for recording, investigating, resolving, and analyzing claim and Member reviews and/or appeals. **Upon receipt of an appeal, the correspondence is routed to the Appeals Management department. It is then logged and forwarded to the appropriate Appeals Specialist for review.** **The Appeals Specialist will determine the nature of the inquiry and research accordingly. The research may include reviewing plan documents, verifying pricing, sending documentation for medical review or a host of other possibilities.** **Once a determination is made, the claim in question will either be adjusted and a new Explanation of Benefits generated or a response letter will be drafted affirming the original claim processing.** **The Appeals Specialist will then advise of the outcome of the review and have the inquiry moved from the outstanding appeals report to the closed appeals report.**	5 points

2.C.6 Describe your process for implementing and maintain an electronic system that includes reviews and appeals, investigations, resolutions, and notifications. **When an appeal is received, it is determined what client directory it belongs to.** **It is then scanned into DocTrax and assigned a Document Control Number (DCN).** **The Appeals Specialist assigned to retain a working log of all appeals will review each DocTrax queue and add new appeals to the log.** **An e-mail is then sent to alert Appeals Specialist of any new pieces received.** **The Appeals Specialist will work each piece and enter comments regarding the claim in question and the outcome into the member's file in the HAXS system.** **A written response is generated to the member to advise them of the outcome of the appeal.** **A copy of this response is routed to be scanned into the member's MISC DOCS file in HAXS.** **The Appeals Specialist then emails the Appeals mailbox and alerts of the determination of the appeal and advises the piece should be closed.** **The specialist in charge of the log will then move the piece from the open log tab to the closed log tab.** **An updated log is emailed weekly to show all outstanding appeals.** **Please note, provider inquiries are also handled in the same manner as above. However, if a provider inquiry results in a claim adjustment, the system generated corrected Explanation of Benefits serves as the written response and no additional letter is drafted.**	5 points

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. **HealthSCOPE Benefits will accommodate these call center requirements and HealthSCOPE Benefits will operate the call center for Members and Providers combined.** **Live customer service representatives are available from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday. During non-business hours, employees and their families will be able to access our on-line and Interactive Voice Response (IVR) Systems to verify eligibility, obtain information about their claims or to address other issues like ordering a replacement ID card. The automated claims inquiry (IVR) feature is available 24 hours a day, 365 days a year. We encourage employees to utilize this feature and take advantage of placing calls at their convenience. The IVR systems can also assist members with obtaining information regarding claims, coverage, utilization management, or provider network inquiries.** **The State of Arkansas will be assigned a dedicated toll free numbers, that will be answered, "Welcome to The State of Arkansas' customer care hotline at HealthSCOPE Benefits". All calls are tracked and recorded.** **We are able to provide services in English as well as other languages. We employ a bilingual staff and utilize the AT&T language translation line, TDD services and provide documents in Spanish.** **Our state-of-the-art phone is cloud based which provides us with instant scalability resulting in members always being able to connect to our call center. Each of our four customer care locations are linked providing redundancy so in the event of inclement weather or other emergency, we will always be available to answer calls during our normal business hours. We record each and every call in order to maintain quality and use this as a valuable tool in the ongoing training of our customer care representatives. Each client team is committed to personal ownership in the management of our success as partners.**	5 points

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. **Our representatives document every call in our claims system. There are required fields to identify the type of caller (member, provider, other) as well as the caller's name, call type and action taken. Each call is categorized using a specific reason code. Among the call reasons tracked are benefit calls, eligibility verification, claim status and claim questions. Monthly reports are generated which shows the type of calls received, as well as the caller type (member or provider). We have the ability to customize reason codes in order to track specific trends and unique situations, for example tracking inquiries to letters a client has sent to employees/members. Reports can be generated outside of the scheduled monthly report.** **We track and record all calls digitally for one year. We use recordings as training tools with our CSRs. The best training is often grading your own work, and we employee this to assist in providing high quality customer service. Managers can also perform "silent monitoring" of calls, and we can provide recordings of calls when necessary. We have a broad listing of categories and have the ability to create client-specific categories, if necessary. No one can edit call documentation. Our claims and customer service reps have access to call documentation. We review categories of calls and changes in call reasons monthly at an executive level.** **Supervisors have access to listen during live call, and all calls are taped and reviewed as necessary.** **Questions that cannot be answered or issues that cannot be resolved by a representative are transferred to a team lead, supervisor or manager. The representative is required to provide the member name, ID#, and details regarding the call prior to transfer. If a transfer is not possible, a message is taken and return calls are made by the end of that business day. It is our goal to insure the caller is completely satisfied and therefore require the representative to use all resources available to them to answer the call. If the representative feels they do not have the necessary information we encourage them to transfer the call to a team of lead or supervisor for resolution.** **We track and report all call statistics specific to the customer. All calls are tracked and documented in our online system, attached to the member's record, and recorded. The information is housed online and allows us to report on the types of calls and track first call resolution.** **Written inquiries are handled within 48 hours or receipt. When possible, and unless a written response is requested, the representative will attempt a phone call in order to provide a more timely response.** **Calls that require claim adjustment or medical review are handed off electronically. The TAT is monitored and any calls over 72 hours are reviewed by management.** **We have extensive capabilities for tracking participant and provider inquiries or complaints and reporting this information to the State on a monthly basis.** **All calls are tracked by caller, date, time, reason, status and resolution(s). Reports regarding call activity for participants will be provided to the State, and will undergo review/analysis during monthly or quarterly meetings. In addition to call tracking, all complaints, grievances and appeals are logged separately and reported on an ongoing basis.**	5 points

	We meet and/or exceed the Department of Labor appeals standards. HealthSCOPE Benefits accepts the appeal (acknowledges receipt in writing), completes appropriate research (up to and including use of independent clinical resources), and utilizing an appeals committee in an attempt to reach a decision regarding the appeal, and forwards the appeal (complete with research and opinion) to the client so that a final determination can be made. Full documentation is maintained throughout the entire process for stop loss purposes.	
2.D.3	Describe your plan for demonstrating that all Call Center software, hardware, and staff are available and operational. **We would welcome an onsite visit to our Little Rock office as proof, but aside from that, we will provide documentation of staffing and system availability.**	5 points
2.D.4	Describe your process for handling calls received outside of normal business hours. **Hours of operation are 8:00 a.m. to 5:00 p.m. (CST), Monday thru Friday. During non-business hours, employees and their families will be able to access our on-line website and Interactive Voice Response (IVR) systems to obtain information regarding claims, coverage, utilization management, provider network inquiries, or to address other issues like ordering a replacement ID card. The automated claims inquiry (IVR) feature is available 24 hours a day, 365 days a year. We encourage employees to utilize this feature and take advantage of placing calls at their convenience. Members may also leave a voice mail and those calls are returned by the end of that business day.**	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

a. Call routing process

We use an automatic call distribution phone system. When the call is received, the caller is provided a short menu of prompts to assure their call is efficiently routed. When routed to the call center, the call is offered to the first available representative assigned to the group. The automatic system allows us to assign secondary representatives and will route the call to the secondary only when no primary representative is available.

b. Call scripting process

Our call scripting process is customizable and allows for a variety of call routing options. The standard call scripting identifies the caller as a member or provider, then takes the caller to the appropriate menu script based on their selection. If a caller is a provider of service, they are directed to the Interactive Voice system first. Eligibility verification and claim status can be handled by this system; however the caller has the option to opt out of the system to speak to a representative.

Member menus can be customized to allow options for each issue listed below.

The standard menu script is:

- **For claims, eligibility and benefits, please press 1 – if the caller selects this option the call routes directly to the Customer Care team (questions regarding ID cards and network providers are all answered by the Customer Care team)**
- **For access to our automated system 24 hours a day please press 2 or visit our website at www.healthscopebenefits.com – if the call selects this option the call routes to the IVR system**
- **For precertification please press 3 – routes directly to the precertification vendor**
- **To repeat this menu press 9 or hold for the next available representative.**

Sample customized menu script:

- **For claims, eligibility and benefits, please press 1 – if the caller selects this option the call routes directly to the Customer Care team**
- **For access to our automated system 24 hours a day please press 2 or visit our website at www.healthscopebenefits.com – if the call selects this option the call routes to the IVR system**
- **For precertification please press 3 – routes directly to the precertification vendor**
- **For assistance locating an in-network provider please press 4- if the caller selects this option the call routes directly to the Customer Care team**
- **To request an additional or replacement Identification card press 5- if the caller selects this option the call routes directly to the Customer Care team**
- **To repeat this menu press 9 or hold for the next available representative.**

c. Call resolution process

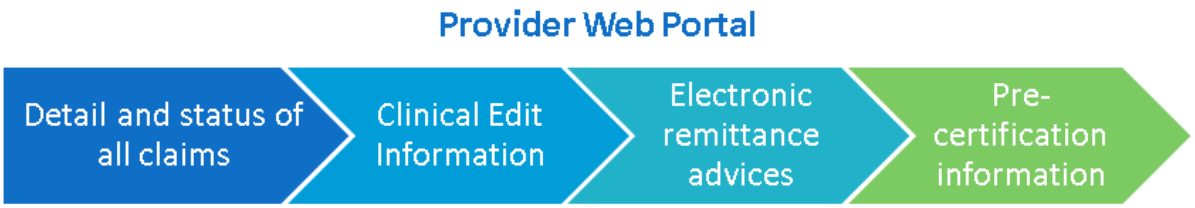
Customer service representatives have the authority for first call resolution. Questions that cannot be answered or issues that cannot be resolved by a representative are transferred to a team lead, supervisor or manager. The representative is required to provide the member name, ID#, and details regarding the call prior to transfer. If a transfer is not possible, a message is taken and return calls are made by the end of that business day. It is our goal to insure the caller is completely satisfied and therefore require the representative to use all resources available to them to answer the call. If the representative feels they do not have the necessary information we encourage them to transfer the call to a team of lead or supervisor for resolution.

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. **All concerns received by the call center would be coded as such in our call tracking system. Our customer care supervisor would run daily reports of these to provide to EBD.**	5 points
2.D.7	Describe your plan for operating the Call Center according to the Performance Standards in the RFP. **HealthSCOPE Benefits will agree to meet the specific call center performance standards provided within the RFP.** **Outstanding customer service is where we truly feel HealthSCOPE Benefits is head and shoulders above our competition. Each client receives a highly experienced account manager to lead an expert team of individuals all dedicated to exceeding client expectations. Our account managers proactively manage clients through providing ongoing information about national and local issues that impact service delivery, and meet at least quarterly with each customer to review not just utilization data, but overall service quality and future planning. Each HealthSCOPE account team assists in the development and distribution of any training or communication materials that keep members informed of the value of the benefits, of new services available, and reminders for benefits already in place. Again, our methods for working with each client are designed specifically with that clients needs always in the forefront of any development.** **Customer Service training consists of 4 weeks of classroom instruction followed by one week of chair side training or "shadowing". Classroom instruction covers general health insurance guidelines, system navigation, internal administrative procedures, role playing and Customer Service etiquette.** **Representatives are then assigned dedicated accounts and are trained on plan specifics the last week of classroom instruction. Chair side training teams a trainee with an experienced representative who listens to every call with the trainee, providing immediate assistance and guidance if necessary.** **Our training coordinator develops and maintains our training manuals and they are updated as needed. Weekly refresher courses are conducted.** **HealthSCOPE Benefits has developed policies and procedure manuals and an in-house training program for all new hires. The Company maintains a private website as a tool for providing interactive training to new and established employees. Employees can access the training resource from any computer with access to the HealthSCOPE Benefits intranet. HealthSCOPE Benefits has dedicated full-time trainers in each operations location who report to the Vice President of Quality Assurance. The trainers are responsible for the development of all training materials and facilitating ongoing training programs. The trainers participate in weekly department meetings and have ongoing interaction with the Benefit Administrators to determine areas for improvement.**	5 points

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. **HealthSCOPE Benefits will develop and maintain 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.** **HealthSCOPE Benefits provides extensive web tools that are developed specifically for our clients. We believe members will use web tools when they are specific to the plan and the area and are not just averages. We have multiple tools available for customization.** **The State of Arkansas would have access to monitor claims, run reports and make enrollment changes online. Personal identification numbers may be used instead of social security numbers.** **We will customize your web page to fit the needs of you and your employees. We can post custom messages as often as the State desires. Through our secure website, you can:** **• Find in-network doctors, dentist, and hospitals** **• Find in-network pharmacies** **• Check the status of a claim** **• Request replacement ID cards** **• Download claim forms** **• View and print duplicate Explanation of Benefits (EOB)** **• View and print your Summary Plan Description (SPD)** **• Check eligibility status** **• Ask customer service questions** **• Account balances for HSA, HRA and FSA** **• Download claim forms** **• Healthcare account benefit calculator** **• Dependent care account benefit calculator** **• Eligible Expenses for FSA** **• Eligible Over-the-Counter Expenses for FSA** **• Health & Wellness Information** **• Summary of Benefits** **• Track Accumulators** **• Method of Payment (e.g. direct deposit, check)** **• Consumer Driven Tools** **• IVR** **Specifically, when there are new processes or products being introduced, communications will take place well in advance. Any new process, procedure or product that would be implemented would be on the agenda and discussed at our regularly scheduled service calls (typically either weekly or bi-weekly based upon client preference). There are also quarterly meetings that are a forum for discussing strategies, service needs, updates, reporting, etc. including any required training. The Account Manager is responsible for coordinating any necessary training, creating a detailed project plan to share, bringing any HealthSCOPE Benefits' personnel needed into the training process. Because each client is unique, HealthSCOPE Benefits has provided on-site training, webinars, created administrative manuals, whatever is required. As with most everything HealthSCOPE Benefits does, we are client specific in our focus and design our programs including training, to meet the needs of each client.**	5 points

Our provider engagement and web portal assist to:

- **Reduce the barriers to provider empowerment and alignment**
- **Streamline billing practices**
- **Timely notification of issues**
- **Clear feedback and communications**
- **Real time eligibility and accumulators on the web and through 270/271**
- **Visible clinical edits**
- **Ability to submit claims through the web**



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. **Our web portals use 128-bit SSL encryption for all communications. Users are required to create a login ID and password for secure account access. Login credentials are encrypted at the database level using the latest industry-standard encryption algorithms to prevent user IDs and passwords from being compromised. Production databases are housed behind firewalls and are protected from SQL injection attacks and other common hacking techniques.** **In accordance with the HIPAA Privacy and Security rules, the company's URAC CORE accreditation, and the company's SSAE-18 SOC 1 Type II audit requirements, HealthSCOPE Benefits maintains a robust IT Security and Compliance Program overseen by the Security Officer to manage the organization's electronic security policies, processes, and procedures.** **The Security Officer is responsible for developing and implementing all policies and procedures necessary to appropriately protect the confidentiality, integrity, or availability of any HealthSCOPE Benefits information systems. In addition, the Security Officer ensures that adequate physical security controls exists to protect HealthSCOPE Benefits' electronic Protected Health Information by implementing a risk management process and conducting periodic risk analysis. All results are reported to the Business Continuity and Corporate Compliance Committees as required by the organization's Continuous Quality Improvement Program.** **Our enterprise standard is to use PGP encryption for all data transfers. We also support other methods such as SFTP with secure certificates. We use Symantec's MessageLabs service for secure e-mail.** **For security, we have implemented tight controls on data exchanges and the storage of data. For transmitted data that contains HIPAA/PHI we utilize file transfer protocol (FTP) and PGP encryption. We also utilize ANSI for claims and eligibility received. In addition, our client's Trustees or members are able to interact with HSB personnel via encrypted e-mail per HIPAA security standards.** **Our office locations are interconnected via secure private MPLS networks. Direct access to our hosting provider is obtained via secure VPN tunnel utilizing AES256 encryption and remote workers access our cloud provider website and Citrix applications utilizing secure SSL SHA 256 encryption. Remote file transfers are either transmitted via FTP with 1024 bit PGP encrypted files or SFTP with SSH protocol.**	5 points
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. **All claims and accumulator information displayed is real time. For other information, the EBD dedicated Account Manager would work with you on the materials displayed.**	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. **Insur-Claims by Healthaxis - Claims, eligibility, medical management, and provider application functions are all fully integrated into one highly functioning platform. We utilize the Insur-Claims system from Healthaxis for the servicing of our clients. This is a highly automated platform featuring fully integrated enrollment processing, medical management records, claims adjudication, provider record management, and Internet self-service. This system is "paperless" in that all documents received in our office are imaged and indexed to a sophisticated workflow.** **Comprehensive and random claim audits 97% first call resolution Preprocessing clinical and claim edits Fraud, waste and abuse review Fully integrated clinical edits Complex network hierarchies Average claim turnaround time under 4 days Call abandonment less than 2% Call wait time less than 30 seconds Claims processors are not responsible for answering telephones. The sole responsibility of our staff is to adjudicate claims. Our Claims Examiners and Claims Supervisors do not handle telephone inquiries, as all calls are taken by Customer Care Representatives.** **We monitor turnaround time daily and work to process claims as quickly and efficiently as possible. Turnaround time is continually reviewed to make sure claims return from pricing vendors. Payment accuracy is reviewed daily with daily audits of every processor and client. Our average claim turnaround is 3.57 days with 99.3% accuracy, however most clients only fund weekly so final disposition depends on client funding. TAT is measured from the date a claim is received by the administrator (either via paper or electronic data interchanges) to the date it is processed for payment, denied, or pended for external information.**	5 points

3.A.2 Describe your processes for each of the following: • claims submission and adjudication, paper and electronic, including receipt of Claims, **We utilize the Insur-Claims system from Healthaxis for the servicing of our clients. This is a highly automated platform featuring fully integrated enrollment processing, medical management records, claims adjudication, provider record management, and Internet self-service. This system is "paperless" in that all documents received in our office are imaged and indexed to a sophisticated workflow.** **We have extensive EDI Capabilities with multiple clearinghouses integrated in one system to receive claims. We receive more than 80% electronically. Paper claims are received, scanned & imaged. After the imaging process, the claim flow is the same. These clearinghouses include Change Healthcare (formerly Emdeon), Availty, Passport, Zirmed and Tesia (Dental only).** **We auto-adjudicate approximately 60-70% of claims processed because we stop claims to review them and confirm accuracy prior to payment. We believe strongly in the value of our claims analysts and their capabilities to manage client costs.** **Front-end imaging involves three separate processes for image capture and indexing. The first step is the receipt and control of the image. The second step is the capture of index information or other data from the images using HealthAxis proprietary workflow, OCR technology, or Key from Image systems. The third is the storage of the image for future retrieval by the customer. These processes can occur in either of two methods.** **Method 1 - Utilizing the HealthAxis Mailroom Operations located in Lubbock, Texas. Using this method, USPS mailboxes are opened in the name of the end user customer (not HealthAxis). HealthAxis personnel retrieve the mail daily from the PO boxes either by secure courier or in person utilizing a company owned vehicle. The mail is delivered to our secure facility where it is shelved in its own unique location. No one customer's mail is ever co-mingled with another. HealthAxis personnel open and prep the mail for scanning one customer at a time. The mail is organized to enhance the scanning process, but practically speaking, very few sorts are necessary, and there is no need for bar codes or patch pages.** **Once prepped, the mail is moved to a scanner located in the same room as the preparation area. HealthAxis utilizes high speed Opex scanners with advanced scanning software to scan the documents. The images are temporarily stored on the scanners local computer hard drive, but then routinely copied to the HealthAxis workflow system for OCR data capture or Key from Image by a trained data capture staff member. The HealthAxis workflow system continuously monitors each document as it moves step by step through the data capture process allowing for instantaneous recognition of issues, should they arise.** **Once the data capture process is completed, the images are securely stored on HealthAxis storage systems, or transmitted back to the customer. Original documents are stored at HealthAxis for a period determined by the customer (usually 60 to 90 days) before being securely destroyed.**	5 points

Method 2 – Using the customer's remote mailroom operations. The customer may maintain its own mailroom operations using its own methods for receipt and control of the documents. If this method is chosen, the customer utilizes its own scanners for image creation, but HealthAxis provides a scanning software system for image capture and organization. The images are temporarily stored at the customer but then routinely transmitted to HealthAxis using a secure connection.

Once transmitted to HealthAxis, the same processes and procedures are followed as described above in Method 1.

The principal benefit of front-end imaging is that documents are converted to an electronic format at the start of the process, whether that process is for document review or claims processing, or some other needed process (authorizations, etc.). This allows the document image to be used by multiple different persons or departments at the same time for different purposes, and potentially allows for document annotation so that one person can communicate changes, inquiries etc. to others in a rapid fashion without having to physically move pieces of paper.

- verification of Member and Provider eligibility,

We can verify plan benefit data and member eligibility during claim adjudication automatically.

We maintain a complete history for each participant (employee and all dependents), including all changed records. This includes demographic and coverage information. Each transaction is "tagged" with a date, time and user so a complete audit trail is maintained. An additional function is the linkage of all enrollment-related documentation (e.g., HIPAA Certificates, Letters, COB investigation, proof of dependent status, etc.) to the group and participant. The system allows for programming of edits related to Plan Document provisions, such as an annual COB review. HealthSCOPE Benefits maintains all eligibility data in our system for as long as the client is active (including run-out periods).

- verification of any needed prior authorization,

Prior authorizations automatically link to a claim based on claims coding, date of service and provider.

- verification of Third Party Liability,

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We edit claims as we pay them to find potential subrogation, COB and Workers Compensation.

We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group.

For subrogation, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our vendor for tracking and recovery.

For COB & Workers Compensation, we would deny the claim until additional information is received.

"Pay & Chase" Approach

For subrogation, the claims are processed and the case forwarded to our vendor, the law firm of McAfee & Taft of Oklahoma City, Oklahoma, for pursuit of a recovery agreement, tracking and recovery.

All of our analysts have responsibility for identifying and pursuing COB. At the time of enrollment, employment by the spouse is reviewed along with any indication of other insurance. If there is an indication of another insurance serving as primary on the spouse, an indicator in the system is activated. That indicator will not allow a claim to be processed until information from the primary carrier EOB is entered. If children are covered by both plans, the Birthday Rule is used to determine primary/secondary responsibility for the plans. If the other plan is primary, the COB indicator is activated.

During the year, any indication on a claim form that other insurance may have paid primary, results in the claim being pended while an investigation is completed by our enrollment unit. This generally includes a letter requesting coverage information being sent to the family. The claim is not released until the investigation is completed. Once per year, a coverage survey is sent to all families covered by the plan to verify that no other insurance has been put in place requiring the COB indicator to be activated.

For Workers Compensation claims, we like to receive a file from clients weekly. We can load this file into our system to deny claims related to the Workers Compensation case.

- denial or approval and submission of payment and to detect/correct these discrepancies

All claim adjustments processed in our administration system are subject to complete reporting, both internally and to our clients. All adjustments begin with (and are linked back to) the original transaction. Our reporting clearly outlines the reason for the adjustments and responsibility.

- **Underpayment**
  When the claim is re-adjudicated, an additional payment is issued and the claim is reflected in the system with two (2) parts.

- **Overpayment**
  When the claim is re-adjudicated, the original claim is reversed and the new claim is completed with the overpayment being tracked in the system; a series of requests for payment letters are issued until the overpayment is received and posted.

	1. After creating an overpayment in the system, a letter will generate to the provider explaining the amount needed and an explanation as to why we overpaid the claim. **2. Letters will continue to generate until we send a final demand type letter. If money is received during the process of letters, once worked back in system, the letters stop. These letters and checks are worked as a priority.** **3. If the provider does not return the funds after the contractual limits, we would recoup the funds from other claims paid to the provider.** **If an Overpayment was made as a result of (i) participant and/or healthcare provider fraud, abuse, misrepresentation, or inaccurate billing, (ii) charges from a healthcare provider for services not covered under the terms of the Plan or excessive charges from a healthcare provider discovered through an audit of such healthcare provider's records, or (iii) non-communication or miscommunication of eligibility or coordination of benefits information by a Participant or other third party, HealthSCOPE Benefits will use its "enhanced recovery services" to attempt to recover such Overpayment. Enhanced recovery services are subject to the fee listed in the cost proposal. PHIA offers strategic recovery and resolution programs that maximize recoveries while maintaining and enhancing provider relationships. We have an on-going contract with PHIA for recoveries not returned. The Claims Director reviews overpayments to identity trends, as well.**	
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 will maintain our claims system according to your specifications. Our system has unlimited customization capabilities. HealthSCOPE's flexible, customized plan design means our client companies are delivering exactly the benefit structure they want. We will work with EBD to design the best solutions possible.** **Regarding offering providers a portal for automated processing, adjudication, and correction of claims, each of our integrated claims clearinghouses allow for the automation noted. Availity also has a provider portal for providers who need to enter claims on the web.**	5 points
3.A.4	Describe your plan for completing and maintaining accurate Claim Data for all services. **All of the data on a claim is captured and stored in our system.**	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? **We paid over 6 million claims last year and less than 1% of the claims generated member complaints. Of these, 99% received 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. **This is an automated process. Non covered services are part of our plan programming, so claims that are non covered will automatically deny.**	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 **93.05%** • Processed within twenty (20) business days **98.86%** • Processed within thirty (30) business days **99.78%** • Percentage of pended claims **We do not pend claims. We deny for additional information.** Formula: Include all claims approved or denied.	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. **45%**	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. **99.44%**	5 points
3.A.10 Provide statistics detailing your financial accuracy from July 1, 2016 to June 30, 2017. **99.78%**	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? **We have clients with many different timely filing periods. We can easily 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.**	5 points

3.A.12 How often are claims processing workflows audited, including pending claims? **Claims processing flows are audited daily including pended claims and the reasons for those pends.**	5 points

3.A.13 Provide your performance standards/expectations for each of the following (including the criteria thresholds): a. Payment accuracy **98% - total audited claims correctly paid** b. Financial accuracy **99.2% - total audited claim dollars are correctly paid** c. Overall accuracy **98.5% – average between payment, financial, and processing accuracy** Include the annual average for each for 2016 and 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) **All claims will be processed from our company headquarters located in Little Rock, Arkansas.** **HealthSCOPE Benefits** **27 Corporate Hill Drive** **Little Rock, AR 72205**  	5 points

3.A.15 Explain your criteria for any out-of-network designation of claims within Arkansas. **Criteria include any claim not provided within the network in Arkansas. These claims will still be processed by our Arkansas analysts. HealthSCOPE Benefits has the flexibility to meet the needs or requirements set forth by the State as it relates to out of network status.**	5 points
3.A.16 Explain your criteria for any out-of-network designation of claims outside Arkansas. **Criteria include any claim not provided within the network in Arkansas. These claims will still be processed by our Arkansas analysts. HealthSCOPE Benefits has the flexibility to meet the needs or requirements set forth by the State as it relates to out of network status.**	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. **Please refer to Section III to review our policy and procedure for tracking claims pended for medical review – file named Question 3.A.17_Section III_Internal Suspends.** **If a claim requiring medical necessity review is received with all necessary records to complete the review, the claim remains in a suspended status and the system is noted accordingly. Management receives daily reports showing all claims in a suspended status.** **If records necessary to review the claim are not received with the initial submission, the claim is soft denied requesting medical records. The claim will remain in a soft denial status until the necessary records are received and the medical review has been completed. The denied claim appears on a report that can be generated on a weekly basis until information is received. Claim notes are documented with all activity.**	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 utilize Optum ACE edits on the front end when an electronic claim is submitted. These edits are based on industry standard, CMS and NCCI edits. These edits return a 277CA to the provider explaining the edit and what they can do to correct the claim prior to adjudication. We feel this education to providers is beneficial for receiving cleaner claims. It also prevents denials for missing information. The providers do have the option to resubmit with no changes. If this is done, then the claim will flow to our adjudication system for processing and edits will be applied there. Once in our claims system, we utilize the latest version of McKesson Clinical Edits Software, which incorporates information from CMS, the AMA and various specialty societies into the edits development and validation process. This approach enables stronger edit rationale backed by industry accepted standards and common clinical practice. The criteria include CPT codes, modifiers, and types of service.** **McKesson Clinical Edits are integrated into our claims adjudication system. When specific code combinations are submitted within the claims or against historical claims, the system will apply the appropriate edit. The explanation of the edit is then noted on the EOB and RA by an EOB comment code for the member and provider.**	5 points

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? **HealthSCOPE Benefits goes above & beyond to help manage our customer's costs. We have the McKesson edits built into our system that looks for bundling and unbundling. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur. We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm, Mullally & Associates. We have done this so that our audits are fully independent and there is no "fox watching the hen house." We want all of our clients to know and trust that someone other than our own internal staff has been reviewing and reporting on the statistics. We are confident that this process sets us apart from the majority of our competitors.** **In addition, our claims supervisors receive a report each morning to review possible duplicate claims paid the day before to ensure overrides are correct.** **We also have an internal Quality Assurance committee made up of management staff who reviews Quality Assurance results from Claims, Customer Service, Provider Relations and Appeals. This committee meets monthly to assess areas for improvement and greater efficiency the committee also takes on projects to improve and create better documentation around processes.** ***Our Quality Assurance Department is a stand alone department outside of the claim and customer service areas. However the three departments work very closely to achieve quality initiatives. All three areas report up to the President.** **External mechanisms include the outsourcing of our random claims auditing and high dollar claims review to a professional audit firm. Mullally Associates reviews 2% of all claims processed on an ongoing basis. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors. All claims over $50,000 are also audited.**	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.

5 points

Review and Identification of Potential Claims

The process begins by receiving the paid or denied claims from the client, and importing these claims into our Claims Review system via an electronic data transfer. Our Claims Review program will filter out the appropriate ICD-10 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident or 'slip and fall' cases. Once imported, theses claims are appropriately categorized by the program.

Our staff will then begin the process of pulling up the member's claims records and reviewing the information and at this point make a decision to investigate further or not. Claims that are targeted (they appear with a check mark next to them) will be reviewed first because these targeted codes are most likely subrogation situations. If the claims appear as though they will not yield the potential for subrogation, the member is sent into a 90 day follow up. In 90 days, the member's record will be re-opened if new claims have been received since the date the diary was started. The staff member will be able to review any claims that have been imported since the last 90 day diary and again make a decision as to whether or not a letter should be sent.

If the decision has been made to send a letter and questionnaire, a letter will be sent that day.

There are two different types of letters that are sent. There are letters for definite auto accidents and letters for more general medical treatments. Each letter has different language and a different questionnaire so that it is more specific to the situation.

If the member does not respond to the first letter, a second follow up letter and questionnaire will be automatically sent in 20 days. If the member does not respond to the 2nd letter, they will appear on a Non-Response report, which can be sent to the client if they wish. The staff will review this report at the end of each month and pull the members that have high dollar amount claims. Additional research and attempts to contact the members will be made if it appears that the potential for subrogation is high.

During this process, if a member receives a letter and has a question, they may respond to an online questionnaire or call a toll free number to contact a staff member for direction. Our staff will also follow up with a phone call to members that have questions or have not responded.

If a letter is sent and the individual responds and indicates there was no accident, and this is consistent with our experience and any other investigation information, the member's records will be appropriately noted that a response was received, and they will be sent into the 90 day follow up process once again.

If a response to a letter indicates that the potential for subrogation exists, a subrogation file will be opened and an investigation will begin.

Investigation

Once a response is received and there appears be an opportunity for subrogation, our staff will begin the research to identify all of the appropriate parties that are involved. Our questionnaires have proven to be very effective in obtaining the information we require to proceed, although there are instances where we must research further.

One valuable feature of our subrogation program is that it contains an extensive database of attorney names and addresses, insurance company names and addresses, and insurance adjuster names and phone/fax numbers. We can search by insurance company name, by the adjuster's name, or by attorney name and find the information quickly. Our program also contains numerous other search methods. This has proven to be a valuable tool and has allowed us to quickly proceed with all necessary action. This database is constantly updated as new insurance adjusters or attorneys are added. Basically, if we are provided with only a name, we can search within our database to attempt to locate the adjuster or attorney. This allows us to focus our time and energy on presenting the lien quickly, therefore protecting the health plan's recovery rights.

Sometimes additional research may be necessary and phone calls will be made by our experienced staff members to gather all of the information required. We exhaust all efforts in gathering information. This includes but is not limited to using the internet, contacting the plan member via phone, contacting the liable third party for insurance information, calling insurance companies to locate the appropriate file handler, searching for police reports, and researching court records. If the member has not set up a claim for an accident, we will contact the responsible insurance company and set up a claim for the health plan.

In addition, our program contains a series of standard forms for different types of incidents that we use to obtain additional information. These forms are specific to the situation that occurred and have yielded positive results in obtaining the required information. For example, we have a separate form for each of the following: slip and falls; boat accidents; dog bite incidents; assaults; ATV accidents; one car accidents; and multiple vehicle accidents.

We continue to investigate until answers are received, while others may choose to terminate the investigation and close the file.

Once all of the information is received, all of the involved parties are placed on notice of the subrogation lien.

Working and Tracking Open Files/Cases

Once a file has been opened and all of the appropriate parties have been placed on notice, the file will go into our maintenance and follow-up stage. Typically, once the parties have been placed on notice, they will request the amount of our client's lien or copies of additional documents. Our staff members will update the files by researching our client's claims database and obtain all of the required and/or requested information (strictly following HIPAA guidelines). We provide this information upon request and often numerous times within the life of one file.

Our subrogation program allows us to update the lien amounts easily. Our program is highly efficient and allows for quick turn-around.

Our program utilizes "Reminders" for file follow up. Basically, once a file is opened and the initial notice letters are sent, a reminder will automatically be placed on the file. No file will ever "fall through the cracks" because there will always be a reminder on the file. Every letter that is sent from our subrogation program is associated with a reminder. Therefore, once a letter is printed, a reminder will be placed on the file for later follow up.

If the designated time expires and a response has not been received from the other party, these reminders will re-open in a "Reminder" Database. The Reminders are reviewed daily by our staff members. Each reminder is very specific and will let the staff member know exactly what needs to be done next. When a member opens a Reminder, they will be taken into the related file record. The staff member will have all of the pertinent information available to them and will evaluate the file appropriately. **We obtain status updates on a regular basis for every file that is opened. We request the status from the member's attorney and insurance adjusters, among others. If we do not receive a response to our first status request, we will follow up with phone calls until a response is received. We feel it is extremely important to call the other parties if there is no response.** **When we receive a response to one of our letters, all of the pertinent information is entered into the file history. A new reminder will be placed on the file that tells us to follow up in the specified number of days.**	
3.A.21 Describe your process for identifying, collecting, and reporting Third Party Liability (TPL). **Medical claims that fall within a pre-determined range of diagnosis codes are sent to McAfee & Taft via electronic data transfer these claims are imported into McAfee & Taft's Claims Review program.** **This program will filter out the appropriate ICD-10 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident and 'slip and falls'. Member's claim records are reviewed and investigated further and a questionnaire is sent if subrogation potential exists.** **If a response to a letter indicates that the potential for subrogation exists, a subrogation file will be opened and an investigation will begin.** **All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We edit claims as we pay them to find potential subrogation, COB and Workers Compensation.**	5 points

We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group:

"Chase & Pay" Approach

For subrogation, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our vendor for tracking and recovery.

For COB & Workers Compensation, we would deny the claim until additional information is received.

"Pay & Chase" Approach

For subrogation, the claims are processed and the case forwarded to our vendor, the law firm of McAfee and Taft of Oklahoma City, Oklahoma, for pursuit of a recovery agreement, tracking and recovery.

All of our analysts have responsibility for identifying and pursuing COB. At the time of enrollment, employment by the spouse is reviewed along with any indication of other insurance. If there is an indication of another insurance serving as primary on the spouse, an indicator in the system is activated. That indicator will not allow a claim to be processed until information from the primary carrier EOB is entered. If children are covered by both plans, the Birthday Rule is used to determine primary/secondary responsibility for the plans. If the other plan is primary, the COB indicator is activated.

During the year, any indication on a claim form that other insurance may have paid primary, results in the claim being pended while an investigation is completed by our enrollment unit. This generally includes a letter requesting coverage information being sent to the family. The claim is not released until the investigation is completed. Once per year, a coverage survey is sent to all families covered by the plan to verify that no other insurance has been put in place requiring the COB indicator to be activated.

For Workers Compensation claims, we like to receive a file from clients weekly. We can load this file into our system to deny claims related to the Workers Compensation case.

Medical claims that fall within a pre-determined range of diagnosis codes are sent to McAfee and Taft via electronic data transfer these claims are imported into their Claims Review program. This program will filter out the appropriate ICD-10 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident and 'slip and falls'. Member's claim records are reviewed and investigated further and a questionnaire is sent if subrogation potential exists.

If a response to a letter indicates that the potential for subrogation exists, a subrogation file will be opened and an investigation will begin.

3.A.22 Describe how you will verify during Claims adjudication that the Member was eligible for Services on the date of service. **Eligibility is housed and updated daily from EBD in the same system where we pay claims.**	5 points
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 **All correspondence is scanned and imaged within the claims and attached to the member record.** b. Correspondence submitted separately **All corresponded submitted separately is scanned and imaged to the member record.** c. Requested medical records to support medical necessity **All medical records are scanned into DocTrax and attached to the member record.**	5 points

3.A.24 Describe in detail your workflow for responding to Customer Service inquiries, including turnaround time requirements. **Our customer care area is staffed with experienced individuals who have extensive medical backgrounds. This experience allows us to gain a comfort level with their communication and interpersonal skills as well as creates a setting where first call resolution is maximized. Customer care representatives are able to review transactions in detail, determine if they have been processed correctly and complete an adjustment if necessary.** **Questions that cannot be answered or issues that cannot be resolved by a representative are transferred to a team lead, supervisor or manager. The representative is required to provide the member name, ID#, and details regarding the call prior to transfer. If a transfer is not possible, a message is taken and return calls are made by the end of that business day. It is our goal to insure the caller is completely satisfied and therefore require the representative to use all resources available to them to answer the call. If the representative feels they do not have the necessary information we encourage them to transfer the call to a team of lead or supervisor for resolution.** **Written inquiries are handled within 48 hours or receipt. When possible, and unless a written response is requested, the representative will attempt a phone call in order to provide a more timely response.** **Calls that require claim adjustment or medical review are handed off electronically. The TAT is monitored and any calls over 72 hours are reviewed by management.**	5 points

3.A.25 Describe your processes for preventing duplicate payments for the same date of service. **The system automatically checks for duplicates, and consistency in processing is part of our claims processing guidelines that would be client specific. We have extensive duplicate edits to identify even partial rebillings that are duplicates. Decimal point errors and other oddities are caught by our analysts. In addition, our claims supervisors receive a report each morning to review possible duplicate claims paid the day before to ensure overrides are correct. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur.** **Our claims system uses various combinations of the date of service, providers tax ID, procedure code, modifier, service code – all both within the current claims as well as the claim history, to either systematically deny the claim as a duplicate or suspend the claims as a possible duplicate for further investigation by the analyst.** **Once we determine a claim has been duplicated and sent to us, we see to it the claim is denied as a duplicate. If the second claim was paid, we create an overpayment in the system. This overpayment will generate a letter to go out to the same location the payment was originally mailed. If the money is not returned, we continue with two more letters and if balance is still outstanding at the 6 month mark, we would turn this over to a collection agency.** **Depending on the amount of money, it is possible to recoup from another payment being made to this same provider. However, this option is not one we do on a regular basis because the recovery usually happens on duplicates.**	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. **Pended claims are maintained in a separate status in our claim system and prioritized for Claim Processor handling based on time on hand. Our system also generates written requests for additional information and reminder notices automatically based on the pend code. Supervisors are responsible for managing pended claim volume.** **We pend very few claims. When we do pend claims it is for pre-payment audit, medical management information, or repricing. We do not pend claims that need additional information. We deny those claims. The system automatically checks for duplicates, and consistency in processing is part of our claims processing guidelines that would be client specific.** • Explain how your company will follow-up for subsequent information once a claim is pended. **Any claim where additional information is required from a provider to process, the claim is denied with a message to the provider requesting the additional information. When the information is received, the claim is re-opened and processed. Claims where information is required from the patient (accident investigation, pre-existing condition, full-time student) are pended and a letter sent to the patient requesting the additional information. If not received within 45 days (the DOL standard of 30 days plus a 15-day extension), the claim is automatically denied. When the additional information is received on a denied claim, the claim is reopened and adjudicated. Less than 5% of claims are pended.** • Explain how your company will prevent duplication of requests to the same individual for the same requested information but for different claims. **Prior to correspondence being sent, the system is reviewed for outstanding requests.**	5 points
3.A.27 Describe in detail your remittance advice/explanation of benefits process for self-insured plans including delivery method. **Once a claim is processed and paid, an EOB form is released. EOBs are produced for every claim and displayed on our website. Denied claim EOBs are produced daily. Monthly EOBs are mailed to members unless they opt for electronic EOBs on our website. Electronic EOBs are available for every claim.** **HealthSCOPE Benefits offers you the ability to receive your Explanation of Benefits (EOBs) electronically. Once enrolled, you will receive an email letting you know when an EOB is available to review online.**	5 points

3.A.28 Describe your workflow for coordinating a request for a transplant.

5 points

HealthSCOPE Benefits' workflow for coordinating transplants is many faceted.

Referrals or notification of potential transplants come from many source; Physicians, clients, our account management team, our customer care team and even members. Other referrals come from our Utilization Management (UM) vendors and their Case Managers.

Once we are notified of a potential transplant or a referral is made for a transplant contract to be placed, our internal review process begins.

The UM vendors and/or their case manager will have a peer-specialty medical review preformed to determine that the transplant is standard of care, medically necessary and not experimental/investigational.

Our first point of review will be the plan document and the Transplant Plan language in the plan document. The verbiage will be reviewed to determine if a Centers of Excellence is mandatory or if there are any network requirements.

A decision tree comparison tool is used to select the best contract for all parties. Once the Transplant contract is selected, a letter of agreement will be submitted to the State of Arkansas for execution. Once all pieces are in place, approval of the Transplant will be communicate to the member and their provider by the UM vendor and the case will be managed by the Case Manager until closed.

We work with a number of Centers of Excellence Programs including:

***Aetna's Institutes of Excellence (IOE)* – specialized care with no buy-up requirement**
Members who need specialized care for transplants can access the Aetna Institutes of Excellence (IOE) network. The Aetna IOE network includes hospitals and transplant centers with a record of successful treatment and superior medical standards. Access to the Aetna IOE network is automatically included for all ASA customers at no added program cost. Aetna IOE facilities have demonstrated excellence in their transplant programs and offer ASA customers exceptional negotiated rates.

When a member uses an IOE facility, a registered nurse case manager is available to help with every phase of the transplant process, from evaluation through recovery. As the client, your organization also becomes eligible for a 20 percent reduction in the Individual Stop Loss level for the transplant individual. The Aetna IOE network covers heart, lung, kidney, pancreas, intestinal, bone marrow and stem cell transplants.

Cigna LifeSOURCE Center of Excellence

Cigna LifeSOURCE Transplant Network contracts with over 650 transplant programs at more than 150 independent transplant centers that are nationally recognized for their clinical outcomes. Programs of Excellence meet Cigna LifeSOURCE national guidelines for network inclusion. We provide our clients with the access they need for organ and bone marrow/stem cell transplantation while improving cost containment and reducing their financial risk.

LifeTrac

From its inception as a pioneer transplant network in 1988, LifeTrac has provided expertise to benefit payors and patients alike. Today, LifeTrac is a national network offering clinical support and access to hundreds of transplant programs at a select group of the world's leading transplant facilities. LifeTrac serves HMOs, TPAs, employer benefit plans, and major insurance, reinsurance and stop loss companies.

The LifeTrac Network was developed through the selection of transplant medical facilities that consistently demonstrate high case volumes, coupled with high patient survival rates. Each LifeTrac participating facility is carefully evaluated prior to network inclusion, and is re-evaluated annually to reconfirm the facility's ongoing adherence to LifeTrac participation standards.

Optum Health

Optum Health's Centers of Excellence networks are the gold standard in complex health care. Our original network, the Optum Health Transplant Centers of Excellence network, was developed in 1986 and has grown to be the largest network of its kind in the world - managing more than 11,000 transplant referrals each year. Today, we offer products and services that promote safe, successful and cost-effective treatment options for many other complex medical conditions, including cancer, congenital heart disease and infertility.

More than 3,000 payer groups, representing more than 48 million lives use our products and services - including the majority of United Healthcare's 16 million enrollees.

Evaluation process

At Optum Health we've been reviewing health care providers who specialize in costly, complex and catastrophic conditions for over 20 years. Each year we conduct a rigorous evaluation process of medical centers throughout the country.

Our evaluation criteria, developed in conjunction with a national panel of industry experts and practitioners, focus on facts not perceptions. We only invite medical centers and programs with proven experience and statistically successful track records to be part of our Centers of Excellence networks. Find out more about our evaluation process and criteria.

Moving patients in the right direction

Optum Health's nurses are expert at guiding patients to the medical center that best meets their needs. Armed with the facts and statistics from our yearly evaluation survey, we encourage patients and their case managers to choose Centers of Excellence network medical centers for their care.

INTERLINK

INTERLINK Health Services Inc. provides the nation's leading outcome-based transplant network. By reviewing performance indicators of transplant centers from all over the country, we have identified the benefits of receiving transplants at medical centers with proven experience and outcomes. INTERLINK clients access the network to decrease overall health plan transplant costs through improved transplant outcomes. There is a well known association between experienced transplant surgical teams and improved surgical outcomes. INTERLINK seeks to improve transplant quality for its membership through a regimental outcome review process.

INTERLINK has formed this "Centers of Excellence" style network for its clients to access. **The next frontier in medical management is in Complex Care. A serious and complex condition is somewhat hard to define in words and its one reason why so few organizations are even attempting to tackle it. HealthSCOPE Benefits sees serious and complex conditions as persistent and substantially disabling or life threatening, requiring treatments and services across a variety of specialties of care. These conditions need multi-disciplinary treatment to ensure the best possible outcomes for each unique patient or member.**	

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. **HealthSCOPE Benefits/Employers' Health Choice:** **We plan to adhere to the CMS guidelines and the Affordable Care Act by allowing health care providers to become members of our network of providers. We have policies that document standards for ensuring our network allows access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services capacity. We also have procedures in place that allows us to monitor and evaluate the quality and appropriateness of care and services to our members. We also make sure that our services reflect the full spectrum of the needs of our service areas.** **For providers who are out of compliance, we notify the provider of their non compliance by phone call and in writing within 5 business days outlining our findings.** **HSTechnology Reference Based Pricing:** **HST's Value-Based Payment (VBP) plans are centered on terminating the hospital PPO and reimbursing them at Medicare/Cost Plus using an Any-Willing-Provider (AWP) model. Health Scope Benefits (HSB) will provide the Physician only PPO and will credential and manage them according to PPO contracts. HST has a 98% acceptance rate nationally and it's Patient Advocacy Center (PAC) will handle any hospital appeals, balance billing and facility inquiries. Hospital that pushback on AWP's Medicare plus payments will be addressed by HST's PAC who will secure individual claims settlements according to plan guidelines or HST will negotiate a Facilitation Agreement with the hospital system.**	5 points
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. **HealthSCOPE Benefits/Employers' Health Choice:** **Coverage Policies are outlined in our standard provider contract and are also available via the web. The Providers are sent our Network Quick Reference Guides and letters to outline any updates or changes to the member's coverage policies for that group. The member would receive a letter outlining any changes to their coverage policy and given contact numbers to call for any additional questions.** **HSTechnology Reference Based Pricing:** **HST provides a host of member/provider communications for hospital VBP plans that include enrollment packets, member/provider announcements, videos etc. Some sample communications include:**	5 points

	• **Employee Announcement Letter that introduce the members to VBP** • **HST Care Connect flyer which describes all of the features available through the HSTechnology app** • **Frequently Asked Questions (FAQ) to help answer any basic questions about the plan.** **HST continuously updates its VBP policies and procedures based on market conditions and regulatory issues.**	
3.B.3	Describe your workflow for determining experimental and investigational status of services. **We have a physician consultant who reviews claims that may be questionable for medical necessity, experimental/investigational, and outside of the customer's plan document. Customers pay a per review fee for these services.** **All experimental and investigational procedures are identified through our claims system edits and by our very experienced claims processing personnel. Once identified, they are forwarded to our medical director for review and determination. Once a determination is made, the member is notified of our decision.** **Medical necessity is defined by the plan document(s), including the summary plan description. HealthSCOPE will undertake medical necessity determinations in accordance with these document(s) and any other applicable provisions of the administrative services only agreement.** **Procedure:** **All submissions must come through a claims supervisor at HealthSCOPE Benefits. Supervisor will review for exclusions under the plan. If service is questionable, they will refer to the Clinical Consultant for additional review. These cases are normally for medical necessity of the proposed service or possible experimental/investigational treatment.**	5 points

Note: If additional information is required, clinical consultant will advise information needed for the supervisor to request or they may make direct contact to request necessary documentation they may need from the provider.

The terms below must be used correctly when transferring calls to UR/CM Vendor and requesting service.

Medical Necessity Review – This term is used for questions of medical necessity, either prior to treatment or after treatment that is not a listed procedure or service in the plan that requires this review.

Claims Department Procedures

1. Claims Administration at HealthSCOPE Benefits will:

• Identify and/or approve services that require a medical necessity review for all types of submissions, including Correspondence and Faxed requests.

• Check if the client utilizes UR/CM Vendor for these services, and if yes see #2

• If no, go to #7.

2. Claims Administration will send the case to UR/CM Vendor.

3. UR/CM Vendor will make a determination and send letters to the patient, provider, and claims payer stating the decision and rationale. Letters will be sent daily.

4. UR/CM Vendor will forward a notification email to the Claim Supervisor, responsible for the client, at HealthSCOPE Benefits

5. The Claims Supervisor will determine if further steps need to occur i.e. if post service claim, assure the claim is processed accordingly

6. The claims system will be updated electronically daily in the Authorization Screen of Medical Necessity Review determinations

7. Supervisor will e-mail the clinical consultant the documentation to be reviewed along with any questions regarding the proposed or completed service.

3.B.4 Describe your process for reviewing and authorizing all Network Provider contracts. **HealthSCOPE Benefits/Employers' Health Choice:** **First we check the service area and the specialties. We establish and maintain provider networks with sufficient numbers of providers and in geographically accessible locations for the populations they serve. Our EHC provider network operates in the state of Arkansas, the border of Oklahoma and Texarkana. We may deem certain specialties and/or regions in the existing EHC provider network as sufficient or adequate according to access and availability standards. These specialties and/or regions are considered "closed." All networks are "open" at this time. Second, we send the contract packet to be completed which includes the contract, application and reimbursement rate exhibit. Third, upon receipt of the completed contract packet, we advise the provider that this process takes 14-21 business days to complete. We send the provider application over for credentialing (for some specialties). Upon completion of credentialing the provider is sent a welcome letter and packet.** **HSTechnology Reference Based Pricing:** **Hospitals that have high utilization, high charge volumes etc. can be considered for VBP Facilitation Agreements (not PPO contracts).**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **We send the practitioners, allied health professionals and facilities to be credentialed. The Credentialing Plan outlines the standards, policies, and process for the acceptance, discipline, and termination of participating practitioners and organizational providers.** **Credentialing determinations are guided by an evaluation of each practitioner's capability to provide comprehensive, safe, effective, efficient, and quality care to EHC members, in light of the practitioner's background, credentials and qualifications.** **HSTechnology Reference Based Pricing:** **VBP plans using AWP rely on state licensure and/or CMS acceptance on a pass thru basis that they're licensed to perform said services in a given state. Additionally, HST uses leading quality indicators to assess their performance in delivering quality care and targets the top 25%. For Direct-to-Employer (DTE) Agreements, HST may perform credentialing and licensing review if required in DTE.**	5 points

3.B.6 Describe your process for enrolling currently credentialed Providers in to your Plan during the implementation period. **HealthSCOPE Benefits/Employers' Health Choice:** **If the provider has already been credentialed, we would send an invitation to participate letter advising the provider of the new client and request their approval to be included in that network. We also verify that the provider is complying with the professional requirements found in state and federal laws.** **HSTechnology Reference Based Pricing:** **See 3.B.4 response and in addition, HST may recruit additional hospitals based on client specific requirements.**	5 points
3.B.7 After the initial implementation period, describe your company's plan for recruiting, credentialing, and enrolling providers. **HealthSCOPE Benefits/Employers' Health Choice:** **We have a long-range recruitment plan as well as a organized recruiting schedule based upon the historical supply and demand for each major healthcare discipline. We implement this plan within the organization. Upon review of the data, we then determine which disciplines we will focus on in the specified area. Compile the data of providers or hospitals for that area and begin our outreach telephonically and by mail.** **HSTechnology Reference Based Pricing:** **Please refer to responses 3.B.4 and 3.B.6 for hospital VBP plans.**	5 points
3.B.8 Describe your plan for re-credentialing and re-validating Providers, at a minimum of at least every three (3) years and five (5) years, respectively. **HealthSCOPE Benefits/Employers' Health Choice:** **For those providers who are up for re-enrollment, HealthSCOPE conducts all Re-Credentialing Services. These services include: re-credentialing services based on specific insurance plan requirements. We process all payer re-credentialing applications and submit to our Credentialing vendor for re-verification of all licensing and credentials to ensure the practitioners/facilities have maintained their eligibility to participate in the network.** **HSTechnology Reference Based Pricing:** **Please refer to responses 3.B.4 and 3.B.6 for hospital VBP plans.**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **HealthSCOPE Benefits is part of the innovative program Comprehensive Primary Care Plus (CPC+) that seeks to improve and promote the quality of healthcare the people of Arkansas receive daily. This national advanced primary care medical home model aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).** **In 2016, the Centers for Medicare and Medicaid Services (CMS) launched this initiative across the country. The state of Arkansas is one of only 14 regions in the country selected to participate in this five-year, multi-payer initiative. This plan is designed to:** • **Strengthen primary care delivery** • **Promote better health outcomes** • **Control overall healthcare costs** **As one of only six public & private payers participating in this program, HealthSCOPE Benefits is able to offer our members and participating providers a program that seeks to strengthen primary care through multi-payer payment reform and care delivery transformation.** **CPC+ Clinics are different. Doctors are able to see what other doctors have prescribed for a patient. They can check for gaps in patient care, track patient health goals, answer patient questions, and verify understanding.** **Patients utilizing the CPC+ program can call for medical advice 24 hours a day, 7 days a week and get same-day appointments—high-risk patients even get priority appointments.** **Patients are also surveyed for patient satisfaction to ensure quality of care.**	5 points

3.B.10 Describe your plans for Provider relations and education. **HealthSCOPE Benefits/Employers' Health Choice:** **We have a dedicated Provider Relations team of 5 Provider Relations Representatives that are able to assist with provider relations inquiries. This team is able to educate and assist the providers with their inquiries.** **To access the most up-to-date information regarding the provider network we have the Provider Portal for the following:** • **Check patient eligibility and benefits** • **Submit or manage authorizations and referrals** • **Review claim status** **HSTechnology Reference Based Pricing:** **HST's PAC handles all hospital pushback and communications as required for VBP plans.**	5 points

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. **HealthSCOPE Benefits/Employers' Health Choice:** **The Provider Relations Specialist is giving a copy of the territory that they will manage. We also outline the job requirements which include the guidelines for outreach and outlines the importance of being available to assist the providers with their inquiries. We also provide the PRS information about the area as well as the providers/hospitals/labs/dme's and other medical service providers within that area. We send out a blast fax, email or letter introducing the new Provider Relations Specialist and providing all of their contact information.** **HSTechnology Reference Based Pricing:** **HST's PAC handles all hospital pushback and communications as required for VBP plans and it's facility. Contractors will go on-site as required.**	5 points

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. **HealthSCOPE Benefits/Employers' Health Choice:** **We educate our participating providers on the importance of utilizing the value-based reimbursement methodology, healthcare providers are encouraged to participate because it allows an opportunity to improve patients' health while decreasing costs. We also understand that physicians are obviously affected by industry changes, and they can have great influence on the cost and quality of care.** **As one of the largest independent TPAs, HealthSCOPE Benefits has the experience, resources and flexibility to develop, administer, and market health system Accountable Care Organizations (ACOs) to:** **o Health system employees** **o Self-funded and fully insured employers** **o Individual Commercial and Medicare Advantage Plans** **o Other Managed Care Organizations and Payers** **o Private and public exchanges** **HealthSCOPE Benefits offers health systems a more unique approach than that offered by the large carriers and carrier-owned administrators. We offer unlimited flexibility, unmatched speed to market, and independence. We produce the data and information needed to drive all the details related to ACO development, manage value-based care and support bundled payments. In 2016, HealthSCOPE Benefits was selected by CMS as a Payer Partner for the CPC+ program for the State of Arkansas. As of 2017, HealthSCOPE Benefits has expanded our participation to include the states of Michigan, Ohio, Kentucky and Oklahoma.** **This is the HealthSCOPE Benefits difference for emerging ACOs - combining the strength and resources of a national platform, with the flexibility and high touch customer service of an independent TPA. We have built and administered Accountable Care solutions and patient-centered medical homes where we have provided capitated payments, patient rosters, and data analysis to support value-based care initiatives. We have assisted with direct provider contracting and with the identification of networks to fill any "gaps" in the ACO offering. HealthSCOPE Benefits' system capabilities and teams are well positioned to support ACOs through custom reimbursement arrangements and the administration of provider incentives for quality outcomes.**	5 points

• HealthSCOPE Benefits was created in the 1980s to develop custom networks in rural areas. This legacy of collaborating with providers combined with our recent investments in value-based care makes us the right partner as health systems introduce the next generation of ACO solutions.

• We have developed, through a relationship with Mayo Clinic and their three geographically positioned destination locations, a Complex and Serious Illness Program for large employers. This includes complex conditions that are substantially disabling, often miss-diagnosed and are rare and unique or life threatening, requiring treatment and services across a variety of specialties of care. We also look to collaborate and develop custom care pathway programs that are disease specific in areas such as cancer or cardiac care and focus on the highest value of care, better outcomes and improved total cost of care.

HealthSCOPE Benefits continues to innovate and participate in multiple quality improvement measures. HSB has worked with the development of and implementation of Patient-centered medical homes (PCMHs), Episodes of Care and Comprehensive Primary Care Plus (CPC+), in fact HSB was the only Third Party administrator in the country to be approved by The Centers for Medicare & Medicaid Services (*CMS)* to participate in CPC+.

Patient-centered medical homes (PCMHs) are teams of providers who take responsibility for the overall health of assigned patients. A patient's team is led by a designated primary care doctor who communicates with other clinical and administrative professionals to better coordinate patients' care.

Episodes of Care or "bundle payments" are where Providers share in the savings or excess costs of an episode depending on their performance for each episode. The participating payers identify the principal accountable providers (PAP) for each episode through claims data. For each episode, all providers continue to file claims as they have previously and are reimbursed according to each payer's established fee schedule. Providers input some basic information related to the care they provide into a Provider Portal. Then, through this portal, providers access reports that show the overall quality of care they delivered during a set time period—typically one year—and at what average cost.

At the end of the set time period, each PAP's average cost per episode is calculated and compared with "acceptable" and "commendable" levels of costs. If the average cost is above the acceptable level, the provider will pay a portion of the "excess" costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer.

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).

3.B.13 Describe your process for developing, distributing, updating, and re-distributing the Provider Manual. **HealthSCOPE Benefits/Employers' Health Choice:** **The Provider Quick Reference Guide is presented to the Provider upon execution of their contract. It is updated when changes are made to our claims and eligibility system and the website which provides access to our Provider Directory.**	5 points
3.B.14 Describe how you will ensure your Network is responsive to all linguistic and cultural needs of minority or disabled Members. **HealthSCOPE Benefits/Employers' Health Choice:** **It is our goal to ensure that our network is sufficient and maintains the appropriate specialty type including those that service our predominantly low-income, medically underserved and disable members. That all covered services to our covered members including children and adults will be accessible without unreasonable travel or delay.**	5 points

3.B.15 Describe your reimbursement method for the below services.

5 points

A substantial segment of our business includes clients with multiple plans and different reimbursement methodologies - including RBR, direct contracts, and multiple networks. Our systems have the built in flexibility to administer multiple plans, with multiple reimbursement methodologies at the member level. We are a one-stop shop for every group's network access and plan needs.

Approximately seven years ago, we began using Medicare as the basis for reimbursements for a variety of applications. Each plan that we have administered required unique plan designs and repricing methodologies. We accept the claims, sort against eligibility and they reprice against the various arrangements identified in the design stage. Each plan requires their own claims flow and is managed and edited throughout the plan year as additional agreements or changes are identified as appropriate.

a. Inpatient hospital facility medical/surgical admission
Provider reimbursement of Medicare plus, 140% target.

b. Inpatient hospital facility maternity admission
Provider reimbursement of Medicare plus, 140% target.

c. Outpatient hospital facility emergency room
Provider reimbursement of Medicare plus, 140% target.

d. Outpatient hospital facility surgery
Provider reimbursement of Medicare plus, 140% target.

e. Ambulatory surgical center
Provider reimbursement of Medicare plus, 140% target.

f. Other outpatient hospital services
Provider reimbursement of Medicare plus, 140% target.

g. Primary care physician
HealthSCOPE Benefits/Employers' Health Choice:
Percent of Medicare

h. Specialist
HealthSCOPE Benefits/Employers' Health Choice:
Percent of Medicare

i. Independent lab (indicate the independent lab organization utilized in Arkansas)
HealthSCOPE Benefits/Employers' Health Choice:
Percent of Medicare

3.B.16 What is your provider turnover for both voluntary/involuntary for 2015, 2016, and 2017?

5 points

HealthSCOPE Benefits/Employers' Health Choice:

HealthSCOPE Benefits / Employer's Health Choice Physician Turnover		
Year	**Voluntary**	**Involuntary**
2015	**1.0%**	**0.3%**
2016	**1.1%**	**0.3%**
2017	**1.3%**	**0.4%**

3.B.17 Describe the criteria you use for determining adequate network coverage for primary/general and specialty care.

5 points

HealthSCOPE Benefits/Employers' Health Choice:

The network adequacy criteria that we have in place includes provider and facility specialty types that must be available and consistent with CMS number, time, and distance standards. Access to each specialty type is assessed using quantitative standards based on the local availability of providers to ensure that organizations contract with a sufficient number of providers and facilities in order to provide healthcare services without placing undue burden on enrollees trying to obtain covered services. The criteria used also include considering the CMS utilization patterns, Utilization of provider/facility specialty types in other programs, Clinical needs of our members and Specialty types measured to assess the adequacy of our plans.

Standard criteria includes:
PCPs
For PCPs, the standards include the following:

- **in urban areas, two PCPs within 10 miles**
- **in suburban areas, two PCPs within 15 miles**
- **in rural areas, two PCPs within 25 miles**

SPECIALTY CARE DOCTORS
For specialty care, the standards include the following:

- **in urban areas, two specialty care doctors within 15 miles**
- **in suburban areas, two specialty care doctors within 20 miles**
- **in rural areas, two specialty care doctors within 30 miles**

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 have a statewide contract with MEMS. For all other providers we would pay at Medicare plus for VBP Plans.**	5 points
3.B.19 Describe how you update and distribute network and service area information to Members, employers and providers. **HealthSCOPE Benefits/Employers' Health Choice:** **The information is updated on our website. We also send letters to the group who will in turn send the information to the employee. We also send letters to the members with any updates to the service area.**	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? **HealthSCOPE Benefits/Employers' Health Choice:** **Lesser of language is included in our provider contract. It states that Participating Physician shall accept the lesser of billed charges or the HealthSCOPE Benefits fee schedule, including multiple codes and modifiers, as payment in full for the applicable HealthSCOPE Benefits network product for Covered Health Services provided during the terms of this Agreement.** **HSTechnology Reference Based Pricing:** **Hospital VBP plans are paid at the Medicare plus rate, the negotiated claim settlement, the facilitation agreement, or DTE rates only never billed charges.**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **We use our standard fee schedules for all of our provider contracts regardless of their insured status. Our standard fee schedules follow CMS guidelines which allows us an opportunity to base our fee schedules on their base rates. The provider contract language is intended as the primary source of reimbursement terms and dictates overall reimbursement methodology. Our policy is generally based on the following:** **• Reimbursement for Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes** **• Reimbursement for codes without an assigned fee maximum** **• Reimbursement adjustments for defined CPT/HCPCS modifiers** **• Reimbursement is based on the frequencies in which refreshed/newer rate sourcing information and availability such as Centers for Medicare and Medicaid Services (CMS) relative value units (RVUs) or community rate-sourcing information for services without an assigned RVU value (e.g., injectable drugs, immunizations, supplies, various laboratory testing procedures) are applied during a provider's contract period.** **HSTechnology Reference Based Pricing:** **Hospital VBP plans are paid at the Medicare plus rate, the negotiated claim settlement, the facilitation agreement or DTE rates only regardless of funding arrangements.**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **No, we are not using a leased network arrangement.** **HealthSCOPE Benefits offers several methods to pay participating doctors and hospitals fairly and to encourage them to provide quality care while managing costs.**	5 points

3.B.23 Describe your provider contracting policies that would increase provider reimbursement on a case-by-case basis. **HealthSCOPE Benefits/Employers' Health Choice:** **Provider Reimbursement is based on the terms agreed upon in the provider contract. Our provider reimbursement rates are largely based on CMS guidelines. As CMS updates their fee schedule, we would update our rates. Our policy outlines our expectation that there is uniformity in reimbursing the providers in an effort to restrain charge inflation and discourage cost-shifting.** **The physician who accepts assignment or participates agrees to accept the Plan's allowance as full payment for his service. In return for this agreement, he becomes eligible to be paid by the Plan rather than by the patient.** **HSTechnology Reference Based Pricing:** **Hospital VBP plans are paid at Medicare plus model and clients preapprove a negotiating corridor; any payments greater than the Medicare allowable price (MAP) negotiated amount are submitted to Plan fiduciary for final payment disposition. Clients determine MAP and approved corridors.**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **Please refer to Section IV to reference copies of the following:** • **HealthSCOPE Benefits Ancillary Agreement** • **HealthSCOPE Benefits Hospital Agreement** • **HealthSCOPE Benefits Physician/Clinic Agreement** **HSTechnology Reference Based Pricing:** **Please refer to Section IV to reference the following Sample VBP Agreement:** • **3.B.24- Sample VBP Agreement**	5 points
3.C Network Coverage	

3.C.1	List in-network hospitals in Arkansas and provide a map showing the hospitals coverage area. **HealthSCOPE Benefits/Employers' Health Choice:** **Please refer to Section IV to reference a map of the Employers' Health Choice hospital coverage area.** **HSTechnology Reference Based Pricing:** **The very nature of VBP plans allow for access to all hospitals. HST's Value-Based Payment (VBP) plans are centered on terminating the hospital PPO and reimbursing them at Medicare/cost plus using an Any-Willing-Provider (AWP) model.**	5 points
3.C.2	Describe your in-network and out-of-network processes for out-of-state access. **HealthSCOPE Benefits/Employers' Health Choice:** **Out of state access is provided on an emergency basis to covered eligible members who are absent from the state when an emergency arises from an accident or illness, when the health of the recipient would be endangered if the recipient undertook travel to return to their residence state, or when the health of the recipient would be endangered if medical care were postponed until the recipient returns to their home state. For reimbursement, the out-of-state provider must enroll as a Participating Provider and must follow established timely filing guidelines in submitting claims.** **Provider participation is automatically assessed at the time the claim is received. For out of state participants, a network could be accessed or VBP could be used for a provider.** **HSTechnology Reference Based Pricing:** **VBP plans pay all providers at Medicare/cost plus for in/out-of-network including out of state providers.**	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. **Please refer to our sealed pricing proposal to review Attachment L – Network Coverage. We have provided results for both Employers' Health Choice and HST.** **HSTechnology Reference Based Pricing:** **The very nature of VBP plans allow for access to all hospitals. HST's Value-Based Payment (VBP) plans are centered on terminating the hospital PPO and reimbursing them at Medicare/cost plus using an Any-Willing-Provider (AWP) model. All VBP plan providers that bill on UB04 are paid at Medicare plus rates approved by clients.**	5 points
3.C.4	During the period of 2015 – 2017 list the percentage of active providers by specialty without any claims activity. **HealthSCOPE Benefits/Employers' Health Choice:** **The requested information is currently not tracked. We would be happy to discuss reporting capabilities during finalist discussions.**	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. **Providers must take responsibility for medical management requirement in our agreement.** Describe the process for communicating this information to the network community. **HealthSCOPE Benefits keeps health care professionals informed of policy updates, guideline changes, and other important information through various communication initiatives, including blast fax, direct mail, newsletter articles, and postings on the secure health care professional websites. Regular outreach includes phone calls and office visits.** Describe the process for communicating this information to the Member community. **This information is communicated through the SPD and EOBs.** Describe the process for monitoring network leakage. **We educate participating health care professionals about working with medical management or utilization management teams to obtain certification for out-of-network referrals when it is medically necessary. Members may review updated health care professional information on our web site or call our toll-free customer care number to see if a particular doctor is in network. HealthSCOPE Benefits may also guide the member on network status when the member is planning to receive services from a health care professional that is not part of the network. We also work with the health care professional to verify benefits and eligibility.**	5 points
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. **HealthSCOPE Benefits/Employers' Health Choice:** **HealthSCOPE Benefits has regional and national wrap networks to accommodate members who live outside the service area. We have providers in all 50 states, as well as over 750,000 providers contracted in these wrap networks. In the rare situation where an out of area member cannot find an in-network provider, the HealthSCOPE Benefits team will reach out to the providers in the community to obtain a single patient agreement for the provider to treat the member at the in-network benefit level.** **HSTechnology Reference Based Pricing:** **Not Applicable to HST**	5 points

3.C.7	Describe the advantages of your company's provider network regarding pricing and Member access within Arkansas and nationwide.	5 points

HealthSCOPE Benefits/Employers' Health Choice:

By balancing cost and access, HealthSCOPE Benefits Employers' Health Choice plans provide clients with choice and medical cost savings. Our programs offer an ideal stepping-stone for clients who want to move away from traditional indemnity health care coverage and toward moderately managed care. The plans provide members with a positive introduction to a more structured managed care environment by providing incentives to use designated health care professionals.

ADVANTAGES TO MEMBERS
The advantages to members include the following:
higher payment levels and lower fees when members obtain care from participating health care professionals no referrals, PCP, or gatekeeper access to specialists whether in network or out of network nationwide in-network access to medical care when traveling on vacation or for business or when away at school access to high-quality medical care—screening of health care professionals occurs before acceptance into the network easy to use, with a broad array of member-friendly features no claim forms when accessing in-network services

ADVANTAGES TO HEALTH CARE PROFESSIONALS
The advantages to health care professionals include the following:
members directed to network health care professionals through the channeling feature of HealthSCOPE Benefits' toll-free number patient base maintained, with the potential to help increase volume automatic assignment of payments to the health care professional traditional fee-for-service (FFS) payment peer-to-peer discussion with nurses and medical directors

HSTechnology Reference Based Pricing:

All hospitals included under AWP and reimbursed at Medicare/cost plus using published reference prices that providers have accepted historically.

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.	5 points

HealthSCOPE Benefits/Employers' Health Choice:

All of our analysts have responsibility for identifying and pursuing COB. At the time of enrollment, employment by the spouse is reviewed along with any indication of other insurance. If there is an indication of another insurance serving as primary on the spouse, an indicator in the system is activated. That indicator will not allow a claim to be processed until information from the primary carrier EOB is entered. If children are covered by both plans, the Birthday Rule is used to determine primary/secondary responsibility for the plans. If the other plan is primary, the COB indicator is activated.

During the year, any indication on a claim form that other insurance may have paid primary, results in the claim being pended while an investigation is completed by our enrollment unit. This generally includes a letter requesting coverage information being sent to the family. The claim is not released until the investigation is completed. Once per year, a coverage survey is sent to all families covered by the plan to verify that no other insurance has been put in place requiring the COB indicator to be activated.

In addition, we have pop ups for our customer care representatives to request COB information when they are on the phone with a member, and we have pop ups on the web for members to update COB.

We maintain a complete history for each participant (employee and all dependents), including all changed records. This includes demographic and coverage information. Each transaction is "tagged" with a date, time and user so a complete audit trail is maintained. An additional function is the linkage of all -related documentation (e.g., HIPAA Certificates, Letters, COB investigation, proof of dependent status, etc.) to the group and participant. The system allows for programming of edits related to Plan Document provisions, such as an annual COB review HealthSCOPE Benefits maintains all eligibility data in our system for as long as the client is active (including run-out periods).

There are three methods of coordination of benefit calculations:

- **Standard**
- **Standard with Savings**
- **Integration/Maintenance of Benefits**

Standard – This calculation allows for a benefit up to the allowable amount of the charge, but benefits between the two carriers will never exceed more than the allowable.

The Plan benefits are calculated as if the group were the primary carrier (normal benefit). Then the payment made by the primary carrier is subtracted from the allowable amount. Then Plan pays the difference.

The allowable amount is the amount of the charge allowed under the plans. The allowable amount does not include PPO discounts. If applicable the PPO allowable is based on the highest allowable of the two carriers or Usual and Customary disallowances.

This method does not establish a 'bank'.

Standard with Savings – The same as above but a 'bank' is established with the amount Plan saved as the secondary payer. This amount can be used in the same calendar year to reimburse the member for out of pocket expense that is part of the allowable amount. The 'bank' amount does not carryover to the next calendar year. Dollars are only paid out of the 'bank' if after both carriers have paid there is an out of pocket expense up to the allowable amount. The bank does not pay out differences between the billed and PPO allowable or Usual and Customary allowances.

Calculation Example:
Provider Billed - $1000.00
Primary Carrier Allowed - $800.00
Plan Allowed - $925.00
Primary Carrier Paid - $640.00

Standard Calculation:
Plan Normal Benefit
Allowed: $925.00 x 80% = $740.00
Normal Plan Benefit = $740.00

COB Calculation:
$ 925.00 (Allowable)
- 640.00 (Primary Plan Payment)
$285.00 (Secondary Plan Payment)

Standard Calculation with Savings – Savings Calculation (uses same calculation as the Standard example)

$ 740.00 (Normal Plan Benefit)
- 285.00 (Secondary Plan Payment)
$ 455.00 (COB Savings)

Integration/MOB – This calculation allows payment between the two carriers to never exceed the amount that would have been payable by the secondary plan. Therefore, if the primary plan payment is equal or greater than the normal benefit of the secondary plan no benefit is payable. This calculation never establishes a COB 'bank'.

Calculation Example: (same example as above)

Provider Billed - $1000.00
Primary Carrier Allowed - $800.00
Plan Allowed - $925.00
Primary Carrier Paid - $640.00

Plan Normal Benefit
Allowed: $925.00 x 80% = $740.00
Normal Plan Benefit = $740.00

Integration/COB Calculation:

$ 740.00 (Normal Plan Benefit)
-640.00 (Primary Plan Payment)
$ 100.00 (Secondary Plan Payment)

3.C.9	What is your policy for allowing in-network providers to balance bill Members? **HealthSCOPE Benefits/Employers' Health Choice:** **Doctors and hospitals agree, by contract, to only bill members for copays, deductibles, or coinsurance. Health care professionals may bill members for services outside the member's plan coverage, subject to any contract limitations.** **Health care professionals must submit every claim and receive an explanation of payment (EOP) before billing members for their applicable coinsurance or deductible.** **Members billed directly by the health care professional for fees other than applicable copays, deductibles, or coinsurance should contact HealthSCOPE Benefits for assistance**.	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. **HealthSCOPE Benefits/Employers' Health Choice:** **Our philosophy is to provide our members a comprehensive, "best of breed" network of providers that will yield maximum savings.** **HealthSCOPE Benefits Network Administration Services supports provider or employer sponsored networks through turnkey management services. HSB provides network solutions in network design, structure, data review, contracting, credentialing, utilization review and benefit design. This process maximizes network access, steerage and cost management.** **HealthSCOPE Benefits has saved our clients millions of dollars through improved network utilization, expanded provider networks and improved fee schedules. HSB has managed PPO transition, improved out-of-network utilization, defined network alternatives and facilitated transitions to new TPAs. Additionally, we have maximized network contract and credentialing compliance avoiding potential legal pitfalls.** **HealthSCOPE Benefits has over 30 years of experience in building healthcare networks that meet the unique needs of employers and payers in rural and urban communities. Our services include: provider contract negotiation, provider reimbursement and fee systems design, provider credentialing, and employee benefit plan design. HealthSCOPE Benefits provides its network development service to employer and provider groups across the country - from initial consulting services to strategic involvement in every stage of the network development process.**	5 points

3.C.11	Provide a list of in-network facilities that do not have a DRG arrangements for all services rendered. **HSTechnology Reference Based Pricing:** **Under VBP plans all hospital reimbursed at DRG/Inpatient or APC/Outpatient.**	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. **HealthSCOPE Benefits/Employers' Health Choice:** **Under normal conditions, an increase/decrease on agreed upon fee schedules is triggered through the opening of a provider's contract with the goal of negotiating a new reimbursement rate.** **HSTechnology Reference Based Pricing:** **Under VBP plans all hospital reimbursed at DRG/Inpatient or APC/Outpatient MAP rates and client approved negotiating corridor. 10% change in employees may result in HST fee adjustments.**	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.	5 points

HealthSCOPE Benefits/Employers' Health Choice:

We work with a number of Centers of Excellence Programs including:

***Aetna's Institutes of Excellence (IOE)* – specialized care with no buy-up requirement**
Members who need specialized care for transplants can access the Aetna Institutes of Excellence (IOE) network. The Aetna IOE network includes hospitals and transplant centers with a record of successful treatment and superior medical standards. Access to the Aetna IOE network is automatically included for all ASA customers at no added program cost. Aetna IOE facilities have demonstrated excellence in their transplant programs and offer ASA customers exceptional negotiated rates.

When a member uses an IOE facility, a registered nurse case manager is available to help with every phase of the transplant process, from evaluation through recovery. As the client, your organization also becomes eligible for a 20 percent reduction in the Individual Stop Loss level for the transplant individual. The Aetna IOE network covers heart, lung, kidney, pancreas, intestinal, bone marrow and stem cell transplants.

Cigna LifeSOURCE Center of Excellence

Cigna LifeSOURCE Transplant Network contracts with over 650 transplant programs at more than 150 independent transplant centers that are nationally recognized for their clinical outcomes. Programs of Excellence meet Cigna LifeSOURCE national guidelines for network inclusion. We provide our clients with the access they need for organ and bone marrow/stem cell transplantation while improving cost containment and reducing their financial risk.

LifeTrac

From its inception as a pioneer transplant network in 1988, LifeTrac has provided expertise to benefit payors and patients alike. Today, LifeTrac is a national network offering clinical support and access to hundreds of transplant programs at a select group of the world's leading transplant facilities. LifeTrac serves HMOs, TPAs, employer benefit plans, and major insurance, reinsurance and stop loss companies.

The LifeTrac Network was developed through the selection of transplant medical facilities that consistently demonstrate high case volumes, coupled with high patient survival rates. Each LifeTrac participating facility is carefully evaluated prior to network inclusion, and is re-evaluated annually to reconfirm the facility's ongoing adherence to LifeTrac participation standards.

Optum Health

Optum Health's Centers of Excellence networks are the gold standard in complex health care. Our original network, the Optum Health Transplant Centers of Excellence network, was developed in 1986 and has grown to be the largest network of its kind in the world - managing more than 11,000 transplant referrals each year. Today, we offer products and services that promote safe, successful and cost-effective treatment options for many other complex medical conditions, including cancer, congenital heart disease and infertility.

INTERLINK

INTERLINK Health Services Inc. provides the nation's leading outcome-based transplant network. By reviewing performance indicators of transplant centers from all over the country, we have identified the benefits of receiving transplants at medical centers with proven experience and outcomes. INTERLINK clients access the network to decrease overall health plan transplant costs through improved transplant outcomes. There is a well known association between experienced transplant surgical teams and improved surgical outcomes. INTERLINK seeks to improve transplant quality for its membership through a regimental outcome review process.

INTERLINK has formed this "Centers of Excellence" style network for its clients to access.
The next frontier in medical management is in Complex Care. A serious and complex condition is somewhat hard to define in words and its one reason why so few organizations are even attempting to tackle it. HealthSCOPE Benefits sees serious and complex conditions as persistent and substantially disabling or life threatening, requiring treatments and services across a variety of specialties of care. These conditions need multi-disciplinary treatment to ensure the best possible outcomes for each unique patient or member.

3.C.14 Outline the various fee schedules your company utilizes for at risk business vs. standard ASO arrangements.

5 points

HealthSCOPE Benefits/Employers' Health Choice:

We would use a fee schedule at a % of Medicare for at risk and standard business.

HSTechnology Reference Based Pricing:

Not Applicable to HST

3.C.15	Describe your company's program and processes in place to systematically evaluate participating providers for: • Cost **HealthSCOPE Benefits/Employers' Health Choice:** **We use HSB DataSCOPE™ to evaluate providers on cost and utilization. We review providers based on their cost and quality.** **HSTechnology Reference Based Pricing:** **All Medicare and cost-plus schedules updated as released for VBP plans.** • Utilization **HealthSCOPE Benefits/Employers' Health Choice:** **We use HSB DataSCOPE™ to evaluate providers on cost and utilization. We review providers based on their cost and quality.** **HSTechnology Reference Based Pricing:** **VBP UM firms measure against national norms and any plan standards**. • Cooperation with administration **HealthSCOPE Benefits/Employers' Health Choice:** **We review provider for compliance annually.** **HSTechnology Reference Based Pricing:** **HealthSCOPE Benefits & HST are preferred partners and work mutually to ensure client satisfaction.** • Member services satisfaction **HealthSCOPE Benefits/Employers' Health Choice:** **We can administer surveys to measure provider satisfaction.**	5 points

3.C.16 Describe your company's objectives regarding provider relations, including training, and the structure in place to support these objectives. **HealthSCOPE Benefits/Employers' Health Choice:** **HealthSCOPE Benefits' provider service and engagement representatives build and enhance the relationships with providers and office staff by assessing their needs and providing knowledgeable, responsive service. This allows providers to focus on their patients' health.** **Training for new representatives includes a role-specific onboarding process, required attendance at an instructor-led new hire session, mentoring, and direct study with supervisory and experienced staff. Our new hire curriculum includes topics such as systems training, customer service, privacy requirements of HIPAA, policies and procedures, and issue resolution. The representative's manager monitors course progress.** **Our five representatives in Arkansas allow for the staffing to have good relationships.**	5 points
3.D Quality Assurance/Management	
3.D.1 Describe your plan for developing and implementing a quality assurance and improvement program. **HealthSCOPE Benefits strives to improve the health, well-being, and sense of security of the members served. We accomplish this through an integrated approach to health care quality and affordability and by providing relevant information to health care professionals to engage them in achieving superior clinical outcomes that exceed industry standards. The quality and medical management program promotes and supports systematic assessment and continuous quality improvement.** **The Quality Assurance Department is a stand alone department outside of the claim and customer service areas. However, the three departments work very closely to achieve quality initiatives.** **Responsibilities of our quality assurance department include:** **• Detect and document inappropriate procedures** **• Detect instances of fraud and abuse** **• Research and report on nationally accepted medical protocols and insure that they are consistently applied to claims data to identify deviations from the guidelines** **• Review Policies and Procedures for each department. Document deficiencies** **• Develop the problem solving process to follow when the reviews show the department is out of acceptance range** **• Develop preventive measures that can be used by properly trained staff** **• Investigate what should be included in training, to include what determines the need for training** **• Identify what quality assurance policies and practices the department has in place or is developing for assuring the quality of its performance** **• Identify any procedural or financial errors causing failures to meet performance guarantee**	5 points

3.D.2 Describe how you will look for opportunities for quality improvement and implement corrective action. **In partnership with our contracted network providers, we endeavor to establish a collaborative working relationship that facilitates quality patient care and services. Program activities used to achieve this goal demonstrate the commitment to quality through establishing policies/guidelines, monitoring performance against the policies/guidelines, and identifying opportunities for improvement.** **Program activities that demonstrate our commitment to provider quality include the following:** • **Credentialing and Re-Credentialing - Participating providers undergo a review of their qualifications, licensure status and liability insurance coverage in accordance with industry standards.** • **Performance Measurement – HealthSCOPE Benefits provides practitioners with feedback about their quality and cost-efficiency.** • **Member Complaints – Our customer care area reviews any provider related complaints about network providers.**	5 points
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. **HealthSCOPE Benefits has a variety of committees that oversee quality and medical management functions. These committees ensure we perform program activities in a way that demonstrates overall program effectiveness and meets organizational quality, health coverage, and medical management goals and objectives.**	5 points
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. **We use several analytical tools and evidence-based medicine (EBM) measures to profile doctors, compare practice patterns, and monitor cost and utilization. These tools account for clinical patient population differences and help identify opportunities for improvement.** **We utilize several tools as indicators to assess participating doctors. Among these:** **National Committee for Quality Assurance (NCQA) Physician Recognition** **adherence to EBM rules** **group board-certification** **American Board of Internal Medicine Process Improvement Module completion**	5 points

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). **As mentioned, we use several tools to profile doctor quality, track and compare practice patterns, and monitor cost and utilization on an ongoing basis. These tools account for clinical patient population differences and help identify opportunities for improvement.** **These tools assist HealthSCOPE Benefits to:** • **identify trends that assist with contracting or medical management to manage health care professional networks;** • **identify potential best practices and benchmark members or groups;** • **identify doctors who are high and low outliers;** • **identify quality-of-care issues by targeting under care situations and tracking specific clinical conditions from episode-of-care results; and** • **conduct consultative sessions with doctors to help them understand the results, how they vary from their peers, and how they can improve or where they exceed.**	5 points

	b. Appropriateness of care (e.g. inpatient critical path audits, HEDIS, Accountable Care Organizations). **We collect data from the records of health care professionals as well as claims systems for HEDIS® reporting. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health care delivery on an apples-to-apples basis.** c. Customer/patient service (e.g. site visits or member surveys). **Confirmed, we do conduct member and/or provider satisfaction surveys. Surveys questions and timing are customized to the individual customer.** d. Referral patterns (e.g. PCP tracking of specialty care referrals, use of specific therapies). **Using episode-of-care data, HealthSCOPE Benefits determines how a doctor group's cost efficiency compares to other groups of the same specialty type (PCP, mixed specialty, multispecialty) in the same geographic market. A doctor or doctor group's performance is a result of its fee schedule, utilization patterns, and referral patterns.** e. Administrative compliance (e.g. documented irregularities in procedure). **We use the compliance rates produced from the HEDIS audits as a measure of the quality of care delivered in the network. We evaluate, analyze, and use the results in a variety of ways to improve the quality of care provided to members (data is never shared that is identifiable, and rates are produced in aggregate).** f. Over-utilization of testing/diagnostic services. **As mentioned, we utilize several analytical tools to profile doctor quality, track and compare practice patterns, and monitor cost and utilization.**	
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) **In partnership with our contracted network providers, it is our goal to establish a collaborative working relationship that facilitates quality patient care and services. Program activities used to achieve this goal demonstrate the commitment to quality through establishing policies/guidelines, monitoring performance against the policies/guidelines, and identifying opportunities for improvement. We consult with doctors to help them understand the results, how they vary from their peers, and how they can improve or where they exceed. The frequency depends on the reason for the outreach.**	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. **HealthSCOPE Benefits has a long history of commitment to quality across programs and services. Monitoring and driving improvements in quality of care and service to members is an integral component of the overall quality management program, which reflects our commitment to continuous quality improvement.** **Our participating health care professionals agree contractually to comply with nationally recognized standards of care. We review and discuss opportunities where costs may be higher than the norm or quality may be lower than peers or the norm.** b. Specific steps followed to rectify a provider quality problem. **Currently, the health care professional services team monitors and investigates every quality-of-service complaint. We will select complaints for a follow-up site visit at the doctor's service location to conduct a site assessment. HealthSCOPE Benefits will inform doctors who do not meet the site visit review requirements of the corrective action needed and monitor until the deficiency is corrected.** **In some instances, a nurse identifies an apparent deviation from the standard of care, based on evidence-based protocols; the nurse brings this to the attention of our medical director, who will then engage a treating doctor to initiate a peer-to-peer consultation upon the reporting of care deviations.** c. Description of programs available for assisting providers in improving effectiveness and efficiency. **In partnership with our contracted network providers, we endeavor to establish a collaborative working relationship that facilitates quality patient care and services. Program activities used to achieve this goal demonstrate the commitment to quality through establishing policies/guidelines, monitoring performance against the policies/guidelines, and identifying opportunities for improvement.** **We use several tools to profile doctor quality, track and compare practice patterns, and monitor cost and utilization on an ongoing basis. These tools account for clinical patient population differences and help identify opportunities for improvement.** 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

	The quality management department evaluates information gathered/received in the investigation of a quality-of-care complaint/adverse event. If escalated, the committee reviews and assesses cases upon referral and identifies follow-up actions that may include the following: • **take no action based upon review** • **conduct further investigation as needed** • **recommend that additional monitoring or corrective action is necessary to maintain credentials in network** • **develop action plan and monitor** **Appropriate follow-up with the member is conducted following the review.**	
3.D.8	State the percentage of physicians who are credentialed prior to contracting (including physicians with leased health plans). **HealthSCOPE Benefits credentials 100 percent of health care professionals in the Employer's Health Choice network.**	5 points
3.D.9	Describe any formal, written credentialing/re-credentialing standards for general medical and surgical hospitals. If applicable, provide a copy. **To ensure the highest quality of care for members, we screen health care professionals using national credentialing standards, which are based on NCQA and state-specific requirements. We collect and verify each health care professional's credentials during initial credentialing and again at re-credentialing.**	5 points
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. **HSTechnology Reference Based Pricing:** **The very nature of VBP plans allow for access to all hospitals. HST as a Hospital VBP plan does not track turnover in the ways of a traditional PPO Plan. HST annually experiences a facility acceptance rate of 98% nationally.**	5 points

3.D.11	How often is a provider's office visited for the purpose of credentialing/re-credentialing/verification of quality practice? **HealthSCOPE Benefits has a long history of commitment to quality across programs and services. Monitoring and driving improvements in quality of care and service to members is an integral component of the overall quality management program, which reflects our commitment to continuous quality improvement.** **Our participating health care professionals agree contractually to comply with nationally recognized standards of care. We review and discuss opportunities where costs may be higher than the norm or quality may be lower than peers or the norm.** **HealthSCOPE Benefits does not require onsite quality audits of health care professionals. We achieve commitment to the quality of the network health care professionals through a variety of activities, including ambulatory medical record review and office site visits for quality of service.**	5 points
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. **HSTechnology Reference Based Pricing:** **The very nature of VBP plans allow for access to all hospitals. HST as a Hospital VBP plan does not contract in the ways of a traditional PPO Plan. HST annually experiences a facility acceptance rate of 98% nationally.**	5 points

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 track and measure all HEDIS measures that can be captured on a claim including immunizations, screenings, and monitoring for non-Medicare populations.**	5 points
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). **We do conduct member and/or provider satisfaction surveys. Surveys are customized to the individual customer. We follow-up on all complaints to find a timely resolution. Results are communicated by the Account Manager as they are completed.** **Our latest results include:** **Member Satisfaction Survey:** **91.6% very satisfied** **• 3 areas of best score – Overall satisfaction, ability to answer questions, claims paid timely** **• 3 areas of lowest score – Understanding plan benefits, cost of plan premiums, requiring additional information** **• Steps to Improve – Completed member communications to improve member experience** **Client Satisfaction Survey Results:** **4.1 on a scale of 5** **• 3 areas of best score – Meets key event & deliverables, responsive to needs and issues, identify savings opportunities** **• 3 areas of lowest score – Provide additional process workflow documentation, provide additional issue resolution details; further define internal communications within client's benefit team** **• Steps to Improve – Additional workflow processes added, developed communication log to share with client**	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). **HealthSCOPE Benefits can administer surveys to measure provider satisfaction. We can do this if network requests. We currently conduct some client-specific surveys.**	5 points
3.D.16	Describe how the actual satisfaction results compare to your target performance goals for members and for providers. **Because we are working with self-funded plans we expect the values to vary for both members and providers based on what they think of the benefit plan offered by the employer.**	5 points
3.D.17	Explain what quality information is provided to members via different communication avenues: web page, mailing, on-site meetings, etc. **This varies by customer and how they wish to communicate it. Some provide on the web, others in mailings or onsite meetings.**	5 points
3.D.18	Detail your tracking and reporting of "never events". **We track and report never events based on the ICD-10 coding on the claim.**	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 Section III to review our data dictionary provided electronically.**	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. **We would send monthly files to verify eligibility with CMS.**	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.). **We offer a number of discount programs including the EPIC Hearing Health Care Program created by and for physicians and audiologists who are dedicated to improving patient care and providing high quality hearing services. Benefits EPIC has negotiated with the top hearing aid manufacturers, including lower prices on hearing aids and batteries, plus extended warranties, truly provide added value to your employees. Not only do programs from EPIC hearing healthcare demonstrate concern for your employees and their families, they also help you to more effectively attract and retain the best workers.** **Other discount programs include services for:** • **Acupuncture** • **Aromatherapy** • **Body care** • **Chiropractic** • **Foot care** • **Health club/fitness center membership** • **Laser eye surgery (e.g., LASIK)** • **Massage therapy** • **Smoking cessation classes** • **Stress relief** • **Yoga tools** • **Vision discounts** • **Weight loss program** • **Vitamins** • **Pet Insurance**	5 points

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. **All Medicare primary claims will be received through Change Healthcare no matter their origin.**	5 points
4 – ACTUARIAL SERVICES	
4.A Actuarial Experience	
4.A.1 Provide an overview of your data analysis capabilities in 750 words or less. **Innovative computing technology has been the key to our ability to provide cost-effective solutions to difficult problems. Since our founding in 1968, we have developed the tools needed to provide top-quality consulting to our clients.** **Over the years, we have** • **Developed a suite of Windows-based actuarial software to assist our consultants and outside actuaries in completing many of their activities in an efficient and effective manner.** • **Built a database of HMO and health insurer information has allowed us to build a data set that reflects the "real" costs in an area.** • **Developed the Lewis & Ellis Health Care Cost tables and models, which are interactive tools that allow us to test changes in utilization, reimbursement, and benefits.** • **Assisted in the development of rate review software which enabled us and others to quickly analyze health insurance information for the state of Arkansas.** • **Utilized powerful statistical software, such as SAS and R, to handle large datasets, manipulate the data and perform stochastic simulations.** **Our team has the experience to handle large amounts of data and determine the best ways to analyze the data.** **We recognize that the creation of projections involves a lot of scenario testing and analysis. In testing "what-if" scenarios, if needed, we will utilize stochastic modeling software with specifically designed stochastic simulations to evaluate the economic and financial impact of all alternatives analyzed. The use of stochastic simulations can bring value to the projections since we and the EBD easily can evaluate the results of alternative assumptions on a statistical basis.**	5 points

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

State of Ohio, Department of Administrative Services

Since 2012, L&E has been assisting the DAS with Health Benefit Fund, Disability Benefit Fund and the Accrued Leave Fund. Our services have included for each fund have included the following:

- **Review of the Fund's financial activities;**
- **Analysis of the adequacy of contribution rates;**
- **Establishment of the estimated liability for health claims that have been incurred but unpaid ("claim reserve") as of the fiscal year end; and**
- **A projection of the expected contributions and claims.**

The health benefit fund has approximately 115,000 members.

Louisiana Office of Group Benefits

L&E has been involved with the Louisiana OGB on through the Group Benefits Estimating Conference since 2016. The services have included

- **Providing oversight of the Office of Group Benefits health and life plans;**
- **Assistance with estimating the operational and actuarial costs of group benefits program;**
- **Assistance in the development, gathering, and presentation of group health and group life premium rates to the Office of Group Benefits and the Policy and Planning Board;**
- **Assistance in the development, gathering, and presentation of group benefits state planning and budgeting.**

The OGB has approximately 220,000 members.

Pension Benefit Guaranty Association

L&E has been the actuarial contractor on the financial audit team for the PBGC since 2005. The PBGC is the federal agency that guarantees private pension benefits. Currently, the PBGC pays benefits for approximately 840,000 participants in single-employer plans and provides monetary assistance to 72 multi-employer plans covering approximately 63,000 participants.

The scope of L&E's assignment includes opining on the reasonableness of the actuarial methods and assumptions utilized by the agencies' management, testing the accuracy of the actuarial liabilities included in the financial statement, opining on management internal control processes, and making recommendations for the improvement of management performance.

Centers for Medicare and Medicaid Services

Since 2007, CMS's Office of the Actuary (OACT) has engaged L&E to handle actuarial aspects of the bid desk reviews for Medicare Advantage (MA) and Prescription Drug Plan (PDP) plans. L&E assembled a team of qualified L&E actuaries, staff, and interns to perform the needed tasks of the high demand, short-task order period project (around 10 weeks). For approximately 1,500 MA and PDP bids annually, L&E analyzed and assessed the reasonableness of financial projections in consideration of

- **CMS' bid submission instructions,**
- **CMS' bid review guidelines,**
- **Actuarial Standards of Practice (ASOPs), and**
- **Professional judgment.**

The bid review period (approximately two months) is short, and thus intense due to the large number of bids for L&E to review. Nonetheless, L&E has been able to meet OACT-provided deadlines. There were no project delays by L&E. We also fulfilled CMS's frequent status report needs.

4.A.3 Describe your company's process for interfacing with a client, including the role of your company's actuary and/or consultant.

5 points

Communication and interfacing with the client is a critical process. L&E's communication strategy is to clearly identify the status and communicate the progress made toward a successful project outcome. The purpose of this strategy is to communicate pertinent discovery, design, and documentation in a clear and concise manner to the client and the project team.

The team will work with the EBD to develop a communication plan that addresses key stakeholders, key messages, frequency, and methods. L&E expects this plan to evolve over the course of the project to sustain a concise and consistent communication channel. Effective communication keeps stakeholders informed. It also builds consensus so stakeholders agree on what needs to be done, how to achieve the final goal, and how to gain commitment and support so everyone works towards the same goals and objectives.

The following are objectives of the communication plan:

- **Provide the EBD with access to project information;**
- **Establish and maintain effective two-way communication channels between the EBD and the project team;**
- **Enlist the necessary support and commitment to the success of the project;**
- **Describe the diverse types of information to be exchanged;**
- **Establish the methods used to gather, store, and distribute information; and**
- **Encourage involvement with stakeholders where necessary, in all stages of the project.**

Item	Purpose	Format	Frequency	Type	Initiator	Recipient
Status Reports	Provide detailed information on the progress of the project against the plan.	Email	Weekly	Mandatory	Primary Actuary	EBD
Status Meetings	Review the status report, resolve issues, and make decisions	WebEx Meeting	Weekly	Mandatory	Primary Actuary	EBD
Internal Meetings	Review project progress, resolve issues, and make decisions	WebEx Meeting or On-Site	Ad-Hoc	As-Needed	Actuarial Team	Primary Actuary
Project Deliverables	Provide deliverables to client for review	Email	Per Project Schedule	Mandatory	Actuarial Team	EBD
Deliverable Review Feedback	Written vetted, consolidated, and actionable comments	Email	Ad-Hoc	As-Needed	EBD	EBD
Meeting minutes	Documentation of meeting	Email	After each meeting	Mandatory	Primary Actuary	All Participants
Project issues	Documentation of project issues	Email	As needed	Mandatory	Primary Actuary	EBD Actuarial Team
Project issues escalation	To resolve project issues	Email	As needed	Mandatory	Contract Manager	EBD Project Director
Change requests	Document project changes to scope of work	Email	As needed	Mandatory	Contract Manager	EBD
Project closeout	Formal project closeout	Email	Per project schedule	Mandatory	Contract Manager	EBD

4.A.4	Outline your company's process for sharing information with EBD that pertains to Internal Revenue Code Sections. **HealthSCOPE Benefits' Legal and Compliance team subscribes to numerous compliance resources and conducts independent research to identify state and Federal laws that may impact our clients and employee benefits. Such laws are tracked and reviewed on no less than an annual basis. Any resulting changes are reported internally to the Board of Directors, executive leadership, and the Continuous Quality Improvement Committee to relevant stakeholders. We then prepare topic-specific communications and distribute to potentially affected external audiences. We agree in particular to provide communications concerning Internal Revenue Code changes that may impact your plan and employee benefits as well as to facilitate training via other communication channels (for example, recorded webinars).**	5 points
4.A.5	Outline your company's process for sharing information with EBD that pertains to ADA. **HealthSCOPE Benefits' Legal and Compliance team subscribes to numerous compliance resources and conducts independent research to identify state and Federal laws that may impact our clients and employee benefits. Such laws are tracked and reviewed on no less than an annual basis. Any resulting changes are reported internally to the Board of Directors, executive leadership, and our Continuous Quality Improvement Committee to relevant stakeholders. We then prepare topic-specific communications and distribute to potentially affected external audiences.** **As to ADA-specific information, we track updates on Title I of the ADA resulting from statutory changes (e.g., the ADA Amendments Act) and interpreting regulations (the 2009 EEOC proposed regulations, the 2011 EEOC final regulations, and 2016 EEOC final regulations regarding workplace wellness programs, as well as the federal district court's decision to vacate certain incentive provisions effective January 1, 2019). We especially monitor the EEOC's Compliance Manual, Chapter 3, Employee Benefits, and related guidance as to plan design, exclusions raising potential red flags, and wellness incentive rules.** **In the event of any change to a statute, regulation, or informal guidance, our Legal and Compliance team would prepare topic-specific communications, distribute to EBD, and work with EBD to facilitate training via other communication channels.**	5 points

4.A.6 Outline your company's process for sharing information with EBD that pertains to HIPAA. **Confirmed, HealthSCOPE Benefits understands and will comply with this requirement. HealthSCOPE Benefits is fully compliant with HIPAA's transaction, privacy and security standards. Our Legal and Compliance Department, privacy officers and security officers have completed intensive HIPAA training. In addition to ongoing monitoring, we also complete testing of procedures as part of our SSAE18 certification. It is also important to note that our Legal and Compliance Department is responsible for drafting and implementing policies concerning privacy/confidentiality with regards to protected client information. In addition to regular consulting in compliance issues, our team is available "on demand" to engage clients with real time issues. Brett Edwards, Senior Vice President of Solutions and General Counsel, leads our team, which consists of plan document and healthcare reform experts.** **HealthSCOPE Benefits currently complies with the practices identified above. HealthSCOPE Benefits' compliance with HIPAA's Privacy, Security, and Administrative Simplification Rules has been independently confirmed through HealthSCOPE Benefits' URAC accreditation, which requires demonstration of compliance of these rules as a necessary part of the accreditation process. Moreover, HealthSCOPE Benefits provides annual HIPAA training to its staff to ensure that its staff is aware of the newest regulatory updates and policy changes to apply during the performance of their duties. In addition to ongoing training, HealthSCOPE Benefits performs complete testing of its policies and procedures as part of its SSAE18 certification.** **At HealthSCOPE Benefits, we believe that compliance with the HIPAA rules is an active process rather than a passive one. While HealthSCOPE Benefits plays a large role in that compliance, we know that compliance with HIPAA rules extends far beyond our reach. For that reason we are committed to helping our clients through our robust initiatives for client, member, and provider education. At some clients' request, we have even performed onsite and remote HIPAA trainings to ensure that information is properly protected in both storage and use, not only at HealthSCOPE Benefits' facilities, but at our client's facilities as well. We believe that this type of close attention to detail is a fundamental step in achieving our goal of Total Health Management.**	5 points
4.A.7 Outline your company's process for sharing information with EBD that pertains to other regulatory issues or laws. **HealthSCOPE Benefits fully supports our clients in compliance and legal support in these arenas. In addition to regular consulting in compliance issues, our team is available "on demand" to engage clients with real time issues. Brett Edwards, Senior Vice President Legal and Compliance, leads our team, which consists of plan document and healthcare reform experts.** **HealthSCOPE Benefits subscribes to numerous compliance resources that provide regular daily and weekly updates on changes in state and federal law and regulation in connection with health and welfare benefit issues, cafeteria plan issues, employer-employee issues, and issues directly related to the business of providing claims administration services. All changes in the statutory or regulatory requirements are communicated via two compliance publications published by HealthSCOPE Benefits:** **Healthy Business (published and distributed to our customer on an "as needed" basis).** **A quarterly newsletter entitled Healthy Futures. In addition, HealthSCOPE Benefits will prepare Summary Plan Descriptions, plan documents and amendments on an "as needed" basis. Amendments/summary of material modifications are prepared whenever there is a statutory/regulatory change that impacts the plan sponsor's health plan.**	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). **Please refer to Section IV to review a sample legislative communication piece.** **HealthSCOPE Benefits has an in-house legal team consisting of four attorneys and two legal analysts. We also subscribe to numerous compliance resources that provide regular updates on changes in state and Federal regulations in connection with health and welfare benefit issues, cafeteria plan issues, employer/employee issues, and issues directly related to the business of providing claims administration services. Our Compliance Official, who is a separate individual from our General Counsel, reports to HealthSCOPE Benefits Board of Directors and Continuous Quality Improvement Community to disseminate regulatory updates as appropriate to internal stakeholders. All attorneys are active in their respective bar associations especially in the areas involving employee benefits.** **Client communications involving statutory or regulatory requirements are communicated via the following two compliance publications distributed by HealthSCOPE Benefits.** **Healthy Business (published and distributed to our customer on an "as needed" basis).** **A quarterly newsletter entitled Healthy Futures. In addition, HealthSCOPE Benefits will prepare Summary Plan Descriptions, plan documents and amendments on an "as needed" basis. Amendments/summary of material modifications are prepared whenever there is a statutory/regulatory change that impacts any plan sponsor's health or tax advantaged account-based plan.** **HealthSCOPE Benefits fully supports our clients in compliance and legal support in these arenas. In addition to regular consulting in compliance issues, our team is available "on demand" to engage clients with real time issues. Brett Edwards, Senior Vice President of Solutions and General Counsel, leads our team, which consists of plan document and healthcare reform experts.** **Other in-house attorneys include Allison Langston, Eric Moore, and Dan Honey, all Legal Counsel for HealthSCOPE Benefits.** **Finally, our team also includes, Mike Castleberry, Senior Vice President of Network Services & Business Development, who lobbies at both the federal and local level on issues impacting our self-funded clients. Mike is a regular speaker on healthcare reform.**	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 **At HealthSCOPE Benefits, we believe compliance starts with the plan's documentation. On-staff attorneys are available to draft our clients' plan documents/summary plan descriptions using the most current language to administer our clients' plan designs while maximizing our ability to help our clients control their healthcare spend. The drafting process is interactive with each client to ensure the document fully addresses the client's needs and undergoes numerous internal reviews, including by our Stop Loss department, to ensure no gaps in coverage exist. In addition to clients' plan documents/summary plan descriptions, we offer drafting services for the Summary of Benefits and Coverage ("SBC") for each individual plan that our clients offer.** **Beyond plan documentation, our compliance team offers numerous other services to support our clients, including the generation, printing, and mailing of Part D Creditable Coverage, WHCRA, and CHIPRA notices, as well as the Notice of Privacy Practices** **Brett Edwards is Senior Vice President of Solutions and General Counsel for HealthSCOPE Benefits. In this capacity, Mr. Edwards is responsible for corporate legal and compliance matters. Mr. Edwards also helps HealthSCOPE Benefits' clients design, administer, and defend, effective, legally compliant strategies for creating innovative health and other employee benefit plans, products, and processes. Prior to joining HealthSCOPE, Mr. Edwards worked in the legal compliance training field with a focus on employment law. During law school, he clerked for the Federal Aviation Administration, where he assisted with drafting federal regulations, as well as for a law firm with an emphasis on general business law and corporate transactions.** **Mr. Edwards regularly speaks at conferences on issues related to healthcare reform. He holds a Bachelor of Science degree from Georgetown University and a Juris Doctor degree, cum laude, from the American University Washington College of Law, both in Washington, DC. Mr. Edwards is licensed to practice law in New York and is a member of the Employee Benefits Committee of the American Bar Association and the Health Law Committee of the Association of the Bar of the City of New York.**	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.) **Our Account Manager would deliver methods of achieving various benefit objectives and methods of proposing changes to the Plan during normal quarterly meetings.**	5 points
4.A.11 Describe who prepares presentation materials (i.e. actuary, consultant, etc.). **Presentation material is prepared by both the actuary and the consultant. The team is highly adept at communicating technical subject matter to non-technical audiences. Our clients frequently call on us to provide consulting and briefing support to educate non-technical stakeholders involved with our projects. Our professionals possess an unmatched blend of oral and written communication expertise.**	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 **HealthSCOPE Benefits' Legal and Compliance team subscribes to numerous compliance resources and conducts independent research to identify state and Federal laws that may impact our clients and employee benefits. Such laws are tracked and reviewed on no less than an annual basis. Any resulting changes are reported internally to the Board of Directors, executive leadership, and the Continuous Quality Improvement Committee to relevant stakeholders. We then prepare topic-specific communications and distribute to potentially affected external audiences.**	5 points

4.A.13 Describe quality control policies and procedures for your company. **The primary actuary will provide oversight and ensure client satisfaction by conducting frequent communications with the project stakeholders. L&E believes that this approach routinely prevents small issues from becoming large obstacles to project success.** **The primacy actuary is responsible for understanding project requirements and client expectations. A preliminary internal project meeting includes a discussion of task assignments to clarify the scope of work and how it will be accomplished. The team's understanding of scope, cost, procedures, deliverables, and schedule is documented in the project management plan for EBD's approval.** **All work elements are completed in a manner in accordance with the EBD's requirements. Before the project begins, the program manager ensures all team members understand the project's requirements and quality control processes. This awareness is maintained throughout the duration of the project.** **All deliverables receive a proactive review before final submittal to the client. It is our policy to have all actuarial analyses peer-reviewed by a qualified actuary. Our reports will undergo both a technical and consulting peer review. The technical review consists of a detailed "double-checking" of the inputs, calculations, and formulas used in our analysis. While no company can completely eliminate errors, this process serves to reduce significantly the potential for problems in this area. This review involves the examination of the analysis for appropriateness of methodology, clarity of presentation, and the reasonableness of the overall results.**	5 points
4.B Methodology	
4.B.1 Detail your approach and methodology for analyzing claims experience as it relates to multiple Plans. **We typically see "plans" and "benefit options" used interchangeably. We will address the plans (e.g., ASE, PSE) and benefit options (e.g., premium, classic, basic), separately to make sure we address your question.** **For the two Plans (ASE and PSE), we will maintain separate reporting. There may be instances where it is advantageous to look at the experience of both plans combined, but in most cases, the claim analysis will be done separately.** **Multiple benefit options introduce additional considerations. Multi-choice environments lead to selection issues. Selection by employees can be favorable or unfavorable (e.g., antiselection). If one or more plan option experiences favorable selection, then the remaining plans will have unfavorable selection.** **To monitor selection issues, it is important to review the experience on a more detailed level. For example, we will review the experience for each plan option, compared to the rates. In addition, we can compare the claim experience to manual rates which are based on industry expectations for the benefits provided.** **As an example, if Plan A's claim experience 1.5 times higher than Plan B, but the rates for Plan A are only 1.25 times more, then there is a disconnect between the claims and the rates of Plan A and Plan B. If we expect Plan A to have claims that are 1.3 times higher than Plan B, based on manually rates, but the actual claims are 1.5 times higher, this indicates that there is likely some antiselection with Plan A.** **This type of analysis can be done based on other rating characteristics where employees have a choice, such as coverage tiers (e.g., employee only, employee & spouse, employee & children, and family).**	5 points

4.B.2 Detail your approach and methodology for identifying and producing necessary reports. **We approach each project with a fresh and open mind. While the actuarial team members have planned, implemented or researched health studies and projections for many clients, we also believe that each client is unique. The actuarial team will be able to leverage the resources utilized in previous efforts and will be able to conduct additional research to identify and incorporate information from work done on those relevant projects to build the necessary reports.** **The actuarial team will utilize all relevant research and studies from the EBD, newly collected information, research organizations, and from other research efforts to incorporate that information to create comparisons and benchmarks as appropriate.** **Above all, it is important to provide information that is relevant, necessary, and useful to our clients. The five primary steps, which will be completed in conjunction with EBD input, include:** **1. Identify outcomes and develop performance measures.** **2. Create and implement an information collection plan.** **3. Analyze the information.** **4. Communicate the results.** **5. Reflect, learn, and do it again, if necessary.**	5 points
4.B.3 Detail your approach and methodology for monitoring the performance of the Plans. **Effective monitoring of the claim experience is essential to a success of the Plans. Key areas that we typically monitor include** • **Reconciliation of claims databases, financials and projection models.** • **Claim-to-premium equivalent ratios for each Plan, benefit option, and enrollee type (e.g., active employees, pre-Medicare retirees, and Medicare retirees).** • **Comparison of actual-to-budgeted claims and expenses.** • **Comparison of changes in health status, demographics.** • **Medical and pharmacy trends.** • **Development of incurred but not reported liabilities and evaluation of the adequacy of prior estimates.** • **Monitoring of utilization trends – in the aggregate, by plan, by benefit option, by type of service, etc.** • **Monitoring of large claims.**	5 points

4.B.4 Detail your approach and methodology for calculating incurred but not reported (IBNR).	5 points

Claim reserves and liabilities are amounts set aside to cover future payments for claims which have been incurred under the contract, but which have not yet been paid.

To calculate the liabilities, we will use the development (or completion factor) method, where factors are computed which "complete" the current period-to-date payment totals for each incurral month to estimate its ultimate expected pay-out. The reserve is then calculated by subtracting the claims that have already been paid from the calculated expected incurred claims. For the most recent incurral months, completion factors can be highly variable and adjustments are usually necessary. Various methods, based on developing an historical claim rate as a function of membership or an anticipated loss ratio are used to estimate the incurred claims for recent incurral months.

- **Other considerations that will be made in identifying emerging trends are**
- **Demographic changes and morbidity shifts in the population,**
- **Changes in benefits,**
- **Changes in provider reimbursements and medical management,**
- **Seasonality in claims costs, particularly with high-deductible health plans,**
- **Changes in claims processing, and large catastrophic claims.**

We have developed a proprietary IBNR model that is flexible and allows for analysis of each of the items above.

L&E is recognized as one of the actuarial leaders in IBNR methods. In 2009, we performed an evaluation of IBNR methods for the Society of Actuaries The study is still the most recent performed and is available here: https://www.soa.org/files/research/projects/research-ibnr-report-2009.pdf

4.B.5	Detail your approach and methodology for calculating other post employee benefits (OPEB) Liability.	5 points

GASB Statements 74 and 75 require plans and employers to recognize the expense for OPEB over the working lifetime of its covered employees. L&E will develop benefit obligation liabilities for those benefits as specified by GASB 74 and 75, including the Total OPEB Liability, Net OPEB Liability, the OPEB Expense, and specified disclosures for the valuation year.

To calculate the liabilities, we project post-employment benefit costs for current retirees and current active employees who may retire in the future. The projection includes all post-employment benefits made available to the Sponsor's retirees. The projection considers the likely cost of future benefits, and the expectation of survival of retirees, employees and dependents to receive such benefits. The projection also includes expected expenses (if any) and retiree contributions.

The statement requires the projections to be based on age-adjusted claims for retirees because medical costs increase with advancing age. Therefore, the claim costs for the retiree group are higher than the claim costs for the employee group, even taking Medicare into account. Stated another way, when a plan includes both employees and retirees, the blended premiums are almost always higher than what the premiums would be for employees, and lower than what the premiums would be for retirees, if each group were rated separately. The premium rate difference is referred to as the implicit rate subsidy.

To comply with the standard, we compute the underlying cost for retiree coverage by imputing an age-dependent claim cost for our projections. We do that by analyzing the risk characteristics of the entire covered group (employees, dependents and retirees) and applying those in the aggregate to the carrier premium schedule.

If a benefit program is self-insured, the projection of the benefit costs is a composite of the expected claims, stop loss premiums, and administrative expenses for each covered individual from the valuation date to the end of the benefit period. Stop loss premiums and expenses are usually known for the coming fiscal year. For the expected claims, we determine an average claim cost from claim and enrollment records, adjusted for the risk characteristics of the covered group and trended to the valuation date.

To develop the total expected benefit costs for each year in the projection, we adjust those values for inflation and for the risk factors for each covered family. If benefits are paid after eligibility for Medicare, then we carve out those benefits that Medicare will cover.

All of our projections are based on assumptions with regard to the survival of plan members, the average per-capita claim costs, and so forth. Those assumptions are disclosed in the appendices attached to our report. One of the most important assumptions is the discount rate, which is used by the model to compute the present value of future post-retirement benefits. The higher the discount rate, the lower the present values, and therefore the OPEB cost.

Another key assumption for the determination of the plan liabilities is the expected survival of current employees and retirees. We develop age-dependent employee turnover and retirement rates based on the group's experience and expectations, and use current industry mortality tables. From these we create a model that calculates the probability that each member will survive to retirement, elect to participate in the plan, and receive benefits over their life expectancy.

The liability (present value of benefits) for each enrollee is simply the sum for each future year over his/her life span of the product of three values:

- **The interest discount factor for that year**
- **The expected cost of benefits (net of retiree contributions) in that year**
- **The probability of receiving retirement benefits in that year**

Our actuarial model allocates a portion of each employee's and retiree's present value to the current fiscal year. The methodology of that allocation is called an "Actuarial Cost Method." GASB 74 and 75 require the use of the "Entry Age Normal" cost method.
Our OPEB valuations provide all of the required disclosures for the financial statement under GASB 74 and 75.

4.B.6	Detail your approach and methodology for auditing network/provider contracts and network adequacy. **Network administration is the core business for HSB. We have in-house experts in Network Administration, Provider Negotiation/contracting and Provider Relations. In addition to employer specific criteria and objectives, we have specific Network benchmarks that we evaluate in the areas of employee satisfaction, employer satisfaction, network provider adequacy, and network contracting/pricing adequacy and TPA adequacy/efficiency.** **Additionally, we have proprietary processes such as PPO Complete, to evaluate adequacy, predict savings and implement preferred provider organizations. HSB's information systems, such as the Cactus Provider Relations database, integrates all aspects of Network Administration. Our organization has extensive infrastructure in place today to provide Network Administration.** **We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm. Mullally Associates reviews 2% of all claims processed on an ongoing basis. We have done this so that our audits are fully independent and there is no "fox watching the hen house." We want all of our clients to know and trust that someone other than our own internal staff has been reviewing and reporting on the statistics. We are confident that this process sets us apart from the majority of our competitors.**	5 points

4.B.7 Detail your approach and methodology for risk assessment and ongoing risk management. **The risk management plan outlines the process to identify and analyze the effects of uncertainties on the project. Risk management allows actions to be taken to reduce or eliminate the negative consequences of any event that may affect the success of the project. This plan establishes a framework of working practices, which enables project team members to identify, analyze, respond to, monitor, and communicate risks before they become issues and jeopardize the success of the project. If a risk becomes an issue, L&E will work with the State and project team to assess its impact on the project and assign responsibility for issue resolution, including a target date for resolution.** **According to the Project Management Institute's Guide to Project Management Body of Knowledge, risk is defined as "an uncertain event or condition that, if it occurs, has a positive or negative effect on a project's objectives." There is a cause and effect to project risk; each risk has a cause and a consequence if it occurs. Every project carries some element of risk, and it is probable that progress will deviate from the plan at some point in the project lifecycle. Risks can be cost related, organizational, external, or technical. To control risks and prevent them from negatively impacting the project, the risks will be identified and tracked. Risk owners will develop response plans designed to prevent negative impacts and contingency plans that can be executed if the risk occurs. When assessing the risk, the project manager will:** • **Assess the risk probability. This step involves determining the likelihood of a risk occurring and directly affecting the success of the project; and** • **Assess the risk impact as it pertains to each of these project categories: schedule impact, scope (change management) impact, and cost impact.** • **Response options include:** • **Risk Mitigation: actions taken to diminish the chance of the risk occurring;** • **Risk Avoidance: actions taken to 'work around' the risk;** • **Risk Acceptance: the act of taking no action and accepting the consequences of the risk should it occur; and** • **Risk Transference: the act of giving the risk to a party outside the project.** **The contract manager monitors and updates risk triggers, exposure levels, and risk response actions and reports on these activities on an ongoing basis. Risk triggers are identified during the risk analysis process and are early warning signs that a risk event could occur.**	5 points
4.B.8 Detail your approach, methodology and strategy for Plan(s) design. **Each client is unique. We monitor plan design and continually review it based on utilization, emerging technology and provider billing practices.** **Effective plan design is critical to providing cost-effective coverage, yet high quality health care. L&E has extensive experience in assisting employers with plan design and plan changes. We work with our clients to determine plan designs that fit the group's philosophy for providing benefits for their employees. We understand that there are many factors, in addition to cost, that come into play when our clients consider plan changes, such as political and competitive pressures.** **We utilize data mining techniques and analysis to provides invaluable information and insight in to utilization trends and identify areas where changes may want to be considered.** **We model the impact of benefit changes and new plan designs with the Lewis & Ellis Health Care Cost Models. This analysis allows our clients to make informed decisions.**	5 points

4.B.9 Detail your approach, methodology and strategy for premium evaluation and determining premiums.	5 points

Our typical approach for premium evaluation is a prospective rating methodology in which past experience is evaluated and adjusted to project future experience.

The starting point is the aggregated past claims of the group, typically over a one-year period. The claims can be aggregated for separate segments, such as ASE/PSE, Active/Pre-Medicare Retirees/Medicare Retirees, and/or benefit options. Care needs to be taken not to segment the claims to the point of losing predictive power, but enough to capture the unique differences of each segment.

Claims above a certain threshold are reviewed and may be excluded from the analysis, which helps dampen the impact of statistical fluctuations caused by catastrophic claims.

We also consider the credibility, or predictive power, of the past experience. When a group's experience is not fully credible, we will blend it with manual rates that are developed from the Lewis & Ellis Health Care Cost Models. In the case of the ASE and PSE plans, there are likely enough members and claims experience within each segment that credibility is not a factor.

Once the claims have been aggregated, they are divided by an exposure base (typically employee or subscriber counts), to get the cost per employee or subscriber.

The next step in the process is the adjustment of the historical experience to arrive at expected future experience. The following adjustments are considered.

- **Utilization and cost trends in medical care;**
- **Changes in demographics of the members (e.g., age, gender, geography);**
- **Changes in benefit designs;**
- **Changes in enrollment between benefit options when there are multiple benefit options;**
- **Changes in the economy or financial environment;**
- **Changes in government regulations which impact the cost of benefits (e.g., ACA changes); and**
- **Any other changes that may benefits or the cost of benefits.**

Gross rates are developed by adding projected claims, administrative expenses, any explicit margins for unexpected adverse experience, and any necessary charges to help build contingency reserves.

The adjustment for utilization and cost trends is typically an important assumption. We develop expected trend amounts by reviewing the Plan's experience, using regression analysis, and the change in rolling-averages. We also consider industry expectations.

The development described above is done at an aggregate level to determine the overall change in rates that is necessary. The next step is to consider the relative rate levels for the benefit options, coverage tiers (e.g., employee only, employee and spouse, family), and other components of the rate structure. The rate levels are compared to historical claims to identify possible subsidization within the rating structure. While there may be times when subsidization is desired, it's important for it to be intentional and understand all the implications.

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. • **Wellness program analysis, including analysis of health assessment screenings in conjunction with claim levels.** • **Stochastic modeling (e.g., Monte Carlo Simulation) of large claimants and other financial and utilization projections.** • **Predictive modeling based on medical and pharmacy data.** • **Medicare Advantage and Medicare Part D plan pricing.**	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. **Eligibility is reviewed based on data received daily from EBD.**	5 points

5.A.2	Describe your process for rendering a decision of pre-authorization requests in a timely manner. **Once benefits are verified, our process will be completed by a team dedicated to the State. First, an intake coordinator will create a case within our iSuite platform based on the service request. iSuite is our proprietary and completely integrated medical management software. If the request is received via phone and the caller is able to provide necessary clinical information at that time, the call will be transferred to a Utilization Review nurse who will transcribe the clinical information provided by the caller, compare the clinical to MCG Health, LLC criteria or Aetna Clinical Policy Bulletins and determine whether medical necessity can be established. If the nurse is able to establish medical necessity, the provider will be informed at that time of the authorization and will be provided a case reference number.** **If the nurse is unable to establish medical necessity, the case will be referred to a physician reviewer from within the iSuite system, and the caller will be advised. Once the physician has completed the review, the determination will be returned within iSuite. The nurse will review the determination and issue letters, in the case of an adverse determination, all from within iSuite. If a provider wishes to submit a pre-authorization request via fax, it will be received on a dedicated fax server and sent, within iSuite, to an intake coordinator, who will build the case based on the service request and attach the fax directly to the case. This will automatically generate a 'task' to alert the Utilization Review nurse to the need for clinical review. This review will be completed using the same steps as requests received via phone.** **We are able to move through the medical necessity review process in a more efficient manner by working completely within iSuite. All documentation and communication related to a member is located in one place. This allows our team to more quickly access all information related to a member. Without the need to manually scan and attach faxes or create letters manually or in another system, administrative time is saved, which allows American Health to render pre-authorization decisions in a timely manner.**	5 points
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. **A member would communicate their need for continuation to a CCR. The CCR would document, request additional documentation and send to our Specialty CM unit for review and approval.**	5 points
5.A.4	Describe your plan for Provider submission of pre-authorization requests. **Providers can call in, submit online or fax all pre-authorization requests.**	5 points
5.A.5	Describe your plan for implementing and maintaining an electronic log of all Adverse Benefit Decisions. **All Adverse Benefit Decisions will be houses in an electronic log updated daily.**	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. **Our experience serving the EBD population makes us uniquely qualified to understand community resources that may be helpful for members with special needs. As part of assessing each member enrolled in Case Management and/or Disease Management, our nurses identify needs and potential gaps that may be addressed locally. As part of the implementation process, we would work closely with EBD to ensure appropriate programs are identified and entered into our system as a referral source for members. Additionally, we look for opportunities to refer to external EBD programs that may be of value to the member.** **American Health's core services focus on patient advocacy by helping members access the appropriate services to help manage their quality of care. Our utilization review nurses ensure the most appropriate care is provided with the use of national clinical criteria and evidence-based guidelines, which protects the member from unnecessary procedures and charges.** **Our case managers are assigned to cases with a focus on nursing expertise in specialties such as oncology, transplant, pediatrics, behavioral health, medical/surgical and rehabilitation. Resources are identified and explored based on the member's individual needs and are enhanced by the experience and expertise of our Case Management team. Resources may include, but are not limited to, the following: identification of co-pay assistance or manufacturer reimbursement programs for specific drugs, low cost meals and transportation, utility assistance, counseling and respite services and disease-specific resources/support groups.** **Our nurse health coaches empower members to become their own health care advocate. They will also provide education related to community resources available to members to help them meet their specific needs. In addition, our 24/7 Nurse Line lends itself to patient advocacy, as nurses can assist State members with basic health information and are available 24 hours a day, seven days per week to provide decision support.** **All resources referenced by our nurses are available on a common internal site; the nurses also network to share available resources. All sources are reviewed by our clinical director to ensure they are reputable prior to being added to the database accessed by the nurses.**	5 points

	As an example, one of our many experienced case managers, through our standard process, researched resources available to assist a member financially while dealing with an illness and treatment. The nurse accessed a national cancer foundation database in search of financial assistance opportunities, located a link to the Cancer Financial Assistance Coalition and was further directed to opportunities within the member's community. The case manager was able to work with the member's family to apply for a grant to cover a mortgage payment. The grant was approved, and the family was extremely grateful as this lifted a large burden. In addition, our case manager assisted the member's family with obtaining co-pay assistance for some of the member's treatments. **In addition, American Health's Pre-Admission and Post-Discharge Counseling programs can assist in the decision support process. These programs are designed to avoid complications and address readmission rates by providing education to members admitted for inpatient procedures. Our experienced case managers make calls to members before and/or after their inpatient admission to discuss their procedure and prepare them for admission and/or discharge.**	
5.A.7	Describe your plan for making a determination of Medical Necessity on a case-by-case basis for services requiring preauthorization. **American Health will conduct medical necessity reviews per our standard process. This process always involves a case-by-case review of an individual's clinical information. The determination is made through a comparison of the clinical information provided by the requesting provider and established medical criteria, such as MCG Health, LLC or Aetna Clinical Policy Bulletins. When a nurse reviewer determines medical necessity cannot be established based on the comparison, the clinical provided, along with the request, are forwarded to a physician for further review. The physician's determination is communicated to the same nurse who conducted the initial review. The physician response includes the medical necessity determination and guidelines relied on when making the determination, as well as any peer-to-peer contact made to complete the review. The nurse then communicates the determination to the requesting provider. In the event of an adverse determination, a verbal and written notification is issued to the requesting provider, as well as written notification to the member and facility when applicable.**	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. **Case managers act as facilitators and can access all available networks on a case-by-case basis in order to achieve the best discounts for our client. When evaluating Centers of Excellence, case managers consider such things as the requirements of the plan, quality outcomes for specific services performed at the facility and the impact access fees may have on the total cost of care. In most situations, since contracts exist between Centers of Excellence and claims payers, case managers act as liaisons between the two parties and will communicate with members and providers to share the benefits of Centers of Excellence utilization. When contracts are unavailable or are not well suited to the member's needs, case managers have the ability to access Centers of Excellence networks to assist in facilitating single case agreements.** **For example, our experienced transplant case managers are knowledgeable about transplant options and keep abreast of the latest technologies and breakthroughs in treatment. If the State requires a referral to a specific Center of Excellence, our transplant nurses work with members and providers to recommend an appropriate Center of Excellence facility. This example would apply to oncology, bariatric and other specialty case types as specified by the State.**	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. **American Health is committed to providing quality, cost-effective solutions to assist our clients with managing costs while encouraging member health and well- being through evidence-based practices. Our population management strategy includes products and services to improve the health of the entire population while reducing long-term health care expenses. Three examples include:** **Re-admissions - American Health's Pre-Admission and Post-Discharge Counseling programs are designed to avoid complications and address readmission rates by providing education to members admitted for inpatient procedures. Our case managers call members before and/or after their inpatient admission to discuss their procedure and prepare them for admission and/or discharge. The goal of this program is to reduce readmissions.** **Uncontrolled Diabetes – Through our Disease Management and predictive modeling, we can identify and engage members with diabetes. For those with an HbA1c > 9.0, our nurses make monthly contact to provide support and education to members who are struggling to manage their diabetes and who possibly need more frequent contact than others to gain better control of their diabetes.** **Lifestyle Coaching – An integrated approach is taken for identification, outreach and engagement for Lifestyle Coaching which prioritizes program recommendation and subsequent outreach based on the member's acuity. Members are stratified as low, moderate or high risk based on factors such as at-risk for diabetes or cardiovascular disease, and negative lifestyle behaviors such as tobacco use or elevated BMI. Lifestyle Coaching is based on a primary coach model to focus on the following lifestyle issues: weight control, tobacco cessation, healthy eating, physical activity and stress management.**	5 points

5.A.10	Describe your workflow for predictive modeling including if performed for specific Participant and/or all Participants? **American Health's Disease Management program uses a predictive modeling process that analyzes a client's medical and pharmacy claims data. The resulting predictions incorporate clinical factors, such as diagnoses, episode treatment groups, gaps in recommended standards of care, prescription use and other risk markers, such as timing and frequency of procedures to identify individuals with chronic conditions specific to each client's population. Its underlying models enable a client's data to "speak" and therefore, identify key drivers of cost and risk in its population. Please see information on the individual workflow addressed in response to 5.A.11 below.**	5 points

5.A.11	Describe your workflow for risk stratification including if performed for a specific Participant and/or all Participants. **American Health has a strong Disease Management data analytics and predictive modeling partnership with our sister company, HDMS. HDMS provides us with access to DART, an industry-leading healthcare analytics and reporting platform. We use the DART tool to identify candidates for Disease Management. Further risk stratification of the individual is performed within the context of our Disease Management program, using the tools described below.** **To develop a participant's individual care plan, nurse health coaches utilize predictive modeling results, as well as information obtained from members, such as clinical test results, biometric values and results from the Patient Activation Measure® (PAM®). The PAM® is a clinically-proven assessment tool that measures the member's awareness of their condition and provides nurse health coaches insight into participants' attitudes and behaviors. Based on the PAM® survey results, nurse health coaches risk stratify participants into one of four progressive activation levels. The four levels are characterized by distinct differences in a member's knowledge, skills and confidence that are essential to managing a chronic condition.** **Instead of assessing behaviors in isolation, the PAM® survey recognizes people who feel in charge of their health engage in a range of behaviors. The PAM® survey is reliable and valid for use with members in taking a significant role in managing a chronic illness. Insights gained with the PAM® survey can be used for predictive modeling, population segmentation, individual tailoring of care support, and the evaluation of program effectiveness.** **Based on a participant's PAM® score, nurse health coaches employ the Coaching for Activation® (CFA®) model to set behavior-change goals and action steps tailored to each individual's capability. Nurses also use clinical evidence-based guidelines to measure results of outbound telephonic education and counseling. Using the PAM®, CFA®, motivational interviewing, and other available resources, nurse health coaches:** ▪ **Set incremental, participant-specific targets and goals for achievement** ▪ **Motivate participants and elevate their self-confidence in managing chronic disease** ▪ **Educate participants on warning signs, symptoms, and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant** ▪ **Identify ways for participants to improve and maintain their health**	5 points

5.A.12	Describe your process for utilizing biometric screening and health risk assessments for improving overall population health for Participants. **The personalized Wellness Portal is the gateway to all online services and is designed to engage participants in their health and drive positive behavior change. Through the portal, members can access a wide variety of online products, including a proprietary Health Risk Assessment (HRA). Our HRA dynamically customizes itself to each user based on age, gender, and any previously answered questions. Available in English and Spanish, the HRA may be updated by the member at any time. Members are encouraged to complete the HRA at least annually, although more frequent updates are encouraged. A telephonic version is also available as a buy up option to accommodate those members without computer access. The HRA covers the following topics:** ▪ **Allergies (environmental, medications)** ▪ **Demographics and biometrics (height/weight, BMI, waist circumference)** ▪ **Women's health (pregnancy, menopause)** ▪ **Mental health (depression screen, stress level)** ▪ **Preventive care (dental, vision, and hearing exams)** ▪ **Health screening (abdominal aortic aneurysm, osteoporosis, cancers of the breast, cervix, colon, prostate and skin)** ▪ **Vaccinations (tetanus, pneumonia, chickenpox, shingles, meningitis, HPV)** ▪ **Lifestyle (tobacco and alcohol use, physical activity, sleep habits)** ▪ **Safety (fall risk, seatbelt use)** ▪ **Lab data (blood pressure, cholesterol level)** ▪ **Medication use (prescribed, over-the-counter, polypharmacy)** ▪ **Productivity and absenteeism (related to personal and family health)** ▪ **Complementary or alternative medical therapies** ▪ **Advance directives** **Aggregated information is analyzed in real-time. Member-provided information from the HRA, such as biometric data, tobacco use, diet, test and procedures, allergies and over the counter medication, is fed into the system to complete the member's clinical profile. Where appropriate, additional questions are asked of the member to create a holistic view of that member's health that is immediately fed back to the system to analyze for any potential adverse outcomes or provide suggestions to the member for their care management. The HRA is designed to provide assessments and identify candidates for our Disease Management and Lifestyle Coaching programs (if purchased).**	5 points

We also offer optional onsite and offsite biometric screening options for clients interested in a basic healthy heart screening and have included cost information in the pricing table. Screenings are available throughout the U.S. and offer total program management that includes oversight, scheduling, onsite staffing, data collection and phlebotomy, testing, physician review, result reporting, data feeds to our Wellness Portal and more. The Wellness Portal is required with Biometric Screenings.

Onsite: Healthy Heart fingerstick includes:

- **TC, HDL, TC/HDL ratio, LDL, triglycerides**
- **Blood glucose**
- **Blood pressure and pulse**
- **Paper-based BMI, self-reported height and weight**
- **Counseling during the screening to review results and answer questions**
- **Counseling brochure with national guidelines**
- **Online appointment system**
- **Health screening standard promotional materials**
- **Aggregate report by site, company, and 5-year trend**
- **Member specific participation report**
- **Electronic upload of member data to our Wellness portal**
- **High risk referral form and counseling**

Offsite: Physician Form includes:

- **Data entry of faxed results into database**
- **Research and correction of illegible writing, as necessary**
- **Electronic upload of member data to our Wellness Portal**
- **Inclusion in aggregate report**

The offsite screening option must be offered in conjunction with an onsite event. There is no minimum participation required (for billing); however, a minimum of 40 participants is required to receive an aggregate report.

Also included in the Wellness Portal, the electronic Personal Health Record (PHR) provides members a view into their health information. Features of the PHR include pre-population of biometric screening results feeds (if preferred screening vendor used), pre-printed forms, including emergency wallet card and immunization record, ability to upload and store health-related documentation, Spanish translation of the PHR, organization of personal health records and bi-directional persistency of data between PHR and HRA (a member only has to input information in one place and it will pre-fill in other applicable areas).

5.A.13	Describe your process for medication reconciliations including any minimum/maximum criteria per case. **Our Case Management medication and safety assessment and reconciliation process is mandatory for all cases when a member is not in an inpatient setting. The medication reconciliation process involves a comparison of the member's current medication list (including drug, dosage, frequency and route) with the provider's orders to identify any potential dosing errors, omissions, duplication or conflicts.**	5 points

Our case managers review the following items when a case is opened, the member is discharged home from any setting, any time there is a change in condition or diagnosis, and/or at a minimum, once within each reporting or case review period.

- **Assess the member/family/caregiver's knowledge and use of their medications, including any side effects experienced.**
- **Provide medication education including the importance of keeping a medication list and sharing it with treating providers.**
- **Determine the need for medication reconciliation and take action as needed.**
- **Document lists from multiple providers in the case notes. Note: reconciliation is only required between the member's and the primary treating provider's lists.**
- **A medication assessment is still completed when member/family/caregiver contact has been lost or was never initiated but contact is maintained with the treating provider in order to follow the treatment plan.**
- **An initial medication assessment should be completed as soon as possible after receipt of the information but no longer than 30 days from case opening. If no information is received within 30 days of case opening, this must be documented.**
- **Continued attempts to obtain a medication list will be made and documented in the case.**

Once a medication list has been reviewed our case managers complete the following tasks:

- **If a medication discrepancy is identified, the action taken in response will be documented in the case.**
- **The case manager will contact the prescribing provider, notifying them of the identified discrepancy.**
- **The primary treating provider will be contacted if we discover two or more providers are prescribing the same medication or medications within the same class.**
- **Case managers utilize their professional judgement in determining whether a medication combination should be checked in Lexicomp to determine any adverse interactions. If an adverse interaction is noted in the Lexicomp system, our case manager will consult with their supervisor and contact the prescribing provider either by phone or fax. If a fax notification is sent, a follow-up call is placed to ensure the letter was received.**
- **With each review of an updated medication list, our clinical staff will document their findings. This includes when no changes are made to the list.**

In addition to the above processes, our case manager will communicate the need for medication reconciliation when transferring care of a member from one nurse to another within our organization, but we will also provide the most recent medication list with our transition report when a member transitions to a new Case Management or Disease Management vendor.

Our nurse health coaches follow a similar process with some slight variations due to the differences between the Case Management and Disease Management programs.

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. **American Health uses a number of techniques and resources to accommodate special populations, including non-English speaking, hearing and visual impaired, and the elderly. For example:** ▪ **Participants who are hearing impaired can communicate with a nurse health coach via email or through the Telecommunications Relay Service, a telephone service that allows persons with hearing or speech disabilities to place and receive telephone calls. TRS is available in all 50 states for local and/or long distance calls.** ▪ **Participants who may have limited English can speak with a nurse using VOIANCE Language Line, a service that allows telephonic translation into more than 100 different languages.** ▪ **Although our participant brochures and educational pieces are written at a reading level that should accommodate most participants, we understand that there may be participants for whom reading is difficult. As a result, we have centered our Disease Management program on telephonic nurse health coaching rather than merely relying on paper educational materials. In accordance with URAC guidelines, a nurse health coach will assess a participant's literacy level during the initial telephone call, and if a literacy problem is apparent, the nurse health coach will make suitable accommodations when developing the participant's steps and goals.** ▪ **A number of participant brochures and other educational materials are available in English and Spanish, including brochures that explain the function of various services and when to use them, posters that promote the various services and provide access information, and check stuffers that remind members about the services and provide access information.**	5 points

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). **We recognize members have different needs and learning styles. Based on this, our products incorporate processes and materials tailored to the member. These vary by product and include conversations with nurses, coaching content tailored to the member's activation level, articles and literature, motivational interviewing, personalized goal setting and online options. Examples are shared below.** **Disease Management** ▪ **Engagement specialists and nurse health coaches employ Insignia's proven Patient Activation Measure® to assess a member's ability to self-manage a condition. Results drive nurse coaching program intensity.** ▪ **Nurse health coaches utilize motivational interviewing techniques coupled with Insignia's Coaching for Activation® model to help participants develop tailored goals that are incremental and achievable.** ▪ **Disease Management toolkit** **Wellness Portal and Lifestyle Coaching** **The personalized Wellness Portal is the gateway to all online services and is designed to engage participants in their health and drive positive behavior change. All members have access to a wide variety of educational resources, including Message Center, calendar with export function, member goal setting, condition/lifestyle topic detail pages, Health Links, Recommended Materials (based on member' clinical profile and indicated interests), Resource Center with tools and trackers, health-related videos from Emmi Solutions, audio files, health education content, and daily news feeds, Quarterly Wellness Webinars on various health topics, ability to sync wearable devices to Wellness Portal and smart phone accessibility (iPhone and Android) that supports calendar reminders.** **We are also able to customize materials from our Wellness eToolkit and provide electronically for distribution by the group.**	5 points
5.A.16	Describe the process for applying Evidence Based Medicine (EBM) into your Medical Management workflow. **In Utilization Management and Case Management, American Health utilizes MCG Health, LLC (formerly Milliman Care Guidelines) to review proposed services and to direct providers toward the use of the most cost-effective, quality services available. In instances in which MCG guidelines are not available, we rely on Aetna Clinical Policy Bulletin guidelines.** **American Health's Disease Management effects improvements in the health status of participants by providing education, tools, and support to promote good self-care practices and adherence to evidence-based care guidelines.**	5 points

	Based on a participant's PAM® score, nurse health coaches employ the Coaching for Activation® (CFA®) model to set behavior-change goals and action steps tailored to each individual's capability, and use clinical evidence-based guidelines to measure the results of outbound telephonic education and counseling. Using the PAM® survey, CFA®, motivational interviewing and other available resources, nurses: ▪ **Set incremental, participant-specific targets and goals for achievement** ▪ **Motivate participants and elevate their self-confidence in managing chronic disease** ▪ **Educate participants on warning signs, symptoms, and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant** ▪ **Identify ways for participants to improve and maintain their health**	
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. **Members would have our customer care department, our website, and their plan document to help them receive medically necessary covered services.**	5 points
5.A.18	Describe the process for maintaining current EBM material and how often your systems are updated. **Specific to MCG Health guidelines, the guideline development cycle occurs annually. Expert clinical editors — medical doctors, registered nurses, epidemiologists and other health care professionals — search the medical literature systematically, seeking the latest information and evidence for each guideline.** **In addition, all guidelines used are reviewed at least annually by our medical management staff, including our medical director, physician review panel, and nurses. We also contract with an independent consultant who provides guidance in relation to these changes.**	5 points
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. **American Health reviews the updates made by our evidence-based medicine partners upon receipt of notification. Clinical operations leadership then incorporates the updates into our day-to-day processes when applicable. Our staff has real-time access to the updates in MCG Health, LLC, as well as Aetna CPBs, which are available to them online. This means they consistently access the latest updates available. In addition, our policies and procedures are reviewed and updated annually and more frequently when laws, standards and evidence-based medicine updates impact our policies and procedures. These updates are communicated to those impacted. The staff have access to policies and procedures at all times during their work day and are encouraged, and in some cases required, to access these procedures as a part of their daily work to ensure consistency in our procedures within each department.**	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. **As part of implementation, we schedule a meeting between the client's key staff and American Health's operations staff to review the implementation plan and assign tasks and timelines to ensure smooth case transition. If desired, American Health will coordinate directly with designated contacts at the client's existing Utilization Management/Case Management vendor for case transition. Our goal is minimal disruption to the member.** **When a new client/group moves to American Health, we work with their current vendor to receive their open Utilization Management, Case Management and Disease Management cases. We also receive future Utilization Management certifications. Once we receive this information, we load the cases into iSuite and will honor any certifications done by the previous vendor. From that point, we resume the certification process. For Case Management, we request individual case reports that provide history on the member, their providers, etc. to ensure continuity of care. Once we receive and review this information, we can schedule conference calls with the current vendor to assist with obtaining any needed information, when applicable.**	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. **Care plans are applicable to our Case Management program. Once a member has been identified for Case Management, the case manager will review the case information, including past and current medical history, any information available in the State's electronic health records system, the member's adherence to the prescribed treatment plan, and develop a plan of care that is member-specific and oriented toward the achievement of short- and long-term goals for the optimal level of wellness. The care plan ensures services are implemented in a safe, timely, efficient and cost-effective manner. The case manager acts as an advocate to the member and family members and serves as a facilitator between physicians, providers, member and family to ensure smooth communication and achievement of the care plan.** **The case manager encourages the involvement of the member and caregivers as the primary decision makers in the development and implementation of the plan. The case manager contacts the necessary providers to coordinate services and facilitate communication between providers. Close contact with member, family and providers is maintained during the course of Case Management in order to monitor the progression of the plan of care. The frequency of contact is determined by the member's clinical status and the services involved. Revisions to the plan of care are made when necessary. These changes are discussed with all parties involved. The case manager assesses the plan's goals for appropriate clinical outcomes, progress toward achievement of member's goals, and cost effectiveness. Any goals not being met are discussed with the member and physician. Additionally, Case Management includes coordination of health care and community resources. As case managers, we try to tap into community resources as often as possible to ensure maximization of the member's benefits.**	5 points

5.A.22	How do you oversee and coordinate continuity of care for Participants enrolled in more than one the Service(s)? **Many members have complex health care needs that may make it appropriate for them to participate in multiple health plan offerings. Our approach to the hierarchy of the programs is that the most acute condition takes precedence. However, we recognize the member's preferences and, if desired, they may participate in multiple programs at the same time. Our hierarchy is outlined below:** ▪ **Case Management takes precedence over other programs. When a Case Management case is closed, we look for opportunities to refer the member to other plan programs, such as Disease Management or Wellness.** ▪ **Disease Management takes precedence over Wellness.** ▪ **Our approach to Behavioral Health services varies based on the circumstances. High acuity, high cost cases are best managed in Case Management and would preclude participation in other programs. However, lower acuity cases managed by an EAP are not viewed as a conflict with Disease Management or Wellness.**	5 points

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

5 points

The scenarios are best answered using our 24/7 Nurse Line model. Our Nurse Line would assist with questions about general health, current illness or injury 24 hours a day, seven days a week. These nurses would provide decision support, helping with information such as child immunizations and routine testing. Our nurses receive charts for all callers who utilize the Nurse Line. Typically, callers who need immediate help would be referred to the emergency room or urgent care center during the initial call. For those with less emergent needs, their chart would be reviewed and triaged by the next business day. If outreach is needed, we would ensure the member is referred to the appropriate resource within the State's program.

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

This question could be handled by our 24/7 Nurse Line. Upon receipt of the inbound call, the nurse would ask the mother if she had specific questions or overall questions regarding her child's asthma. The nurse would then answer the mother's questions and provide her with information requested and information regarding asthma and asthma attacks. The nurse would also explain to the mother what she should discuss with her pediatrician at the child's next checkup. If there are no further questions, the call would be resolved.

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

This inbound call would be received by a 24/7 Nurse Line nurse, who would educate the caller on the elevated A1C. After the call, the nurse would refer the member to our Disease Management program and a case would be built. When the case is built, an invitation letter is automatically generated and sent to the member. Within two weeks of receiving the referral, our engagement specialist will make the first outreach attempt to the member. Upon contact, the engagement specialist will provide an overview of the Disease Management program to the member and transfer the case to our nurse health coach.

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

This inbound call could be received by a 24/7 Nurse Line nurse. The nurse would provide the caller with general information about prostate cancer. However, if the member asks a question specific to her husband's diagnosis, verbal authorization from the spouse would be required to discuss. With the appropriate authorization in place and PHI protected, the nurse would talk through the diagnosis. The chart would be reviewed by a nurse post-call, who could then refer the member to our Case Management program. Our Case Management Coordinator would review the referral, obtain any necessary clinical information and open the Case Management case within three business days. A case manager would then outreach to the member and spouse within seven days of being assigned the case.

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.

Our philosophy for managing member care costs is reflected in how we designed, developed and implemented each of the URAC-accredited medical management programs that we are proposing to you. In addition, our staff is able to maximize savings by capitalizing on fee negotiation and prediction of high claims costs.

- **American Health's Utilization Management program is designed to positively impact claims costs and provide savings to benefits plans. Our highly specialized team of doctors and nurses use care guidelines from MCG Health, LLC during the precertification process to help establish appropriate, member-specific goals while focusing on discharging the member from acute care settings to less intensive care settings when medically safe and appropriate. Our Utilization Management staff views the best member outcomes as its goal while ensuring opportunities for cost savings are maximized.**

- **American Health's Case Management services are designed to improve the quality of patient care while maximizing cost savings. We provide individuals a better understanding of specialized care needs, access to centers of excellence and specialty care facilities, education on alternatives to costly inpatient care, and direction toward in-network discounts. We work with members to educate and help them make choices that contribute to a healthier lifestyle, thus reducing the incidence of complications and future medical costs.**

- **American Health's Disease Management program targets nine prevalent disease states—Asthma, Diabetes, Chronic Pain (from osteoarthritis, rheumatoid arthritis or low back pain), Coronary Artery Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, and Hypertension—for which evidence-based guidelines are available to measure improvements while impacting health and member care costs.**

American Health uses the following methodologies to measure effectiveness and Return on Investment (ROI) for its various medical management programs:

- **Utilization Management – We benchmark our performance against MCG Health, LLC criteria for Average Length of Stay, Admits per 1000, Bed Days per 1000, and other key indicators. ROI for inpatient Utilization Management is currently 4.7 to 1, and ROI for outpatient Utilization Management is currently 5.6 to 1, both as determined by dividing estimated savings to the plan over the cost of the program. Utilization Management estimated savings is determined by applying national commercial plan average costs to the difference between requested days/units and certified days/units.**

▪ **Case Management – We benchmark our performance based on measures used to evaluate outcomes and satisfaction in regard to the quality and effectiveness of our Case Management program. These measures include monthly case-specific reports that outline Case Management interventions and savings impact, member feedback on the program obtained through member satisfaction surveys, monthly monitoring of the quality and delivery of our Case Management process, and monthly monitoring of client and member complaints or concerns. ROI for our various Case Management programs is determined by calculating the savings gained from interventions over the cost of the program. ROI is currently 6.6 to 1 for Case Management, 33.2 to 1 for Maternity Case Management, 5.8 to 1 for Neonatal and Pediatric Case Management, 5.7 to 1 for Oncology Case Management, 19.1 to 1 for Transplant Case Management and 3.8 to 1 for Mental Health and Substance Use Disorder Case Management.** ▪ **Disease Management – Our cost savings reports for the Disease Management program focus on showing how well we are containing costs for members with chronic conditions. Our PAM®-based Cost Savings Analysis report is available to all groups and quantifies the financial impact of our program based on changes in a client's aggregate PAM® score over time. For example, based on research, a four-point increase in a client's aggregate PAM® score equates to approximately $156 in annualized savings per month. For groups who meet historical eligibility, historical medical and pharmacy claims, and minimum number of participant requirements, American Health can provide a Claims-based Cost Savings Analysis. This report is based on our comparative analysis methodology that was developed through our partnership with SCIO Health Analytics, a leading health analytics services company. Savings are calculated by comparing utilization of the managed population (members enrolled in the Disease Management program) versus the unmanaged population (members identified but not enrolled in the program) over a defined period. The average medical cost savings per managed member per month is $512, with an average annual savings of $5,071 (based on a population of 46,131 eligible lives over a seven-year period).** **Additionally, American Health has a proven track record of controlling overall costs for the State's plans and would continue to control overall plan costs for the State through our proven medical management programs.**	
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 Provide supporting documentation for each example provided.	5 points

a. **Preventative Care - During the initial assessment, as well as each subsequent assessment completed during each contact between the nurse health coach and the member, we address questions related to preventative care. The assessment not only addresses preventive care, we provide education related to preventative care at the same time, when applicable.**

b. **Emergency Room Utilization - Avoiding unnecessary emergency room visits is a key goal of all our medical management programs. For example, our Disease Management program coaches members using the clinically proven Patient Activation Measure® and Coaching for Activation® model. Patient activation is linked to better health outcomes and lower rates of health service utilization. Addition, our Nurse Line, which is available 24/7, provides members with an opportunity to speak with a nurse about their symptoms and receive decision support regarding whether to seek immediate care at an emergency room, wait to see their primary care physician or even provide care at home, thus avoiding unnecessary emergency room visits. Our pre-admission and post-discharge program provides education to members prior to and/or after admission. Through education and support from our case managers, the member is more likely to avoid unnecessary emergency room visits due to an increased knowledge of what to expect after discharge and reinforcement of post-discharge physician orders. Depending on the reason for admission, members are advised of the importance of monitoring for signs and symptoms of infection or recurrence of their illness, regular physician follow-up visits and adherence to medications.**

c. **Disease Management/Appropriate Drug Utilization - While the benchmark for the appropriate use of medications is 82.5 percent, our Disease Management program far exceeds that mark with 98.7 percent. We feel this is due to our program design, which requires regular telephone contact and education regarding the importance of medication adherence as well as providing assistance with obtaining medications when a need is identified.**

d. **Inpatient Admission – The UR process includes the determination of the most appropriate level of care and the determination of medical necessity of the admission based on MCG Health, LLC criteria and/or Aetna Clinical Policy Bulletins. When necessary, a more appropriate level of care is recommended by our physician reviewers. Based on an analysis of inpatient discharges during the 2016 calendar year, 3.6 percent of inpatient days were saved across our book of business.**

e. **31 Day Re-admissions Rate - Our case managers and nurse health coaches can influence readmission rates through contact with engaged members after discharge. During these calls, the reason for their prior admission is discussed, as well as their current state of health and knowledge of their condition. In addition, nurses provide education and support. Through our pre-admission and post-discharge program, our case managers contact members prior to admission to provide education and support and place follow-up calls to members post-discharge from their admission to reinforce education, provide support and assess the member's status and knowledge of discharge instructions. Based on our 2014-16 book-of-business, members who participated in the Pre-Admission Counseling program had a 30-day readmission rate that was 52 percent lower than non-participants; members who participated in the Post-Discharge Counseling program had a 30-day readmission rate that was 37 percent lower than non-participants. Members participating in both programs had a 30-day readmission rate that was 55 percent lower than non-participants.**

f. **Rehabilitation – Our utilization review process includes prospective and concurrent review to include rehabilitation. Concurrent review is completed based on the member's acuity in order to determine the medical necessity of ongoing rehabilitation level of care. Discharge planning is addressed with the facility case manager or discharge planner from the date of admission and continues throughout the member's stay. When complex discharge needs are identified, a member is engaged with a case manager prior to admission, or a member has been opened to Case Management during their hospital stay, our case manager will reach out to the facility case manager or discharge planner to assist with the discharge planning process to ensure the member is moved to the most appropriate level of care based on medical necessity guidelines. Case managers also ensure the member's length of stay is no longer than medically necessary.**

g. **Hospice Care - Our Utilization Review and Case Management process will provide oversight of care planning that sometimes involves the decision to transition a member into hospice care. While the decision is often difficult for families, our Case Management team of over 247 licensed, experienced nurses will collaborate with providers to help plan the best possible option for the member.**

5.A.26	What peer review literature sources are utilized by your company to maintain current industry standards in the review process? **American Health's Utilization Management program utilizes MCG Health to certify treatments and to direct providers towards the most cost-effective, quality treatment available. In instances in which MCG guidelines are not available, we rely on Aetna Clinical Policy Bulletin guidelines. We also use National Comprehensive Cancer Network Clinical Practice Guidelines, Case Management Society of America Standards for Practice and other guidelines for specialty services.** **The care guidelines are developed in accordance with the principles of evidence-based medicine. Relevant randomized controlled trials, meta-analyses, and systematic reviews published in the peer-reviewed literature have primacy, followed by observational studies and information obtained from textbooks and specialty society guidelines. When published studies or information is scant or nonexistent, MCG recognizes the value of frontline experience and incorporates data from unpublished sources, including large database analysis and expert opinion. MCG strives for practicality and completeness. However, when there is a lack of evidence for some steps in the care of a member, the care guidelines may offer a strategy based on the best information available and identify the limits of evidentiary support underlying the recommendation. In general, the care guidelines offer comprehensive recommendations for all steps in a member's care plan, recognizing the limits of the evidence base rather than discussing only the steps with good evidence.**	5 points
5.A.27	Describe the workflow for developing the criteria for both medical/surgical guidelines used for conducting a review. **American Health uses both MCG Health, LLC and Aetna Clinical Policy Bulletins as our medical and surgical guidelines related to conducting a medical necessity review.**	5 points

Following is an overview of methodology for MCG Health, LLC guideline development: The guideline development cycle occurs annually. Expert clinical editors — medical doctors, registered nurses, epidemiologists and other health care professionals — search the medical literature systematically, seeking the latest information and evidence for each guideline.

MCG employs customized, tested, proprietary search strategies to allow efficient yet comprehensive identification and analysis of relevant publications for a given topic and to maximize retrieval of articles with information pertinent to a specific guideline.

Retrieved materials are individually reviewed by an MCG clinical editor and selected for use based on quality and relevance to the guideline in question. Available evidence of the highest quality and published in the most widely read and referenced journals is preferentially used. Based on careful review of this evidence, an MCG clinical editor makes any necessary changes to the guideline. Once this update process is complete, each guideline is reviewed again by a supervising clinical editor to verify the accuracy and appropriateness of all changes.

Each guideline undergoes external review by clinically active experts (board-certified specialist physicians who affirm no financial conflicts of interest) to confirm the relevancy and clinical appropriateness of each guideline in accordance with the selected evidence/documentation. A supervising clinical editor evaluates external reviews and changes the guideline as appropriate.

Certain components of MCG products (such as Goal Length of Stay) are additionally developed and validated through analysis of several databases that include millions of inpatient and outpatient records. Sources used include external databases, as well as those developed internally by expert statisticians and epidemiologists. Comparing optimal care as described in the medical literature to care as actually delivered helps ensure the reasonability and clinical appropriateness of the guidelines' benchmarks.

The following is an overview of the Aetna Clinical Policy Bulletin development process: For each medical technology selected for evaluation, the Clinical Policy Research and Development Team conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. In addition, the opinions of relevant experts may be obtained when necessary.

Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a "Background" section that describes the medical technology and provides the rationale for Aetna's policy. Each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) codes.

	Process for CPB Review and Approval **Both new and revised CPB drafts undergo a comprehensive review process. This includes review by Aetna's Clinical Policy Council and external practicing clinicians, and approval by Aetna's Chief Medical Officer or his/her designee.** **The Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the National Medical Policy and Operations Department, National Accounts Department, Behavioral Health Department, Clinical Pharmacy Department and Health Care Delivery. The Clinical Policy Council usually convenes twice monthly. Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting and are discussed at the bimonthly meetings. The Council votes whether to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend further revisions.** **The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by Aetna's Legal Department and the Vice President of Clinical Strategy and Policy, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the Chief Medical Officer or his/her designee for review and final approval. Draft CPBs approved by the Chief Medical Officer or his/her designee will be published on Aetna's websites within 60 days of the Clinical Policy Council's recommendations. This review process is monitored by a CPB Tracking Tool to ensure compliance with this goal.** **Clinical Policy Bulletins are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. If the Clinical Policy Research and Development Team determines new evidence or other information has emerged to warrant a change in Aetna's clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in Aetna's position, the CPB may be updated with additional supporting background information and references. Each revised CPB is submitted to Aetna's Clinical Policy Council for review and approval. Additional changes to the revised or updated draft CPB may be made upon the recommendations of the Clinical Policy Council.**	
5.A.28	Describe your process for updating clinical protocols including the frequency of updates. **MCG Health, LLC publishes an updated edition of the care guidelines every February, based on an annual process of systematic evidence review, conducted throughout the previous year. Each edition typically includes approximately 20,000 unique citations, of which around 30 percent are new references. Throughout the annual production cycle, their clinical editorial staff monitors medical literature for new evidence (including published research studies, practice guidelines, and new editions of textbooks) that may be relevant to current guideline content. When new evidence dictates a marked change to accepted clinical practice referenced in the care guidelines, MCG notifies its clients.**	5 points

	As described, Clinical Policy Bulletins (CPBs) are reviewed annually unless relevant new medical literature, guidelines, regulatory actions or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed, published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. If the Clinical Policy Research and Development Team determines new evidence or other information has emerged to warrant a change in Aetna's clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in Aetna's position, the CPB may be updated with additional supporting background information and references. Each revised CPB is submitted to Aetna's Clinical Policy Council for review and approval. **American Health reviews and updates clinical policies and procedures annually, in accordance with URAC standards. In addition, updates to policies are made when new evidence-based guidelines and standards impact our current policies and protocols and necessitate a change. Decisions regarding updates to American Health-specific protocols are made by clinical operations leadership after review of new guidelines and standards. Other departments such as compliance are engaged in the decision process when necessary.**	
5.A.29	Describe your workflows for incorporating new procedures and/or new technology into clinical protocols. **Following is an overview of methodology for guideline development:** **The guideline development cycle occurs annually. Expert clinical editors — medical doctors, registered nurses, epidemiologists and other health care professionals — search the medical literature systematically, seeking the latest information and evidence for each guideline.** **MCG employs customized, tested, proprietary search strategies to allow efficient yet comprehensive identification and analysis of relevant publications for a given topic and to maximize retrieval of articles with information pertinent to a specific guideline.** **Retrieved materials are individually reviewed by an MCG clinical editor and selected for use based on quality and relevance to the guideline in question. Available evidence of the highest quality and published in the most widely read and referenced journals is preferentially used. Based on careful review of this evidence, an MCG clinical editor makes any necessary changes to the guideline. Once this update process is complete, each guideline is reviewed again by a supervising clinical editor to verify the accuracy and appropriateness of all changes.** **Each guideline undergoes external review by clinically active experts (board-certified specialist physicians who affirm no financial conflicts of interest) to confirm the relevancy and clinical appropriateness of each guideline in accordance with the selected evidence/documentation. A supervising clinical editor evaluates external reviews and changes the guideline as appropriate.**	5 points

	Certain components of MCG products (such as Goal Length of Stay) are additionally developed and validated through analysis of several databases that include millions of inpatient and outpatient records. Sources used include external databases, as well as those developed internally by expert statisticians and epidemiologists. Comparing optimal care as described in the medical literature to care as actually delivered helps ensure the reasonability and clinical appropriateness of the guidelines' benchmarks.	
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)? **Notification of adverse outcomes can be received through our Utilization Management, Case Management and/or Disease Management programs in the following ways:** ▪ **Via the Utilization Review precertification process for initial admission to a facility or through the concurrent review process. Our iSuite automated system will trigger a Case Management referral based on the established trigger list, which is per client specifications and includes diagnoses and procedures. Our UR nurses are also able to create manual Case Management triggers based on their clinical expertise. Readmissions within 30 days can be identified through the Utilization Review process and referred for Case Management for review of potential need for support.** ▪ **Through conversations between nurse health coaches and members during regularly scheduled conversations or member outreach, as well as through review of medical records received from physicians related to engaged members.** ▪ **Our case managers can receive direct referrals from providers, facilities and clients to assist with interventions related to the adverse outcomes, as well as through the triggers noted above.**	5 points
5.A.31	Describe your plan for implementing and maintaining an electronic log of all Adverse Benefit Decisions. **All adverse benefit decisions will be tracked, logged and available for viewing at any time. This information is documented when the decision is made and allows for easy communication.**	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. **Through our iSuite platform, we are able to access medical records associated with a member related to any services managed within our programs, not just those specific to one case. American Health's intake coordinators, Utilization Management nurses, case managers, and nurse health coaches will request medical records via phone or fax from treating providers and/or facilities. Our request is limited to the information necessary to make a determination of medical necessity related to the adverse outcome and based on client precertification or predetermination requirements. Our requests include verbiage related to our relationship with the client, and an explanation that we are requesting the records to provide services related to the member's medical plan. We do not pay for charges related to obtaining medical records.**	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. **As part of American Health's ongoing effort to work collaboratively with our clients, our Utilization Management, Case Management and Disease Management staff will document the presence of any potential adverse event which will then be reported to the applicable claims payer. This is for notification purposes only, and review of the event shall be the responsibility of the claims payer.**	5 points
5.A.34	Describe how your organization personalizes responses to each patient. **In Utilization Management, we alert members directly in the event of an adverse determination. When an adverse determination is made, an appropriate letter is mailed within 24 hours after the date of the request and all medical information necessary to substantiate the need for the treatment or service recommended is received. System-generated, editable adverse determination letters are sent to the member, which allow the nurse to provide the specific reason for the adverse determination.** **Once a member has been identified for Case Management, the case manager will review the case information, including past and current medical history, the member's adherence to the prescribed treatment plan, and develop a plan of care that is member-specific and oriented toward the achievement of short- and long-term goals for the optimal level of wellness. The care plan ensures that services are implemented in a safe, timely, efficient and cost-effective manner. The case manager acts as an advocate to the member and family members and serves as a facilitator between physicians, providers, member and family to ensure smooth communication and achievement of the care plan.** **The case manager encourages the involvement of the member and caregivers as the primary decision makers in the development and implementation of the plan. The case manager contacts the necessary providers to coordinate services and facilitate communication between providers. Close contact with member, family and providers is maintained during the course of Case Management in order to monitor the progression of the plan of care. The frequency of contact is determined by the member's clinical status and the services involved. Revisions to the plan of care are made when necessary. These changes are discussed with all parties involved. The case manager assesses the plan's goals for appropriate clinical outcomes, progress toward achievement of member's goals, and cost effectiveness. Any goals that are not being met are discussed with the member and physician. Additionally, Case Management includes coordination of health care and community resources. As case managers, we try to tap into community resources as often as possible to ensure maximization of the member's benefits**. **Disease Management nurse health coaches are trained in motivational interviewing techniques and use proven tools, including the Patient Activation Measure® (PAM®) and the Coaching for Activation® (CFA®) to assess participants' confidence and ability to self-manage.**	5 points

	By setting specific behavior change goals and action steps, Coaches effectively motivate and strengthen participants' ability to manage their conditions and improve clinical outcomes by taking on the role of personal health coach for participants with chronic conditions. Using PAM®, CFA®, motivational interviewing, and other available resources, nurse health coaches: ▪ **Set incremental, participant-specific targets and goals for achievement** ▪ **Motivate participants and elevate their self-confidence in managing chronic disease** ▪ **Educate participants on warning signs, symptoms, and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant** ▪ **Identify ways for participants to stay healthy** **Our Maternity Management program is customized for the member based on the information obtained in the assessments. After the mother-to-be is enrolled in the program, she is contacted by a maternity nurse specialist who conducts a detailed psycho/social and medical assessment, coupled with physician confirmation, to determine risk status. Information obtained during the assessments will determine frequency of calls and the information shared with the member.** **Our 24/7 Nurse Line is available to assist with a variety of topics. The nurse will personalize the response based on member need.**	
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. **Through contact with members and providers, if any of our clinical staff becomes aware of a quality of care issue, it would be addressed based on the issue and the program in which the member is enrolled. In the case of a potential reportable adverse event, the clinical staff would follow our quality event tracking process through our iSuite system. It allows the clinician to select a category most appropriate for the situation, and in some cases, choose a subcategory to track in more detail. This is followed by the entry of a detailed note in iSuite which outlines the situation. This allows for the recording and tracking of the event. A notification to the dedicated client contact is then provided and documented in the case within iSuite. Any review of the reported event would be the responsibility of the claims payer. American Health would provide a medical review of the case only through a request from the claims payer. This review would be conducted by our Medical Review department.** **In the event our clinical personnel determine a treatment provided by a physician or facility is outside of current evidence-based protocols, most often through a medical necessity review, the case is forwarded to our physician reviewer for further review and determination of medical necessity. The physician reviewer will reach out to a provider in certain circumstances to discuss the treatment plan and collaborate to determine an appropriate, evidence-based treatment. In some cases, the case manager will reach out to the claims payer contact to alert them to any potential quality of care issues with a particular provider or facility.**	5 points

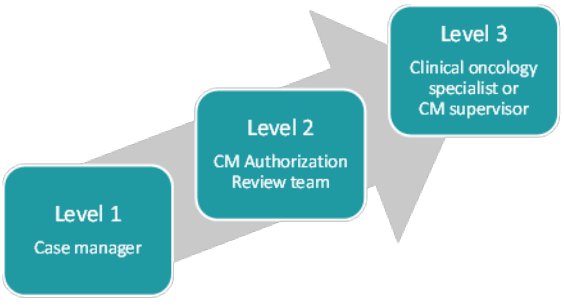
5.A.36	Describe your workflow for managing an EBD request for independent, external review. **American Health's Independent External Review is designed to help plans comply with the Patient Protection and Affordable Care Act (PPACA) by providing administration and management of final medical necessity determinations by URAC-accredited Independent Review Organizations (IROs). Though we coordinate and manage IRO requests, we rely on the IRO to render independent decisions.** **Our program allows clients to respond quickly to claimant requests for expedited appeals while providing a thorough, structured process that meets all PPACA requirements. The program serves as the source of three URAC-accredited IRO contracts and manages the assignment and tracking process for external appeals. Through objective, clinically driven determination of medical necessity for appeals and ensuring impartiality of the assignment process, the program positively impacts the process and outcome of member care.** **Independent External Review allows the client to outsource the management of the process for obtaining independent external reviews. It provides an efficient, cost-effective solution to internal administration of adverse determinations while ensuring compliance.**	5 points
5.A.37	Describe your process for coordinating with the pharmacy claims administrator (i.e. prior authorization for prescriptions, specialty drugs). **American Health has extensive experience coordinating with claims administrators. Specific to the pharmacy claims administrator, American Health is adept at utilizing preferred resources for coordination with medical and pharmacy claims administrators and with tracking those processes. We communicate with all vendors regularly and maintain good working relationships.** **Through our iSuite system, we can provide our intake coordinators with a contact number for the pharmacy claims administrator, as well as the specialty pharmacy manager, to ensure requests for medications which do not require precertification through American Health are directed to the pharmacy claims administrator.** **American Health case managers have experience coordinating with pharmacy claims administrators most often when reviewing oncology treatment plans including oral agents. Our comprehensive review process considers the entire treatment plan, including oral agents when part of a prescribed regimen. In the event an oral agent requires prior authorization through the pharmacy benefit manager or claims administrator, our case managers will reach out to coordinate the review.** **Through our Specialty Pharmacy Advocacy program, our case managers regularly work with specialty pharmacies to secure medications for members. They work with clients and providers to ensure the medications are administered in the least acute and most cost-effective setting required to safely meet the member's needs when medically appropriate. Many members who require specialty medications have complex health issues.**	5 points

	These health issues often mean multiple medications and treatments. When determining medical necessity, we consider all medications the member is prescribed rather than focusing on a single drug. Our case managers also provide education and support to members related to their condition, as well as the specialty medication and any other medications when a knowledge gap is identified. This is an optional program. **We have worked collaboratively with PBMs and formulary management companies to meet the requirements of established drug protocols and prior authorization requirements, such as with Hepatitis C. Our team members can communicate with the pharmacy claims administrator via phone, fax, confidential email or the secure task system.**	
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. **American Health's Medical Transportation program serves as a safety net to ensure quality treatment for members who cannot receive care at their current location, who need to be transported to a facility closer to home after an illness or injury while traveling, or who need to travel for medical treatment. Our services match a patient's needs and condition to the best method of transport, such as air ambulance, ground transport or commercial airline. Our dedicated, experienced clinical care coordinators have managed more than 1,000 domestic, international, urgent and planned medical transportation cases since 2007. They relieve clients and members of the administrative duties of complex medical transfers while overseeing the end-to-end process and managing the full medical transport and care continuum, including:** ▪ **Pre-trip preparations such as benefits and eligibility verification** ▪ **Identification of the destination facility for treatment** ▪ **Coordination with preferred provider networks or negotiating discounts with non-participating providers to minimize claims cost** ▪ **Worldwide travel coordination for members and their families, including assistance with travel documents** ▪ **Communicating with all parties, including providers at the departing and receiving facilities, the member's family, the client and all transport carriers** ▪ **Assistance with hospital admissions** ▪ **Discharge planning to a skilled nursing facility, rehabilitation hospital or hotel prior to returning home, if necessary** ▪ **Support with return travel, if needed** ▪ **Referrals to Case Management** **International transportations can be particularly complex. A core competency of our team is lending logistical support to help navigate complicated immigration guidelines and international entry requirements. Clinical care coordinators are extremely knowledgeable on U.S. Citizenship and Immigration Services, Department of Homeland Security, and U.S. Border Patrol requirements for incoming medical transportation aircrafts at all U.S. international airports, as well as other countries' requirements for receiving a patient from abroad.**	5 points

Types of Transportation

When managing a medical transport, clinical care coordinators evaluate the mode of transportation that meets the member's needs and the urgency of his or her condition and is most cost effective for the client while maximizing the coverage of the benefit plan. Our Medical Transportation team is experienced in coordinating many types of transfers, including:

- **Emergency air ambulance – Care coordinators can coordinate fixed-wing air ambulance transfers for both domestic and international cases. These transfers are for emergencies or for transporting members long distances when the member either is in a location that cannot provide the necessary care or is unstable from an illness or injury sustained while traveling. American Health works closely with the air ambulance carrier, the discharging facility and the receiving facility, and we can arrange peer-to-peer conversations between the parties if necessary.**
- **Complex ground transport – Care coordinators can assist with emergency or planned complex ground transports that are provided when members need to be transported shorter distances, members are located in remote areas, or air transport is not possible due to inclement weather. In these transports, members are generally medically stable but need a high level of care.**
- **Medical escort – In some instances, members may be stable and able to travel on a commercial carrier but need medical assistance or oversight. For these cases, our care coordinators can arrange a medical escort representative to travel with and aid the member, which could include administering medication, hygiene assistance or monitoring oxygen. This service is a planned travel arrangement and can be international and domestic. Our care coordinators also can book the member's flight, arrange medical clearance through the airline's medical department and arrange for priority boarding and seating.**
- **Commercial travel assistance – For members who are stable and can fly a commercial carrier without a medical escort, the Medical Transportation team can provide commercial travel assistance. This includes ensuring the member is cleared for travel by a physician, notifying the airline and obtaining approval for any medical equipment, arranging priority boarding and seating and coordinating ground transportation to and/or from the airport.**
- **Transplant patient transport – Members who are on a transplant list may need to travel long distances on short notice to receive their transplant. Our care coordinators can assist in arranging the details of the transportation in advance. This pre-trip planning allows members to travel and be received by the facility quickly when their transplant becomes available.**
- **Bariatric coach transport – Bariatric coach transports provide specialized equipment and a team trained in transporting members who are unable to travel by ambulance, commercial airline or air ambulance due to their body size. Care coordinators work with bariatric coach transport companies to arrange transportation to and from doctor's appointments for these members.**
- **Repatriation services – Our Medical Transportation team can also assist families of a deceased member in transporting the member back to his home country or state. The team works with the family, health care facilities and funeral homes to assist with the health care and legal requirements that vary by state and country.**

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. **Case Management opportunities are identified during the notification review process using an automated, customizable trigger list based on ICD-10, CPT and dollar threshold criteria, along with nationally recognized criteria and systems, to flag a member's current medical situation. A case is also flagged when a member's length-of-stay reaches five days or when they have been admitted three times in three months. Our utilization review nurses are also able to manually trigger any case for which they feel Case Management could be of assistance, based on their clinical knowledge and the member's clinical situation.** **Please refer to Section IV to review American Health's suggested Case Management trigger list attached.**	5 points
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). **American Health's Case Management identifies members with specific health care needs and develops efficient treatment plans formulated to produce the most cost-effective outcomes. While the fundamentals of our program are strong, and we rely on them for cost containment and member outcomes, we continually look for opportunities to expand our offerings and keep pace with expanding customer and URAC requirements. The following examples show how our program has been adapted and/or customized for oncology, bariatric, and depression screening. These customizations are testaments to our commitment to flexibility.** **Specialty Pharmacy Advocacy: American Health developed Specialty Pharmacy Advocacy, which is a timely, tailored program designed to support members and plans with the high cost of specialty drugs. Medical management support is extended to members who are prescribed a specialty drug, but who do not meet the criteria for Case Management. As a result, we are able to impact quality and savings in this complex and evolving specialty market.** **Oncology: American Health developed a high-quality, leading oncology Case Management program. While we previously covered oncology under our traditional management process, we noted an increase in pharmacy costs, which required more stringent Case Management. In response, in addition to providing patient advocacy and education, our team reviews oncology chemotherapy and/or radiation treatments in a three-level process, as shown in the graphic below. This ensures each case is reviewed consistently, efficiently and correctly.** 	5 points

Bariatric: This integrated Bariatric Program includes pre-operative education and coaching and post-operative Case Management support. Once the member completes the mandated coaching process and all pre-operative program requirements, the nurse reviews all clinical submitted by the bariatric surgeon to determine medical necessity. Members in the Bariatric Program must agree to participate in Case Management for one year post-surgery.

Assessment and Screening: We perform a complete Medication Assessment to capture, review and reconcile member medications. In addition, we utilize a general health assessment, which assists us in identifying complications and opportunities to provide additional support to members involved in Case Management.

Our Case Management program helps members manage their complex health needs. Our case managers assess, plan, implement, coordinate, monitor and evaluate options for members, their families, caregivers and providers to promote positive outcomes. Below is an example of an actual case within our program that demonstrates how our case managers provide a comprehensive support system — complete with clinical knowledge and emotional support — to our members.

Background: "Lauren" is a female in her 20's who was 24 weeks pregnant with her second child and diagnosed with gestational diabetes. She had a history of pre-term labor and delivery with her first child. Her physician prescribed weekly progesterone injections and diabetes monitoring through home health visits. Lauren was not placed on bed rest and continued to work. However, she was admitted at 32 weeks for elevated blood pressure and pre-term labor. Although Lauren was stabilized and discharged home, she continued to experience elevated blood pressure.

Intervention: American Health's case manager immediately began coordinating with Lauren's doctors. The case manager's work on the case included:

- **Communicating with Lauren to obtain member information, identify needs, assess member knowledge, and provide support as needed**
- **Speaking with Lauren every one to two weeks to monitor any preterm labor symptoms, pre-eclampsia (hypertension during pregnancy) and to follow up on her prescribed injections**
- **Encouraging Lauren to stay off her feet as much as possible so that she could maintain her pregnancy to at least 35 weeks**
- **Establishing contact with Lauren's physician to monitor clinical status, authorize needed services and provide network steerage**
- **Providing continued education and monitoring on pre-term labor, the importance of taking all prescribed medications and injections, staying hydrated, and eating a balanced diet to help balance glucose levels, and emphasize the importance of delivering post 35 weeks**
- **Discussing causes of elevated blood pressure, signs to look for, and what to do if she feels like it is elevated**

Results: Lauren delivered a healthy baby boy via caesarean section at 38 weeks with no resulting complications or NICU bed days. Initially Lauren experienced some left calf pain, but an ultrasound ruled out a deep vein thrombosis. During her post-partum period Lauren's blood pressure remained stable and both were discharged home after an uneventful stay. Follow up with Lauren revealed she and the baby are doing great. She is breastfeeding with the baby latching on well. **The savings for Lauren's case currently total more than $585,000.*** ***This communication is intended for informational, promotional purposes only. The reference to previous outcomes made as a part of this communication does not guarantee success in any new or future case(s), as the result of each case depends upon many factors, including the facts of each case.*** ****Case savings include managed savings and negotiated savings and follow guidelines prescribed by the Case Management Society of America (CMSA). Managed savings reflect avoidance of potential charges realized through the intervention/actions of the case manager. Negotiated savings reflect savings off actual charges negotiated by the case manager with an individual provider.***	
5.B.3 Describe your process for managing Participants with congestive heart failure. **Throughout the coaching process, nurse health coaches:** ▪ **Provide participant-centric coaching that is tailored to each member's comfort and self confidence levels (PAM® level)** ▪ **Emphasize clinical outcomes and personal health goals (clinical metrics are listed below)** ▪ **Help to reduce gaps in care (i.e. receiving nephropathy screening and annual exams – listed below under clinical metrics)** ▪ **Address the changes that have occurred since the last call** ▪ **Teach self-management** ▪ **Provide educational resources** ▪ **Utilize motivational interviewing techniques** **Nurse health coaches also use Coaching for Activation to:** ▪ **Help participants develop tailored goals that are incremental and achievable as based on their activation levels (PAM® level)** ▪ **Motivate participants and elevate their self-confidence in managing chronic conditions** ▪ **Educate participants on warning signs, symptoms and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant**	5 points

▪ **Coaching for Activation focuses on seven core areas of self-management:** o **Help participants develop tailored goals that are incremental and achievable as based on their activation levels** o **Motivate participants and elevate their self-confidence in managing chronic conditions** o **Educate participants on warning signs, symptoms and what to do if they occur** o **Provide educational resources specific to the interactions and needs of each participant** o **Stress and coping** o **Information seeking** o **Smoking cessation** **For participants with congestive heart failure, we also focus on the following clinical metrics to ensure the member is compliant with all and coach them on these metrics.** ▪ **ACE/ARB use** ▪ **Annual flu vaccine** ▪ **Beta blocker use** ▪ **BP<= 130/80** ▪ **Monitor Weight** ▪ **Pneumonia vaccine** ▪ **Smoking cessation ID and advice** ▪ **Appropriate use of medications**	
5.B.4 Describe your process for managing Participants with chronic obstructive pulmonary disease. **Throughout the coaching process, nurse health coaches:** ▪ **Provide participant-centric coaching that is tailored to each member's comfort and self confidence levels (PAM® level)** ▪ **Emphasize clinical outcomes and personal health goals (clinical metrics are listed below)** ▪ **Help to reduce gaps in care (i.e. receiving nephropathy screening and annual exams – listed below under clinical metrics)** ▪ **Address the changes that have occurred since the last call** ▪ **Teach self-management** ▪ **Provide educational resources** ▪ **Utilize motivational interviewing techniques** ▪ **Motivate participants and elevate their self-confidence in managing chronic conditions**	5 points

▪ **Educate participants on warning signs, symptoms and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant** ▪ **Coaching for Activation focuses on seven core areas of self-management:** o **Help participants develop tailored goals that are incremental and achievable as based on their activation levels** o **Motivate participants and elevate their self-confidence in managing chronic conditions** o **Educate participants on warning signs, symptoms and what to do if they occur** o **Provide educational resources specific to the interactions and needs of each participant** o **Stress and coping** o **Information seeking** o **Smoking cessation** **For participants with COPD, we also focus on the following clinical metrics to ensure the member is compliant with all and coach them on these metrics.** ▪ **Annual flu vaccine** ▪ **Pneumonia vaccine** ▪ **Smoking cessation ID and advice** ▪ **Spirometry evaluation** ▪ **Appropriate use of medications** ▪ **Use of appropriate long-term medications**	
5.B.5 Describe your process for managing Participants with asthma including any age-related variations. **Throughout the coaching process, nurse health coaches:** ▪ **Provide participant-centric coaching that is tailored to each member's comfort and self confidence levels (PAM® level)** ▪ **Emphasize clinical outcomes and personal health goals (clinical metrics are listed below)** ▪ **Help to reduce gaps in care (i.e. receiving nephropathy screening and annual exams – listed below under clinical metrics)** ▪ **Address the changes that have occurred since the last call** ▪ **Teach self-management**	5 points

- **Provide educational resources**
- **Utilize motivational interviewing techniques**

Nurse health coaches also use Coaching for Activation to:

- **Help participants develop tailored goals that are incremental and achievable as based on their activation levels (PAM® level)**
- **Motivate participants and elevate their self-confidence in managing chronic conditions**
- **Educate participants on warning signs, symptoms and what to do if they occur**
- **Provide educational resources specific to the interactions and needs of each participant**
- **Coaching for Activation focuses on seven core areas of self-management:**
  - **Help participants develop tailored goals that are incremental and achievable as based on their activation levels**
  - **Motivate participants and elevate their self-confidence in managing chronic conditions**
  - **Educate participants on warning signs, symptoms and what to do if they occur**
  - **Provide educational resources specific to the interactions and needs of each participant**
  - **Stress and coping**
  - **Information seeking**
  - **Smoking cessation**

For participants with asthma, we also focus on the following clinical metrics to ensure the member is compliant with all and coach them on these metrics. We identify adult and pediatric members with asthma and outreach to the parents of children identified with asthma to provide coaching.

- **Annual flu vaccine**
- **Personal action plan**
- **Pneumonia vaccine**
- **Smoking cessation ID and advice**
- **Appropriate use of medications**
- **Use of appropriate long-term medications**

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. **DO NOT INCLUDE ANY ACTUAL COSTS.** **We benchmark our performance based on measures used to evaluate outcomes and satisfaction in regard to the quality and effectiveness of our Case Management program. These measures include monthly case-specific reports that outline Case Management interventions and savings impact, member feedback on the program obtained through member satisfaction surveys, monthly monitoring of the quality and delivery of our Case Management process, and monthly monitoring of client and member complaints or concerns. ROI for our various Case Management programs is determined by calculating the estimated savings achieved through case manager intervention over the cost of the program:** ▪ **ROI for 2016 was 6.6 to 1 for Case Management, 33.2 to 1 for Maternity Case Management, 5.8 to 1 for Neonatal and Pediatric Case Management, 5.7 to 1 for Oncology Case Management, 19.1 to 1 for Transplant Case Management and 3.8 to 1 for Mental Health and Substance Use Disorder Case Management.** ▪ **ROI for 2015 was 6.8:1 for Case Management, 37.3:1 for Maternity Case Management, 5.6:1 for Neonatal and Pediatric Case Management, 5.8:1 for Oncology Case Management and 15.2:1 for Transplant Case Management.** ▪ **ROI for 2014 was 6.0 to 1 for Case Management. ROI for Oncology Case Management was 5.2 to 1, for Maternity Case Management was 38.9 to 1, for Neonatal and Pediatric Case Management was 4.6 to 1 and for Transplant Case Management was 13.8 to 1.** ▪ **Additionally, we measure our member participation rate, which is the percentage of members who agree to engage in the program when we contact them. We are proud of our overall Case Management participation rate. Part of our success is due to the fact that we make more attempts to contact members. We make an average of 3.5 attempts per member, compared to an industry average of 1.7. (This is based on reports from URAC-accredited Case Management companies. Data was not audited or made public by URAC.)** ▪ **2017: 97.2 percent of members who were offered the service participated in the program.** ▪ **2016: 96.7 percent of members who were offered the service participated in the program.** ▪ **2015: More than 95 percent of members who were offered the service participated in the program.** **We also track satisfaction through a biennial client satisfaction survey and send a survey to members after their case has been closed. Our satisfaction rates are also outstanding. In 2017, we completed a full-scale customer satisfaction survey which was administered by an independent consultant, Saperstein Associates. The results showed that 100 percent are satisfied with American Health's programs and services. In our 2015 survey, 98 percent of our clients were satisfied with American Health's programs and services. (As the survey is biennial, we do not have numbers for 2016.)**	5 points

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. **American Health conducts satisfaction surveys for Case Management by sending a survey to the member after the case is closed. Our most recent average for Case Management was 98 percent satisfaction.**	5 points

5.B.8	What percentage of your total population was referred for Case Management during each of the following years 2015, 2016, and 2017?	5 points

Metric	2015	2016	2017
% of total lives in Case Management	1.1%	1.3%	1.2%
% of UM cases referred to CM	21.5%	22.7%	23.6%

5.B.9	Describe your Company's view of your role when working with the patient, family, attending physician and hospital staff? **The case manager acts as an advocate for the member and family members (with the member's permission) and serves as a facilitator between physicians, providers, member and family to ensure smooth communication, achievement of the care plan and the best outcomes for the member.** **In instances where the member is not able to communicate or is not available, case managers will follow HIPAA requirements before speaking with a family member or legal guardian. Case managers step in to help members efficiently navigate the health care system. They work with members to:** ▪ **Help them understand what to expect during the course of their treatment** ▪ **Establish collaborative long- and short-term goals** ▪ **Complete telephonic assessments that assist in determining Case Management needs and requirements; optional onsite visits by case managers are also available** ▪ **Provide education on how to effectively interface with their providers** ▪ **Address questions or concerns the member and/or family members may have throughout treatment and recovery** **Case managers follow cases from start to completion and continually communicate with all parties involved. At the onset of Case Management, a case manager may make multiple calls per day regarding a case, working with the member, provider, facility, client contact, and stop-loss carrier. As the member's condition improves, the number of calls will decrease; but the case manager will continue to manage the case until the member is stable and all cost savings have been realized. Case managers may also work with providers and facilities to negotiate at all levels of care for members and clients in an effort to reduce claims cost.**	5 points

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. **Maintaining successful relationships with participants, payers, physicians/providers, and facilities is at the core of our Case Management program. Our case managers work to judiciously expedite a member's move from a costly inpatient setting to the most appropriate alternate setting. This requires the case manager to work with the member, family, treatment providers and facilities; as well as with additional ancillary vendors, such as home health care and local support groups, to coordinate a caring treatment plan using the member's plan benefit dollars as efficiently as possible.** **We work to help members efficiently navigate the health care system, help them understand what to expect during the course of their treatment, establish collaborative long- and short-term goals, complete telephonic assessments that assist in determining Case Management needs and requirements, provide education on how to effectively interface with their providers and address questions or concerns the member and/or family members may have during treatment and recovery.** **As advocates to the member and family members, case managers serve as facilitators between physicians, providers, the member and family to ensure smooth communication and achievement of the care plan. The member's plan of care is designed to ensure services are implemented in a safe, timely, efficient and cost-effective manner. Case managers encourage the involvement of the member and caregivers as the primary decision makers in the development and implementation of the plan. They contact the necessary providers to coordinate services and stay in close contact with all parties in order to monitor the progression of the plan.**	5 points
5.B.11	What are your procedures to identify and assess alternative services and/or treatment protocols? **Identifying and helping members access alternatives is one of the foundations of our Case Management program. When case managers receive a new case, they review the member's diagnosis. Our case managers are knowledgeable in their specialties and may be aware of alternative options. They also conduct research on the accepted treatments along with alternative treatments. Case managers may identify alternative services, procedures, treatments, facilities, community resources, and more to assist the member in managing his or her care. In addition, our medical director is available as a resource to the nurse.** a. If you identify alternatives to treatment what is your procedure to get those approved? **If an alternative treatment is found, it is communicated with the contact at the client both verbally and in the Case Management report. Alternative treatment options are also discussed with the member, who in turn is encouraged to review these options with his or her physician. If appropriate, the proposed alternative services can also be sent for physician review and approval.**	5 points

b. Who do you think would need to be involved in that process? **As stated above, the process to approve alternative treatment would involve the case manager, the member, possibly the attending physician and/or a physician reviewer and EBD.**	
5.B.12 Describe the criteria your company uses for defining the severity levels related to the Services currently provided. **High Acuity/Intensity is used for all cases during the member/claimant's first month in Case Management. After the first 30-day clinical report is generated, cases that remain in high acuity/intensity include those where the member/claimant's condition is unstable or when the member/claimant remains in an inpatient setting such as an acute care hospital, inpatient acute rehab facility, skilled nursing facility or long term acute care facility.** ▪ **Included in this level are members/claimants who are receiving weekly home care or outpatient services where there is potential for significant change in needs/services.** ▪ **Reports are generated approximately every 30 days (except for Workers' Compensation cases, where the report is generated based on clinical interventions).** **Medium Acuity/Intensity is used for cases where the member/claimant is in an outpatient or home setting and whose medical condition is somewhat stable (member/claimant is receiving less intense services and clinical changes are occurring slowly).** ▪ **Included in this level are members/claimants who are receiving intermittent home care for monitoring; those who are receiving long-term therapy where progress is expected to be slow; or those who are receiving intermittent follow-up care or treatments.** ▪ **Reports are generated approximately every 60 days, unless otherwise indicated (except for Workers' Compensation cases, where the report is generated based on clinical interventions).** **Low Acuity/Intensity is used for cases where the member/claimant's medical condition is stable and where significant changes are not expected (services are minimal or nonexistent).** ▪ **Included in this category are stable members/claimants awaiting transplants, stable oncology member/claimant requiring low monitoring, or recovering rehab or medical/surgical members/claimants with minimal ongoing needs.** ▪ **Reports are generated every 90 days, unless otherwise indicated (except for Workers' Compensation cases, where the report is generated based on clinical interventions).** **All cases are opened as High Acuity/Intensity for at least the first 30 days, unless otherwise indicated. At the time of the first Case Management monthly clinical report, the case manager will assess the member's needs and determine the appropriate acuity level. A member's acuity level is reassessed at the time of each subsequent report for changes to status or needs. If appropriate, the case manager will change the acuity/intensity level in the system.**	5 points

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. **Case managers speak with the member's family members with member's permission. In instances where the member is unable to communicate or is unavailable, case managers follow HIPAA requirements before speaking with a family member or legal guardian.**	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. **For an active case, case managers speak with the member, family members (with member's permission), treating physicians and facilities to ensure the best treatment plan for the individual. Case managers step in to help members efficiently navigate the health care system. They work with members to:** ▪ **Help them understand what to expect during the course of their treatment** ▪ **Establish collaborative long- and short-term goals** ▪ **Complete telephonic assessments that assist in determining Case Management needs and requirements** ▪ **Provide education on how to effectively interface with their providers** ▪ **Address questions or concerns the member and/or family members may have throughout treatment and recovery** **Additionally, contact with physicians/providers will vary in frequency based on the member's needs and plan of treatment. Individual situations requiring alternate frequency of contact are documented in the Case Management notes.** **For a closed case, if contacted by a provider or a member, the case manager will determine whether the reason for the call necessitates opening a new case management case, if a referral to another program, such as disease management, would be appropriate or if the reason for contact can be addressed in one phone call without the need for follow-up. During any contact after a case has been closed, the case manager will ask clarifying questions to make a determination regarding next steps, if any.**	5 points
5.B.15	Describe your process for incorporating tele-medicine services. **American Health partners with Teladoc®, the first and largest provider of telehealth medical consultations in the U.S., to offer 24/7 Physician Consultations that provide clients and members the following benefits:** ▪ **Expanded access – Our telemedicine program expands member access to quality care and improves outcomes.** ▪ **Cost reduction – By eliminating unnecessary visits to the doctor, urgent care or ER, telemedicine reduces claims costs for benefit plans and member out-of-pocket costs, including travel to a facility, missed time from work and the cost of care.**	5 points

- **Member demand – 24/7 Physician Consultations provides access to a doctor whenever and wherever members need it. Members can avoid waits for appointments with a PCP, long-distance travel in rural areas and missed time from work.**

While 24/7 Physician Consultations is not intended to replace a member's PCP or be used during medical emergencies, there are many situations for which it is ideally suited. For example, when a member:

- **Has a common or acute condition that can be treated without a face-to-face visit**
- **Needs assistance after hours, during the evening, on weekends or during a holiday**
- **Is unable to reach his or her PCP or is unable to take time off from work**
- **Cannot make it to a physician's office due to inclement weather or a remote location**
- **Is traveling for business or vacation**
- **Has a health question or is seeking advice**

Physicians providing consultations are U.S. board certified and state licensed and have an average of 15 years of experience. They pass a background test and are extensively trained in telemedicine. Teladoc is the first and only telehealth company to receive NCQA certification for its credentialing process. In addition, strict protocols prevent physicians from prescribing DEA controlled substances, medication for psychiatric illnesses and erectile dysfunction medications. Access to the network of licensed physicians provides members alternatives to visiting higher cost settings for non-emergent conditions, such as colds, flu and digestive issues. This correlates to a reduction in sick-leave absenteeism and less time off work. Members can choose to consult with a doctor by telephone or video through the following process:

- **The member contacts the 24/7 Physician Consultations program by calling the toll-free number or requesting a consult online or via the mobile app. Members can also schedule a consult. Appointments are available seven days a week, every 15 minutes from 7:00 a.m. to 9:00 p.m. in the member's time zone.**
- **The physician contacts the member to conduct a phone or video consultation. The physician is licensed in the member's state, reviews the member's medical history form before the consult, and then discusses the member's medical issue.**
- **The physician recommends appropriate treatment. Based on the consultation, a physician may provide a prescription to the member's pharmacy of choice or recommend the member see a PCP or go to the ER.**
- **The physician updates the member's Electronic Health Record (EHR) in the system. Members may access their EHR online and can choose to send their information to their PCP.**

24/7 Physician Consultations provides members with quality care, offers peace of mind and saves time and money while providing savings for benefit plans by reducing the overuse of urgent care facilities and the ER. In addition, the program follows up with members within three days of the consultation to check on their condition and to check their satisfaction with the service (member satisfaction with the program is 95%). This is an optional program.

Member Website **Members can activate their account on the website, update their medical history, request a consult, access the online Message Center for information about a diagnosis and post-consult care directions, ask follow-up questions, print ID cards and get answers to FAQs.** **Mobile App** **Mobile apps for Android and Apple operating systems provide the benefits of 24/7 Physician Consultations from members' phone or tablet. The app allows members to set up their account, manage dependent accounts and request phone or video consults.**	
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? **When a case is identified for potential Case Management, it is referred for further evaluation by a case management coordinator. The case management coordinator assigns a case manager based on team region and specialty. American Health assigns one case manager who follows the case from identification through case closure.** **We hire and assign cases to case managers based on their specialty background, which is integral to our success. We leverage case managers' experience to provide members with a nurse who is knowledgeable and can be the best advocate for their care. The specialty backgrounds of our nurses include:** ▪ **Maternity** ▪ **Medical/surgical** ▪ **Neonatal and pediatric** ▪ **Oncology** ▪ **Mental health/substance use** ▪ **Rehabilitation** ▪ **Transplant**	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. **Our Case Management program maximizes client savings through intense focus on those members most in need of intervention. To achieve this level of focus, all cases are first triaged by a case management coordinator (CMC). If the CMC determines the member is in need of intervention, only then is a case referred to the Case Management program and assigned to a case manager who has expertise relevant to the member's needs.**	5 points

This unique approach optimizes our ability to achieve cost containment in an expedited and efficient manner. **Once the case is assigned to a case manager, a welcome letter is sent to that member containing case manager contact information, information outlining the case manager role. The member also receives a consent form to be signed and returned to the case manager. The referral reason and all current and previous Case Management, Disease Management and Utilization Management history within iSuite is reviewed to establish any pertinent history. The case manager will obtain benefit and network information/status and any client-specific requirements. All information obtained through this processes is summarized and documented in the case along with a brief plan of care. The case manager will then reach out to the member and, if unable to reach him/her, will send an additional letter to the member outlining attempts to reach the member by phone. Once contact is made, verbal consent is obtained from the member.** **A participant is considered 'engaged' when that individual is actively interacting with a case manager at the frequency prescribed by his or her acuity level.** **A compliant participant adheres to the prescribed treatment plan. The case manager develops a personalized plan of care oriented toward the achievement of short- and long-term goals for the optimal level of wellness. The frequency of contact is determined by the member's clinical status and the services involved. Revisions to the plan of care are made when necessary. These changes are discussed with all parties involved. The case manager assesses the plan's goals for appropriate clinical outcomes, progress toward achievement of member's goals, and cost effectiveness. Any goals not being met are discussed with the member and physician.** **American Health has the flexibility to adjust to certain client-specific criteria and requirements and can ensure all American Health Case Management team members working with plan participants have access to the specifics on an internal site. This promotes efficiency and accuracy as all updates are made in one area and are available to American Health team members in real time.**	
5.B.18 Provide your goal/target for Participants consent to Medical Management? **Once accepted into Case Management, the Case Management staff will mail the member a letter of introduction along with a "Consent for Case Management Services and Authorization to Release Medical Information" form and a Case Management brochure. Once returned, the signed consent form (or verbal acknowledgment) is retained in the member's file and the date of receipt documented in the system.** **The case manager will attempt to contact the member/family for consent at least two times telephonically within the first 10 calendar days of case opening. The case manager will attempt contact at different times and, if possible, leave a voice message requesting a callback. If a telephone number is not available, the case manager will attempt to find a current number. If a number is not located, an "Unable to Contact Letter" is sent to the member.**	5 points

If the member is in an inpatient setting, the case manager will leave a name and number with the discharge planner and request the member, family member or primary caregiver contact the case manager as soon as possible. When the case manager speaks with the member/family, they review the purpose of Case Management, request verbal consent and ask that the consent form be signed and returned as soon as possible. **Consent Exceptions: The case manager will request consent from the member but may obtain consent from another family member or primary caregiver in extenuating circumstances. The case manager may also obtain consent from the member's guardian, parent of a minor child or legal Power of Attorney, when appropriate.**	
5.B.19 Provide your goal/target for Participant engagement of no less than 2 calls with certified case manager. **High Acuity/Intensity members are contacted every one to two weeks based on the member/claimant's needs and plan of treatment. Medium Acuity/Intensity members are contacted every two to four weeks or four to eight weeks based on the member/claimant's needs and plan of treatment. Low Acuity/Intensity members are contacted every eight to 12 weeks based on the member/claimant's needs and the plan of treatment. Our goal is to have the member engage with our medical management staff throughout their disease/illness.**	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? **Our current process allows two business days for review of a referral to Case Management by the case management coordinator (CMC). The CMC review includes the reason for the referral, any current clinical information available in existing utilization review or Disease Management cases, the member's eligibility to participate in Case Management and case history. From this review, the CMC determines potential Case Management needs and assigns the case to a case manager. The case manager then has seventy-two (72) hours to open a case from the time it is assigned. Contact attempts are always first initiated by phone in order to most quickly attempt to engage the member. If phone attempts are unsuccessful, a letter is mailed to the member. To meet the timeframes set forth in the RFP, a team of dedicated case managers and CMCs will be assigned to this business.**	5 points
5.B.21 If the assigned Case Manager is not available, describe the process for addressing the Participant's needs. **Nurses are assigned back-up team members to cover when they are not available. When someone leaves the organization, an assessment of their open remaining cases takes place, and any open tasks are assigned to team members to transition, work and resolve remaining cases.**	5 points

5.B.22 Describe your process for confirming Participant eligibility, provider network status, and covered services before recommending a care plan. **As a part of our standard Case Management process, our case managers verify member eligibility, benefit language, plan limitations and network information upon case initiation and throughout the time the case remains open. In addition, when a specific service is requested, our case managers will verify benefit language, any plan limitations and provider network status specific to that request. They take into consideration the member's needs, care requirements, geographic location and provider network status when developing a plan of care.**	5 points
5.C Utilization Management (UM)	
5.C.1 How often do you review participant utilization? **We are proposing advanced Utilization Management services that support cost containment through Reference-Based Pricing. On a daily basis, American Health's integrated iSuite platform provides reporting to our utilization review supervisors and clinical team for review of specific member utilization. On a monthly or more frequent basis, our team will review member utilization and assess any negative trends that may adversely affect the plan. On a quarterly basis, our dedicated Business Intelligence unit will evaluate macro-level member utilization across time to discern any patterns – such as increased use of diagnostic testing – that may be indicative of over-utilization by specific members or providers.** **At American Health, our depth of experience in medical management, coupled with our state-of-the-art data mining, reporting and analytics tools, provides our clients with the most extensive and proactive cost containment framework in the industry.**	5 points
5.C.2 Describe your company's workflow for notification of high utilization Participants. **Avoiding unnecessary emergency room visits is a key goal of our programs. iSuite, our integrated medical management platform, will notify us of high utilization for specific members through its automatic triggering system. Among other "triggers," our system will, for example, automatically look for members who have been admitted multiple times over the course of time (typically the last 30 days for acute inpatient admissions) and create a referral to Case Management. The referral is reviewed by a registered nurse to determine if the member is a candidate for more in-depth Case Management services.**	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. **When a specific medication requires prior authorization, our utilization review nurses will review the reason it is being prescribed and clinical information related to the condition for which it is being prescribed. They will then compare the clinical to MCG Health, LLC criteria or Aetna CPB to determine the medical necessity. As a part of their review process, the utilization review nurses request and review a list of medications administered to a member. This also is the concurrent review process for continued inpatient hospital stay when medication information is provided.**	5 points

Our Case Management and Disease Management nurses perform a medication reconciliation review during each member contact, as well as at the time of receipt of new or updated information from treating providers. This process involves a comparison of the member's current list of medications with the treating provider's orders and is used to identify potential conflicts, omissions, duplications or dosing discrepancies. Members are asked a series of questions regarding knowledge of their medications and the condition(s) they are used to treat and any side effects. Members are also encouraged to share their updated list with their treating provider.	
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? **When Disease Management is part of medical management services, we can use the pharmacy and lab data provided to review for medications. We also review medications for members in Case Management via information provided by the physicians/providers. Integration of services allows our nurses to address a number of issues, such as multiple prescribing physicians. Our standard Case Management model includes a medication reconciliation process and, if duplication is identified, the case manager can obtain the names of the physicians prescribing medications to the member and work with both the member and the physicians to make sure each physician knows what the others are prescribing. Also, if needed, the case manager can work with the patient to have one primary care physician who oversees all medications.**	5 points
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. **We utilize Trilogy internally, as well as the Aetna guidelines. Many of our clients, including the State of Oklahoma, use these guidelines as their basis even though they do not use Aetna. They are publicly available on the internet.**	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. **The definition of a cosmetic procedure varies by health plan. Some clients require a letter of medical necessity be submitted prior to services being rendered. Once the Utilization Management nurse deems a service is potentially cosmetic according to MCG Health, LLC criteria, we advise the member's physician/provider that we are unable to certify services. We document in the system that criteria have not been met and indicate the case has been referred to a physician reviewer. American Health employs one full-time medical director who oversees a panel of medical specialists for all initial reviews that involve medical necessity determinations.**	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. **Concurrent review is conducted based on severity of illness, intensity of service, and length of stay when the member remains hospitalized, or when the course of treatment extends beyond the initial certified length of stay. The review frequency for extension of the initial determination varies and is not routinely conducted on a daily basis.** ▪ **On the assigned review date, the Utilization Management staff will contact the physician's office, or hospital/facility, and request information regarding continued stay, continued outpatient services or discharge status of the member.** ▪ **If clinical criteria are met for continued stay, the nurse will:** o **Advise the requestor of the certification of additional days/services and the reference number.** o **Advise the caller of the following and document in the case notes: For admissions, the number of extended days certified, the new total number of certified days, the last covered day and the next review date for medical necessity determination for continued services. For services, the number of extended visits certified, the new total number of certified visits, total certification period and the next review date for medical necessity determination for continued services.** ▪ **If clinical criteria are not met for continued stay, the nurse will:** o **Advise the member's physician/provider, that we are unable to certify services, and refer the case the same day to a physician reviewer.** o **Document in the UR System that criteria has not been met and indicate that case has been referred to a physician reviewer.** **The attending physician then has the opportunity to request a peer-to-peer review or reconsideration based on additional clinical information either provided by fax or phone and an appeal of the adverse determination, if necessary.**	5 points
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. **When we determine a member requires a medically necessary service not available in the member's area or that cannot be performed or provided within a network facility or by a network provider, our experienced case managers will work with the member, based on the service to be provided and their geographic area, to locate a qualified out-of-network provider to perform or provide the service. Once the out-of-network provider has been located, the case manager will work with that provider to negotiate an agreement to provide those services at a reduced cost, which is typically a percentage of billed charges. In addition, as a part of the agreement, the case manager will work with the provider to ensure the member is not balance billed for the service.**	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?	5 points

Precertification (pre-service or prospective) review

- **The member, provider, claimant or their authorized representative may initiate a precertification request for a review by telephone, letter or fax.**
- **Participants should follow their health plan's rules and guidelines for making a Utilization Management request, including contacting the Utilization Management vendor regarding an inpatient admission or outpatient service, (including elective, urgent, emergent, or other services defined by the client's health plan).**
- **If the initial caller is a member or their authorized representative, the intake coordinator or Utilization Management nurse will:**
  - **Search the UR system for an existing member or member, record and verify the demographic information or, if no record is found, obtain and enter the initial demographics in the UR system within 24 hours of receipt of request.**
  - **Contact the attending physician's office or the admitting/UR Department at the hospital/facility to verify the information provided by the member or their authorized representative.**
  - **Request any additional clinical information needed to complete the review.**
- **If the initial caller is a physician's office, the admitting/UR department at a hospital or a medical provider, and the caller has clinical information, the intake coordinator will transfer the caller to a nurse who will:**
  - **Confirm the type of review request. The nurse may override late notification as needed or upon request of Client.**
  - **Obtain and document all relevant clinical information, including the type of admission, diagnosis code, and procedure code(s) requested or performed.**
  - **After receipt of the clinical information necessary for completion of the review, the review determination will be made.**
- **Apply appropriate clinical criteria when making medical necessity determinations for requested services. Review determinations are based solely on the clinical information obtained at the time of the review determination.**

▪ **If necessary clinical information is provided and clinical criteria appear to be met, results of the review will be verbally communicated to the caller at the time of the determination. The caller/requestor will be advised of the following:** o **Number of certified days/services;** o **Reference number;** o **Last day covered by certification; and** o **Date that an update is needed for continued inpatient stay settings.** o **Read the appropriate disclaimer, document that it has been given, and certify the case in the UR system.** ▪ **If necessary clinical information is provided and clinical criteria are not met, the nurse will:** o **Advise the member's physician/provider, that we are unable to certify services, and must refer the case the same day to a physician reviewer.** o **Document in the UR System that criteria has not been met and indicate that case has been referred to a physician reviewer.** ▪ **Assess the member's discharge planning needs/services to determine if appropriate for Case Management referral.** ▪ **Record detailed information about each contact in the UR system, including the date and name of person(s) contacted.**	
5.C.10 Describe your process for monitoring provider transparency related to evidence based medical (EBM) outcomes. **We would work with the State to align provider transparency and evidence based outcomes. Incorporating the Department if Health and Medicaid would create a more realistic opportunity to impacting this.**	5 points

5.C.11 Detail any value-based program incentives (i.e. PCMH, CPC+, ASO, etc.) offered for best practice care. **As one of the largest independent TPAs, HealthSCOPE Benefits has the experience, resources and flexibility to develop, administer, and market health system Accountable Care Organizations (ACOs) to:** **Health system employees** **o Self-funded and fully insured employers** **o Individual Commercial and Medicare Advantage Plans** **o Other Managed Care Organizations and Payers** **o Private and public exchanges**	5 points

We currently work with ACO programs with Mercy Health Systems in St. Louis and Springfield, MO, with Baptist in Memphis, TN and Blanchard Valley Health System in Findlay, OH. In addition, we administer ACO/CINs for health systems for their own employees in Missouri, North Carolina, South Carolina and Ohio. We are currently working to implement ACO arrangements in Connecticut, Oklahoma, Georgia and Iowa.

As one of the largest independent TPAs, HealthSCOPE Benefits has the experience, resources and flexibility to develop, administer, and market health system ACOs to—

- **Health system employees**
- **Self-funded and fully insured employers**
- **Individual Commercial and Medicare Advantage Plans**
- **Other Managed Care Organizations and Payers**
- **Distribution through private and public exchanges**

HealthSCOPE Benefits offers health systems a different option than the large carriers and carrier-owned administrators. We offer unlimited flexibility, unmatched speed to market, and independence. We produce the data and information needed to drive ACO development, manage value-based care and support bundled payments.

This is the HealthSCOPE Benefits Difference for emerging ACOs - Combining the strength and resources of a national platform, with the flexibility and high touch customer service of an independent TPA.

We have built and administered Accountable Care solutions and patient-centered medical homes where we have provided capitated payments, patient rosters, and data analysis to support value-based care initiatives. HealthSCOPE Benefits' system capabilities and team are well positioned to support ACOs through custom reimbursement arrangements and the administration of provider incentives for quality outcomes.

HealthSCOPE Benefits was created in the 1980s to develop custom networks in rural areas. This legacy of collaborating with providers combined with our recent investments in value-based care makes us the right partner as health systems introduce the next generation of ACO solutions.

• We have developed, through a relationship with Mayo Clinic and their three geographically positioned destination locations, a Complex and Serious Illness Program for large employers. This includes complex conditions that are substantially disabling, often miss-diagnosed and are rare and unique or life threatening, requiring treatment and services across a variety of specialties of care. We also look to collaborate and develop custom care pathway programs that are disease specific in areas such as cancer or cardiac care and focus on the highest value of care, better outcomes and improved total cost of care.

We have had a lot of success with PCMH and have seen great results. Our biggest success and longest running has been Whirlpool in Findlay, Ohio. We have learned the physicians and hospital must trust each other, physicians are reluctant to add staff without revenue guarantees and PCPs need help with disease management and smoking cessation in order to be successful.

Medical Home is having an impact on engagement of members.

- **People in the MH are more likely to have a Biometric Screening and complete a Health Assessment. Wellness Exams, Mammograms and other activities are received at higher rates by the MH population.**

Medical Home members are more expensive on a PEPY basis, but this can largely be attributed to utilization of the services that have a long term impact like PCP visits and wellness.

- **Members with chronic conditions are engaged and using the plan.**
- **IP Admits and ER visits are less for MH.**
- **PCP and Specialist utilization is higher for MH members**

We have several other PCMH arrangements in place, as well. We can provide daily data feeds and monthly physician rosters to support the PCMH.

HealthSCOPE Benefits continues to innovate and participate in multiple quality improvement measures. HSB has worked with the development of and implementation of Patient-centered medical homes (PCMHs), Episodes of Care and Comprehensive Primary Care Plus (CPC+), in fact HSB was the only Third Party administrator in the country to be approved by The Centers for Medicare & Medicaid Services (*CMS)* to participate in CPC+.

5.C.12 Provide sample copies of all reports, including but not limited to: a. Participant utilization **Please see our sample Utilization Management Summary, Case Management Summary, and Disease Management Summary reports included as attachments to our proposal within Section IV.** b. Re-admission rates **Please see our sample Readmission Report included as an attachment to our proposal within Section IV.** c. Gap analysis **Please see our sample Gaps in Care Report included as an attachment to our proposal within Section IV.** d. Co-morbidities **Please see our sample Disease Management Summary included as an attachment to our proposal within Section IV. If a member has one of the nine conditions covered in Disease Management and agrees to coaching, we will also coach for co-morbidities.** e. Financial (i.e., provider discounts) **Please refer to our Standard Reporting Package located within Section III.** f. Clinical criteria **Clinical criteria are not included in our reports.** g. Appeals related to Medical Management (and their results) **Please see our sample Appeal Log included as an attachment to our proposal within Section IV.**	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. **American Health's staff of nurses includes a number of behavioral health specialists, the hiring requirements for whom are as follows:** ▪ **Active, unrestricted RN or LSW licensure and three years of clinical practice experience** ▪ **Practice Case Management within the scope of their licensure (based on the standards of the discipline)** ▪ **Associates (or higher) degree in a health-related field preferred** ▪ **Certification as a case manager preferred** ▪ **Diverse medical background with exposure to multiple environments** **American Health's Utilization Management staff includes six nurses who are dedicated to mental health. Our Case Management team members' clinical knowledge and expertise is the foundation of our URAC-accredited program. Our Case Management team includes:** ▪ **Twenty RNs with the clinical specialty of mental health/substance use disorder** ▪ **Six licensed social workers** ▪ **One Case Management supervisor with over 12 years mental health/substance use disorder experience** ▪ **Seven board-certified physicians whose specialties include psychiatry, psychology, neurology, pain management and addiction medicine** **Case managers are hired by specialty background and receive training consisting of overviews of Case Management department and process, orientation to the telephone and software systems including the Utilization Management module, and an understanding of the relationship between Utilization Management and Case Management. Trainees receive intensive classroom education pertinent to all aspects of the Case Management process, including Case Management requirements outlined by URAC and other state or national accrediting Case Management agencies impacting Case Management practice standards. Case managers' cases are monitored closely during and after training.** **Case Management supervisors hold monthly team rounds to review cases and share information regarding Case Management processes and methods of achieving impact on cases. Additionally, Supervisors and Case Management Staff Development Coordinator assess and develop focused training programs as needed, and are available to case managers for questions and guidance. Continuing education is part of our daily process, as evidenced by our frequent updating of training and policy/procedure manuals, regular departmental meetings which include updated client requirements, and quarterly continuing education and Enrichment programs designed to keep the nurses updated on new trends and health care issues and standards.**	5 points

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

5 points

Utilization Management nurses have at least five to eight years of clinical experience and the following qualifications:

- **Registered nurse**
- **Active licensure in state of practice**
- **Diverse medical background, with mental health/substance use disorder background preferred**
- **Three years acute hospital care and/or Utilization Management experience**

Utilization Management staff undergo up to four weeks of training—either onsite or from our dedicated, fully equipped training facility in Ohio. Training is comprised of intensive classroom experience, including overviews of managed care, training on all the telephone and software systems utilized, URAC requirements, and state and federal regulations impacting Utilization Management. Trainees observe experienced staff as they demonstrate processes, and then are provided with hands-on training under supervision. New staff members demonstrate a return checklist of competencies, and are monitored as part of their training. Continuing education consists of frequent updating of training manuals, regular departmental meetings which includes updated client requirements, and quarterly continuing education and enrichment programs designed to keep staff updated on new trends and health care issues and standards.

The Utilization Review process entails a thorough review of the proposed treatment plan by licensed medical professionals to evaluate the plan for appropriate and cost effective mental health care services. The relevant clinical information provided by the physician or the hospital/facility at the time of the review request is utilized in completing a review. We provide mental health and substance use inpatient certification by working with mental health providers to assess treatment goals and objectives, and providing medical necessity determinations for mental health and substance use disorder inpatient admissions. Our specially trained psychiatric nurses or master level licensed social workers review psycho/social/medical assessments and member risk levels, support systems and cognitive learning capabilities and use established criteria to determine the medical necessity of the inpatient setting and length of stay. Following admission, our psychiatric specialists conduct concurrent reviews to assure goals have been achieved and work with the treating providers to determine date of discharge.

Using the ASAM Criteria (Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions) and MCG Health, LLC Behavioral Health Guidelines for mental health, nurses are able to direct Mental/Behavioral Health members toward the most appropriate level of care. The guidelines are established for five levels of behavioral health care:

- **Inpatient Care**
- **Residential Care**
- **Partial Hospitalization Program**
- **Intensive Outpatient Program**
- **Acute Outpatient Care**

If necessary clinical information is provided and clinical criteria are not met, the nurse will advise the member's physician/provider, that we are unable to certify services and must refer the case the same day to a physician reviewer. The nurse will then document in the UR System that criteria has not been met and indicate that case has been referred to a physician reviewer.	
5.D.3 What criteria does your company use to determine if a Participant needs immediate placement by a mental health professional? **This depends on the program in which the member is engaged. In Case Management, case managers follow cases from start to completion and continually communicate with all parties involved. A case manager may make multiple calls per day, working with the member, provider, facility, client contact and stop-loss carrier. Our master-level LISW or LSW, social workers and psychiatric nurses work with treatment centers to develop psycho/social assessments and identify community resources to ensure appropriate behavioral treatment plans. They are also able to refer members to the State's EAP when it is the most appropriate solution. The case manager would refer the member to an appropriate mental health professional, if deemed necessary in the course of Case Management services.** **In Disease Management, American Health's program provides a one-to-one experience—each participant benefits from working with a primary nurse health coach assigned to the case. The nurse health coach will use other resources based on his/her judgment and the participant's desires. The nurse would be aware of any co-morbidities and may have already engaged mental health resources. These resources may include community resources, additional services provided by the employer such as health and wellness programs, the State's customized EAP services, or referral to a local professional. Our one-to-one interaction model carries the added benefit of providing a member with a treatment plan that is highly individualized and specific to the member's individual needs.**	5 points
5.D.4 How do you assist a Participant in connecting with a mental health professional? **In Case Management, after conducting the initial assessment, the case manager will refer the member to a local mental health professional who also participates in his/her group health plan's mental health and substance use network. Additionally, we can load the plan's provider network, which can be a resource for referrals.**	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.	5 points

The Patient Activation Measure (PAM®) and Coaching for Activation (CFA®) comprise the foundation of our Disease Management program. Our nurse health coaches use these proven, evidence-based tools, described below, to guide their interactions with members:

The Patient Activation Measure® (PAM®) survey from Insignia Health - A validated instrument developed by the University of Oregon that measures a participant's knowledge, skills, and ability to:

- **Self-manage a condition**
- **Collaborate with providers**
- **Maintain health status and prevent declines in health**
- **Understand important clinical signs relevant to his/her condition**

The survey process results in a confidence level (1-4) that drives nurse coaching, dialogue and goals in order to improve participants' confidence and self-management skills.

Coaching for Activation® (CFA®) to:

- **Help participants develop tailored goals that are incremental and achievable as based on their activation levels**
- **Motivate participants and elevate their self-confidence in managing chronic conditions**
- **Educate participants on warning signs, symptoms and what to do if they occur**
- **Provide educational resources specific to the interactions and needs of each participant**

CFA® focuses on seven core areas of self-management:

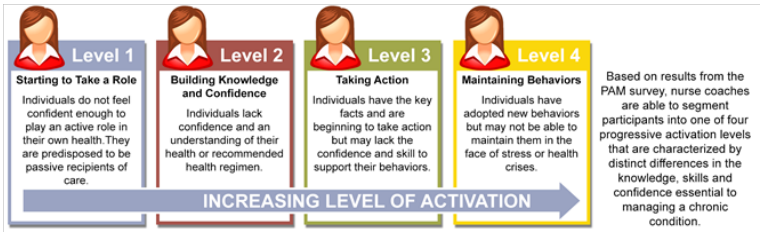
- **Condition and symptom understanding**
- **Medication adherence**
- **Diet and nutrition**
- **Physical activity**
- **Stress and coping**
- **Information seeking**
- **Smoking cessation**

Motivational interviewing is a highly effective form of counseling that elicits the member's motivation for making behavior changes in the interest of his or her health. It involves guiding more than directing, listening more than telling and collaboration in a joint decision-making process.	
5.E.2 How long have you had the Disease Management program in place? **American Health has offered URAC-accredited Disease Management since 2005.**	5 points
5.E.3 Provide the workflow for identifying and enrolling Participants in your DM services. **Identification Process** **American Health uses a predictive modeling process that analyzes a client's medical and pharmacy claims data. The resulting predictions incorporate clinical factors, such as diagnoses, episode treatment groups, gaps in recommended standards of care, prescription use and other risk markers, such as timing and frequency of procedures to identify individuals with chronic conditions specific to each client's population. The predictive model's underlying models enable a client's data to "speak" and therefore, identify key drivers of cost and risk in its population.** **Engaging Identified Members** **American Health recognizes the importance of implementing an engagement model that meets the needs of the population. Our Disease Management program is based on an opt-in engagement model that includes a combination of letters and phone calls to inform members of this benefit and to encourage them to enroll if identified with one or more of the nine conditions. We have a flexible engagement model and can adjust the process to improve the member experience and thus the opportunity for increased program success.** **At the start of the program, American Health mails a customized letter from the group's CEO or HR Representative to each employee's home. In the letter, a client may convey any general information it chooses, such as benefits of the program, incentives for participation, or information regarding other worksite wellness programs it offers. We collaborate with our clients to craft a message specific to their needs. After participants are identified for Disease Management via predictive modeling, an Invitation letter from American Health is sent explaining the program and informing them that a program representative may contact them.** **About a week after the invitation letter is sent the member will receive a phone call from an Engagement Specialist who explains the benefits of the program, answers any questions the member may have, and administers the PAM® survey. The Engagement Specialist will warm transfer the member to a nurse health coach or schedule a time for the coach to call the member back. We will make four attempts to reach the member by telephone. If after the fourth attempt we have not yet reached the member, we will close the case and make a notation in iSuite. In order to increase our ability to reach members, it is critically important that we are provided with current and comprehensive listings of member telephone numbers and addresses during the implementation process. Telephone contact with members – not only for enrollment purposes but for ongoing education and intervention – is an integral component of all of our programs.**	5 points

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

Coaching and Counseling

In order to develop a participant's individual care plan, nurse health coaches utilize results from the predictive modeling process as well as information obtained from members such as clinical test results, biometric values and results from the Patient Activation Measure (PAM®) survey – our unique, clinically-proven assessment tool that effectively measures activation and provides nurse health coaches insight into participants' attitudes and behaviors:



Insights Gained from the PAM Survey

Instead of assessing behaviors in isolation, the PAM® survey recognizes that people who feel 'in charge' of their health engage in a whole range of behaviors. The PAM® survey is reliable and valid for use with both consumers managing a chronic illness and has been found useful wherever consumers have a significant role to play in managing their health. The insights gained with the PAM® survey can be used for predictive modeling, population segmentation, the individual tailoring of care support, and in the evaluation of program efficacy. Based on a participant's PAM® score, nurse health coaches employ the Coaching for Activation® (CFA®) model to set behavior-change goals and action steps tailored to each individual's capability, and use clinical evidence-based guidelines to measure the results of outbound telephonic education and counseling. Using the PAM® survey, CFA®, motivational interviewing and other available resources, nurses:

- **Set incremental, participant-specific targets and goals for achievement**
- **Motivate participants and elevate their self-confidence in managing chronic disease**
- **Educate participants on warning signs, symptoms, and what to do if they occur**
- Provide educational resources specific to the interactions and needs of each participant
- Identify ways for participants to improve and maintain their health

Targeted Conditions

American Health's Disease Management program addresses nine of the most prevalent conditions. Our nurse health coaches work with participants to help them self-manage their conditions and address the following topics:

- **Asthma (pediatric and adult) – The asthma program focuses on increasing awareness of a member's symptoms and when they occur; encourages the use of a daily diary to track symptoms; addresses issues regarding diet and exercise; provides information about asthma medications and the importance of good medication management; addresses barriers members may have with medication adherence; and works with members to identify causes of asthma symptoms and potential adjustments to reduce symptoms.**

- **Chronic kidney disease (CKD) – The CKD program helps members gain an understanding that kidney disease is a slow deterioration of kidney function and if not managed can lead to ESRD (end stage renal disease), kidney transplant, and kidney dialysis; discusses lifestyle related behaviors that can slow the progression of kidney disease such as keeping blood pressure and blood glucose in the target ranges, not smoking, physical activity and eating healthy diet; educates members about the behaviors that might make kidney disease worse such as high salt/sodium diet, high protein diet, smoking and uncontrolled stress; educates members on the symptoms of kidney disease and encourages members to track symptoms with a symptom diary which can help them determine when they should call a doctor.**

- **Chronic obstructive pulmonary disease (COPD) – The COPD program focuses on educating members about the signs and symptoms of Chronic Obstructive Pulmonary Disease along with what activities can cause members to feel better or worse; encourages the use of a daily diary to track symptoms; provides education on oxygen therapy (if applicable) and on medications and how they should be taken; and addresses opportunities for improving diet and nutrition.**

- **Chronic pain (from osteoarthritis, rheumatoid arthritis or low back pain) – The chronic pain program helps members gain basic self-awareness of the link between behavior and pain self-management focus areas; provides education on the "Pain Gate" theory and how the 10 focus areas can be applied; raises awareness of how slight changes in behavior can lead to big improvements in health, wellbeing, and pain reduction; helps members develop skills to engage/improve communication with their providers; and teaches members how to troubleshoot, in advance, during difficult times or stressful events.**

- **Congestive heart failure (CHF) – The CHF program provides education on heart health and how medications can work to treat Congestive Heart Failure; educates members on the self-identification of symptoms (such as sudden weight gain) and behaviors that may cause the symptoms; and helps members identify opportunities to reduce symptoms through lifestyle changes such as diet and nutrition.**

- **Coronary artery disease (CAD) – The CAD program educates members on medications and how they work; discusses other health conditions caused by high cholesterol; addresses medication compliance and creates action plans to close any gaps; discusses nutrition and foods that can lower cholesterol levels as well as stress reduction strategies.**

- **Diabetes (pediatric and adult) – The diabetes program helps members manage their diabetes and low blood sugar; provides education on targets for blood sugar, cholesterol and blood pressure; addresses the relationship between carbohydrates and blood glucose and ways to adjust carbohydrate intake; focuses on insulin self-management (if applicable); and helps build awareness of the importance of physical activity and healthy coping strategies.**

- **Hyperlipidemia (high cholesterol) – The hyperlipidemia program provides members with education on cholesterol and how to achieve healthy target ranges for cholesterol levels; addresses risk factors of high cholesterol; discusses lifestyle impacts to high cholesterol and opportunities for changes; discusses how stress may impact cholesterol levels and opportunities for stress management; and provides education on medications and how they should be taken.**

- **Hypertension (high blood pressure) – The hypertension program helps members to understand blood pressure targets and the importance of knowing their numbers; discusses how member lifestyle, activity level, diet and salt intake can impact blood pressure; and addresses different medications and how they work to lower blood pressure.**

Personal Health Coaches for Members with Chronic Conditions **Depending on the participant's level of activation, the frequency of contacts from a nurse health coach will vary. Nurse health coaches work one-to-one with members who have chronic conditions, providing them with a variety of opportunities to receive motivational health counseling and condition-specific education that focuses on self-care, clinical improvements, and prevention of complications. Nurse health coaches are trained in motivational interviewing techniques and use clinically-proven tools to assess participants' confidence and ability to self-manage their health. They have access to as much member data as is available, including, for example, viewing a member's medical and prescription claims data when this information is provided.** **Online Digital Coaching** **As an additional option to the Wellness Portal, members can access Disease Management digital coaching options. Categories include:** ▪ **Asthma** ▪ **CAD/Coronary Artery Disease** ▪ **Cancer Care** ▪ **Chronic Condition Management** ▪ **Chronic Pain** ▪ **Diabetes** ▪ **GERD/Gastric Reflux Disease** ▪ **Heart Health** ▪ **Kidney Disease** ▪ **Lupus** ▪ **Migraines** ▪ **Osteoarthritis** **Digital Coaching includes motivational interviewing techniques and is personalized to members, predicting the best tools for each individual based on their profile and behavior. Activities include a mix of articles, videos, graphics, surveys and quizzes. As members complete activities, they earn Heart Beats, which track progress and can be incentivized. A limited number of Heart Beats can be earned per week to encourage long-term behavior change. For those members also engaged telephonically, online programs supplement and support the telephonic program, and the coach will encourage the member to complete various activities online.**	
5.E.5 Provide a list of the co-morbidities you actively manage. **Once the PAM® and clinical assessment are completed, identification of the disease state and risk stratification is begun to help the participant ensure appropriate services and interventions are rendered while considering the potential for health care disparities. This includes any comorbid conditions and risk factors (including behavioral health problems such as depression or tobacco use). Common comorbidities may include:** ▪ **Asthma: obesity, smoking** ▪ **Chronic Kidney Disease: obesity, diabetes, hypertension, congestive heart failure** ▪ **Chronic Obstructive Pulmonary Disease: chronic kidney disease, diabetes, hypertension**	5 points

▪ **Chronic Pain: obesity, depression** ▪ **Congestive Heart Failure: chronic kidney disease, diabetes, chronic obstructive pulmonary disease** ▪ **Coronary Artery Disease: obesity, diabetes, hypertension, hyperlipidemia, depression** ▪ **Diabetes: obesity, chronic kidney disease, hypertension, hyperlipidemia** ▪ **Hypertension: obesity, hyperlipidemia, diabetes** ▪ **Hyperlipidemia: obesity, coronary artery disease, diabetes, hypertension**	
5.E.6 Provide an overview of your experience managing Participants with multiple co-morbidities? **Most participants in our program have more than one condition or co-morbidity, which has provided us with a wealth of experience in managing these members. Our nurse health coaches use clinical assessments to get a picture of the overall health of the member. They then provide education and support for all health issues.**	5 points
5.E.7 Provide an example of managing two Participants with the same co-morbidities, but differ in age, gender and overall health? **Our nurse health coaches tailor coaching to each member's needs. Factors including age, sex, other health conditions, support system, current treatment plan for the condition, and more are identified through assessments and addressed during coaching. Following are the requested examples:** **Background:** **Member 1 is a 70 year-old who presents with DM/CAD/HLIP. Upon initial enrollment, his PAM® score was 4.** ▪ **Last lab work provided: A1c 5.4; TC 168; HDL 62; LDL 88; TRG 90** ▪ **Diet: Low carb diet, small evening snack** ▪ **Exercise: Goes to the gym and walks four miles every day on the treadmill.** ▪ **BMI: 27** ▪ **Medications: Metformin; Crestor; Lisinopril; ASA** **This member is well-controlled with his health conditions and does a great job with his diet and exercise. He understands the important roles diet and exercise play in maintaining his health and keeping his numbers within the limits set by his PCP. This member, per his PAM® level of 4, requires a call every three months. At this level, the member is maintaining his behaviors and the focus is on preventing a relapse and handling new or challenging situations as they arise.** **Background:** **Member 2 is a 38 year-old female who presents with DM/CAD/HLIP. Upon initial enrollment, her PAM® score was 3.**	5 points

▪ **Last lab work provided: A1c 10.8; TC 309; HDL 25; LDL 188; TRG 480** ▪ **Diet: Does not follow any special diet; habits include a significant amount of fast food and sweets.** ▪ **Exercise: none** ▪ **BMI: 42** ▪ **Medications: Metformin; Lantus; Tradjenta; Omeprazole; Crestor; Metoprolol; Plavix; Mobic** **This member's diabetes and cholesterol are not controlled. The member does not have an understanding of her health conditions and what changes need to be made to improve her numbers and overall health. Their initial PAM® level was 3, requiring a call, per the level coaching timeframe, every two months. However, due to the member's lab results (A1c >9) and her lack of understanding regarding diet/exercise, we will contact the member monthly. We will focus as the Nhc on a combination of the levels, first building knowledge and confidence with the member then, as they progress, adoption of new behaviors.**	
5.E.8 Provide a description of how you measure the results of your Disease Management services and provide examples. **Our cost savings reports for the Disease Management program focus on showing how well we are containing costs for members with chronic conditions. Our PAM®-based Cost Savings Analysis report is available to all groups and quantifies the financial impact of our program based on changes in a client's aggregate PAM® score over time. For example, based on research, a four-point increase in a client's aggregate PAM® score equates to approximately $156 in annualized savings per month.** **For groups who meet historical eligibility, historical medical and pharmacy claims, and minimum number of participant requirements, American Health can provide a Claims-based Cost Savings Analysis. This report is based on our comparative analysis methodology that was developed through our partnership with SCIO Health Analytics, a leading health analytics services company. Savings are calculated by comparing utilization of the managed population (members enrolled in the Disease Management program) versus the unmanaged population (members identified but not enrolled in the program) over a defined period. The average medical cost savings per managed member per month is $512, with an average annual savings of $5,071 (based on a population of 46,131 eligible lives over a seven-year period).** **For an example of how we can make an impact for individual members, please see the success story below.** **Primary Condition: Coronary artery disease** **Baseline: "Aaron" is a male in his 50's who enrolled in Disease Management with coronary artery disease. He had high blood pressure, weighed 220 pounds and had a BMI of 29, which is overweight and nearly obese.** **Intervention: During their calls, Aaron's nurse health coach helped him focus on his goals of weight loss and increasing his activity. She provided him with educational information from the American Heart Association and introduced him to My Fitness Pal to help him track his food intake.**	5 points

Results: Over six months, Aaron has made changes to his diet, chooses healthy snacks and stopped eating late at night. He has also increased his exercise to four or more times a week by walking and has lost 37 pounds. He has encouraged his wife to get healthy with him, and she has lost 57 pounds. **Aaron recently saw his primary care doctor, who said Aaron could discontinue his blood pressure medication thanks to his weight loss and healthy lifestyle. Aaron's PAM® score has increase from level 2 to level 4.** **Aaron's PAM® score increased from a level 2 to a level 4, a total of 30.1 points. Estimated monthly savings for his case are more than $1,000 with estimated annual savings of more than $14,000.*** *This communication is intended for informational, promotional purposes only. The reference to previous outcomes made as a part of this communication does not guarantee success in any new or future case(s), as the result of each case depends upon many factors, including the facts of each case.* **Savings are based on evaluating paid claim trends for participating vs. non-participating members, or alternatively, by applying a research-based dollar value to changes in the participating member's Patient Activation Measure score.*	
5.E.9 Describe how you would accommodate a Participant that is only available to staff during the evenings or weekends? **While many of our nurses work until 8:00 p.m. local time several nights a week, if a State employee wishes to engage with a Disease Management nurse health coach after hours or on weekends and holidays, we will actively work with the member to accommodate their schedule. Members can also leverage our 24/7 Nurse Line.**	5 points
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? **American Health developed its Maternity Management program in 1993 to provide education and support to expectant mothers. The goals of the program are to decrease the number of premature births and subsequent complications and to promote optimal delivery outcomes, which can result in minimized costs and reduced hospital admission.** **The program is designed to provide education and support to all members and to identify and aggressively manage women with risk as early as possible through continual monitoring throughout pregnancy. In addition to helping prevent birth complications, American Health's Maternity Management offers savings in the following ways:** ▪ **Minimizing future complications through health management and continuous assessment** ▪ **Reducing the number of work hours lost from complications during pregnancy and/or birth** ▪ **Decreasing the number of premature deliveries through assessment, early intervention and referrals to Maternity Case Management**	5 points

Members less than 34 weeks gestation are eligible to enroll in the Maternity Management program. After the mother-to-be is enrolled, she is contacted by a maternity nurse specialist who conducts a detailed psycho/social and medical assessment, coupled with physician confirmation, to determine risk status. **American Health's maternity nurse specialist team is comprised of licensed registered nurses who have an average of 20 years of maternal and neonatal experience. They are extremely knowledgeable regarding the management of high-risk pregnancies, premature babies, childhood diseases, treatments, growth and developmental stages.** **After the initial call between the newly enrolled member and their assigned maternity nurse specialist, the nurse will mail the member an enrollment packet that includes a welcome letter, a comprehensive resource book on pregnancy and infant care and various educational materials. The maternity nurse specialist will also encourage participants to enroll in the StrongMoms® online program to receive additional educational mailings, weekly emails, coupons, and savings, along with access to online forums (Spanish resources also available).** **The frequency of outbound calls to the member by a maternity nurse specialist is determined by the risk level established during the detailed assessments and individual needs:** ▪ **High-risk program participants are contacted every three weeks** ▪ **Low-risk program participants are contacted every six weeks** ▪ **The nurse will tailor the content and frequency of calls to the member's risk level**	
5.F.2 Provide the following information from each of the following years 2015, 2016, and 2017 regarding your Maternity Management Services: a. Total number of maternity admissions ▪ **2015: 7,744** ▪ **2016: 6,657** ▪ **2017: 5,570**	5 points

b. Total number of Participants who received high risk maternity screening

- **2015: 100% of Maternity Management participants receive a high-risk screening to identify those members that need Maternity Case Management services**
- **2016: 100% of Maternity Management participants receive a high-risk screening to identify those members that need Maternity Case Management services**
- **2017: 100% of Maternity Management participants receive a high-risk screening to identify those members that need Maternity Case Management services**

c. Total number of Participants identified as high risk

- **2015: 6.8% of Maternity Management participants were considered high acuity**
- **2016: 11.1% of Maternity Management participants were considered high acuity**
- **2017: 5.7% of Maternity Management participants were considered high acuity**

d. Total number of Participants managed through case management services, including outcome data.

- **2015: 1,422**
- **2016: 1,427**
- **2017: 1,048**

5.F.3 Describe your company's process for identifying high risk Participants. — 5 points

The maternity nurse specialist administers a detailed assessment each trimester of the member's pregnancy. If the maternity nurse specialist determines from the member's assessment that the mother and/or baby are at risk, the nurse will transition the member to Maternity Case Management. A pregnancy may be identified as high risk and appropriate for Maternity Case Management for many reasons, for example, multiple births or a birth anomaly. Early detection of these possible high-dollar cases creates significant savings opportunities by:

- **Minimizing future complications and decreasing instances of premature birth**
- **Network steerage**
- **Negotiating costs for home health care services if needed**
- **Reducing the number of work hours lost that result from complications during pregnancy and/or birth**

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

Please refer to Section III to review the sample Maternity Management eToolkit provided within the enclosed CD.

American Health provides newly enrolled moms-to-be with a copy of the Mayo Clinic Guide to a Healthy Pregnancy. In addition, we will provide an eToolkit, which can assist the State with customizing a communication plan for participants.

5.G Predictive Modeling	
5.G.1 Provide an overview of the claim analysis process used for predictive modeling, including application benefits and restrictions. **Predictive modeling is a core element in HSB's ability to manage its customer's costs. We utilize artificial intelligence to identify potential "at risk" members and to isolate the related health factors. Detailed pharmacy experience also serves as an important data input to our cost management programs. By combining pharmacy data with medical experience, a comprehensive picture is drawn to providing the basis for the plan of care. This knowledge enables the program to effectively focus medical management resources on specific patients and diseases by developing a comprehensive plan of care for the individual. The customer has full access to reports. Our Wellness, Disease Management, and HSB DataSCOPE™ programs are based off of the data. We can provide CLIENT with access if desired.** **We offer access to our data warehouse and analytics product called HSB DataSCOPE™, a powerful information reporting system developed by HealthSCOPE Benefits to help our clients understand and manage the factors that drive cost and quality of healthcare delivery. HSB DataSCOPE™ compiles data from the client's health plan into valuable reports on factors such as provider performance, employee health status, and disease management.** **American Health has a strong Disease Management data analytics and predictive modeling partnership with our sister company, HDMS. HDMS provides us with access to DART, an industry-leading healthcare analytics and reporting platform. We use the DART tool to identify candidates for Disease Management. Further risk stratification of the individual is performed within the context of our Disease Management program, using the tools described below.** **To develop a participant's individual care plan, nurse health coaches utilize predictive modeling results, as well as information obtained from members, such as clinical test results, biometric values and results from the Patient Activation Measure® (PAM®). Based on the PAM® survey results, nurse health coaches risk stratify participants into one of four progressive activation levels. The four levels are characterized by distinct differences in a member's knowledge, skills and confidence that are essential to managing a chronic condition.** **Instead of assessing behaviors in isolation, the PAM® survey recognizes people who feel in charge of their health engage in a range of behaviors. The PAM® survey is reliable and valid for use with members in taking a significant role in managing a chronic illness. Insights gained with the PAM® survey can be used for predictive modeling, population segmentation, individual tailoring of care support, and the evaluation of program effectiveness.** **Based on a participant's PAM® score, nurse health coaches employ the Coaching for Activation® (CFA®) model to set behavior-change goals and action steps tailored to each individual's capability. Nurses also use clinical evidence-based guidelines to measure results of outbound telephonic education and counseling. Using the PAM®, CFA®, motivational interviewing, and other available resources, nurse health coaches:** ▪ **Set incremental, participant-specific targets and goals for achievement** ▪ **Motivate participants and elevate their self-confidence in managing chronic disease** ▪ **Educate participants on warning signs, symptoms, and what to do if they occur** ▪ **Provide educational resources specific to the interactions and needs of each participant** ▪ **Identify ways for participants to improve and maintain their health**	5 points

5.G.2 Provide the workflow used to identify Participants with co-morbidities include the workflow for both chronic and at-risk conditions. **A nurse health coach will administer an initial assessment to evaluate the member's overall health status, including any signs of depression or other co-morbidities, in order to help each participant become a better self-manager of his/her health. Because each participant's steps and goals are put together based on their complete clinical background, including the presence of co-morbidities, nurse health coaches work to help participants manage their overall health condition.**	5 points
5.H Nurse Line	
5.H.1 Describe your 24/7 Nurse Help line. How long has your Nurse Help Line been in place? **American Health's 24/7 Nurse Line provides callers with confidential health care advice and information 24 hours a day, 365 days a year. The program, which is URAC-accredited through Alicare Medical Management, is based on the premise that informed members make better and more cost-effective health care decisions. We have offered the 24/7 Nurse Line since 1993.** **Callers can discuss current illnesses or health challenges to receive education on treatment options, lifestyle choices and self-care strategies. They can also learn about local resources to receive additional support and information. In some instances, talking to a nurse can provide reassurance and avoid unnecessary, and costly, trips to the emergency room. Benefits of the 24/7 Nurse Line include:** ▪ **Live, toll-free and confidential health care advice and triage** ▪ **Access to a team of specially trained nurses who are supported by a flexible software system**	5 points
5.H.2 Describe your system's guidelines used to provide recommendations to Participants. **The protocols are established by Thompson for adults and Schmitt for children, the standards for computerized clinical information systems. These guidelines provide consistent, accurate triage information, as well as home treatment options and health education.**	5 points
5.H.3 Describe additional resources provided by your help line such as a medical library. **Our program does not include a medical library. Rather, American Health's 24/7 Nurse Line provides callers with confidential health care advice and information 24 hours a day, 365 days a year.** ***American Health will, upon written request by EBD, review available call copies and will exercise reasonable efforts to provide the EBD with answers to its quality assurance questions. Our corporate policy provides that it does not externally release call recordings to customer or disclose the sensitive protected health information of members, except as required by law, subpoena or court order.***	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.

5 points

Emotional Well-being:

- Grief and loss
- Personal relationships
- Marriage and family issues
- Divorce and separation
- Mental Health issues
- Violence and crisis management
- Financial planning

Emotional Well-being- Provided.

Masters level licensed mental health clinician explains limits of confidentiality and assesses risk of harm to self and others. Intake Specialists offer in-the-moment support and can connect clients to face-to-face counseling or virtual visits to address emotional well-being per the client's preference. Lifestyle EAP counselors are trained to help support employees during their difficult time and offer complimentary face-to-face counseling. Lifestyle EAP also offers on-site group and individual counseling to employees if needed due to a tragic event. Articles, webinars, newsletters, and other supportive materials are also available on this topic.

Personal relationships- Provided.

Lifestyle EAP provides employees with complimentary face-to-face and virtual visit counseling to address any personal relationship concerns. Lifestyle EAP counselors are equip to conduct individual, marital/couples, and family counseling to address these concerns. Lifestyle EAP also offers wellness seminars that address a variety of topics that can be used to educate the client on healthy relationships. Articles, webinars, newsletters, and other supportive materials are also available on this topic.

Marriage and family issues- Provided.

Lifestyle EAP provides employees with complimentary face-to- face and virtual visit counseling to address marriage and family issues. Lifestyle EAP counselors are equip to conduct individual, marital/couples, and family counseling to address these concerns. We believe a wellness focused EAP service that is well utilized and trusted by employees can extend not only EAP support but wellness services to family members. Family members make up approximately 30% of all clients seen through Lifestyle EAP. Family members covered include spouses, partners, dependents, individuals living in the home, and any individual covered on the employee's health insurance. Each individual covered will have access to their own set of counseling sessions to address their concerns.

Divorce and separation- Provided. **Lifestyle EAP provides employees with complimentary face-to-face and virtual visit counseling to address divorce and separation. Lifestyle EAP counselors are equip to conduct individual, marital/couples, and family counseling to address these concerns. Lifestyle EAP also provides a legal benefit which includes a free 30 minute consult with an attorney if representation, which can be over the phone or in person.** **Mental Health issues- Provided.** **Lifestyle EAP operates an 800 number which is answered live, 24/7, by a masters level licensed mental health clinician who explains limits of confidentiality and assesses risk of harm to self and others. EAP counselors address many different areas including, limited to; substance abuse, family concerns, marital issues, stress, anxiety, depression, grief, finances, legal, eldercare, transition/change, and work/life balance. Face-to-face and virtual visit counseling is included for employees and eligible participants.** **Violence and crisis management- Provided.** **Lifestyle EAP has a variety of offerings through the EAP to help with violence and crisis management including face-to-face counseling, work/life specialists that can locate emergency resources, wellness seminars specific to these topics, and a dedicated Account Manager that will work with key leadership to help manage crisis situations at the workplace. Crisis resources include onsite debriefings and one-on-one consultation, EAP staff on-call 24 hours a day, and a secured same day counseling appointment.** **Financial planning- Provided.** **Lifestyle EAP provides clients with unlimited access to financial educators. This specialist can help clients in a variety of ways, including financial counseling and education, budgeting, credit and debt management, debt consolidation, financial planning, retirement, college preparation, information on loans and grants, and online tools for ongoing support. Lifestyle EAP's interactive website also contains a wide array of articles and resources for financial wellness.**	
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 **Diet/Nutrition- Provided.** **At the core of Lifestyle EAP is a focus on wellness. Lifestyle EAP is housed within the Cleveland Clinic Wellness Institute and thus has access to Registered Dieticians to assist employees. Diet and nutrition presentations are offered as wellness seminars though Lifestyle EAP. Lifestyle EAP also offers access to the Cleveland Clinic Wellness Institute's monthly newsletter which includes ways to improve employee overall wellness.**	5 points

• Importance of daily activity **Importance of daily activity- Provided.** **Lifestyle EAP is housed within the Cleveland Clinic Wellness Institute and thus has access to Registered Dieticians to assist employees. Diet and nutrition presentations are offered as wellness seminars through Lifestyle EAP. Lifestyle EAP also offers access to the Cleveland Clinic Wellness Institute's monthly newsletter which includes ways to improve employees overall wellness. Cleveland Clinic has been able to successfully bend its own cost curve by implementing strategies, such as minimum of 5000 daily steps tracked by an approved device and uploaded onto an employee dashboard.** • Pain management **Pain management- Provided.** **At the core of Lifestyle EAP is a focus on wellness. Lifestyle EAP offers a robust counseling benefit to address overall wellbeing including pain management. Lifestyle EAP is housed within the Cleveland Clinic Wellness Institute and thus has access to Registered Dieticians and Exercise Physiologists to assist employees. Diet and nutrition presentations are offered as wellness seminars though Lifestyle EAP. Lifestyle EAP also offers access to the Cleveland Clinic Wellness Institute's monthly newsletter which includes ways to improve employee overall wellness.**	

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- Provided.** **Lifestyle EAP offers a variety of services to help create stronger cohesion among team members. Complimentary face-to-face and virtual visit counseling is offered to employees to address any individual concerns. Lifestyle EAP also has a supervisory referral process that can be utilized to help employees who need extra assistance. Finally, Lifestyle EAP has wellness seminars focusing on strengthening relationships among team members.** **Adjusting to change- Provided.** **Lifestyle EAP offers a variety of services to help employees and managers adjust to change. Complimentary face-to-face and virtual visit counseling is offered to employees and managers to address any individual concerns. Lifestyle EAP also has wellness seminars focusing on how to cope with change and transition successfully. Lifestyle EAP provides unlimited consultation with an Account Manager for leaders.** **Management issues- Provided.** **Lifestyle EAP values the importance of managers as ambassadors to the program and is committed to empowering and enriching the development of leaders. Management coaching for dealing with employee conflict and helping employees cope with the ongoing stressors inherent in the workplace are offered as program components through the EAP along with unlimited management consultations. Lifestyle EAP conducts unlimited management orientations as part of program implementation and ongoing as needed. A formal management referral process is available for employees demonstrating job performance issues or policy violations.** **Stress management- Provided.** **As a component of Lifestyle EAP, wellness seminars are offered to educate employees on stress management and emotion regulation. Some stress management presentations include: "Understanding Stress and Depression," "Positive Psychology," and "Creating a Vision Board." Lifestyle EAP also provides complimentary face-to-face and virtual visit counseling to employees to address stress and anxiety.** **Retirement planning- Included.** **Lifestyle EAP provides employees with access to unlimited financial counseling with financial educators. This specialist can help clients in a variety of ways, including: financial counseling and education, budgeting, credit and debt management, debt consolidation, financial planning, retirement, college preparation, information on loans and grants, and online tools for ongoing support.** **Discrimination- Provided.** **Through management consultations, Lifestyle EAP can assist in making sure companies are adhering to state rules and regulations. Lifestyle EAP also offers a supervisory referral for employees who are having difficulty adhering to state rules, regulations, and company policy. Lifestyle EAP also offers a supervisory referral for employees demonstrating job performance issues or policy violations. Lifestyle EAP is able to assist leadership in policy development and provide sample materials.**	5 points

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.

5 points

Legal:

Will/Living will assistance- Provided.

Through Lifestyle EAP's legal services, will and living will preparation require an in-person attorney meeting. An additional feature of the Lifestyle EAP website is our Interactive Online Will Planner. This tool is delivered in partnership with Nolo and enables clients to create a no-fuss, individually customized, legally valid will directly online.

Estate planning. Provided.

Through Lifestyle EAP's legal services, employees have access to a 30 minute consultation per legal issue. Employees can also speak with financial educators to discuss estate planning.

Aging:

Retirement planning- Provided.

Lifestyle EAP provides clients with access to unlimited financial counseling with financial educators. This specialist can help clients in a variety of ways, including: financial counseling and education, budgeting, credit and debt management, debt consolidation, financial planning, retirement, college preparation, information on loans and grants, and online tools for ongoing support.

Caregiver resources- Provided.

Lifestyle EAP has a vast network of resources that it utilizes to assist employees in whatever caregiving needs they have. Lifestyle EAP's website offers employees an opportunity to gather information on resources that they may need without calling our 800 number.

Living with a disability- Provided.

Lifestyle EAP provides face-to-face and virtual visit counseling per the employee's preference in order to remove potential barriers to treatment and assist those who cannot travel to see a counselor face-to-face. Lifestyle EAP also offers a resource guide and a specialist that can assist employees who have a disability find assistance depending on their unique circumstance.

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.

5 points

Addiction & Recovery:

- Alcohol issues – **Provided.**
  Drug(s) issues – **Provided.**

The process for addiction & recovery is as follows: the client calls the Lifestyle EAP 800 number, answered live, 24/7, by a masters level licensed mental health clinician who explains limits of confidentiality and assesses risk of harm to self and others. Incorporating the SBIRT model to identify risk for substance use (alcohol and drug) and the WOS-5 to evaluate work-related impact, demographic and presenting problem information is gathered. In-the-moment support is provided, an action plan is developed and appropriate referral information is given to client. Lifestyle EAP clinicians provide an in- depth substance abuse evaluation to determine the appropriate level of care. In some circumstances, a higher level of treatment is indicated and the clinician will provide coordination of care to ensure that the client is being treated at the appropriate level based on the severity of the issue.

Lifestyle EAP also supports family members dealing with loved ones affected by addiction. Our work/life services can connect employees and family members to a variety of community supports and resources. Lastly, Lifestyle EAP is able to support managers and HR through the Formal Management Referral process when there is a positive screen. Unlimited sessions are available for Formal Management Referral counseling to follow the employee from start to finish in achieving counseling goals.	
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. **Lifestyle EAP is committed to growing our national provider network to provide the highest accessibility to all employees at all locations. Lifestyle EAP has licensed clinicians in all 50 states. Lifestyle EAP recruits providers who meet NCQA credentialing guidelines and the rigorous credentialing standards of the Cleveland Clinic. Provider Relations staff contact providers to discuss current availability, ability to schedule urgent appointments as needed, and builds relationships with provider practices in the area to provide high quality EAP services. Lifestyle EAP's commitment to clinical excellence is evidenced by our stringent network eligibility criteria not typically used by our competitors. The minimum professional requirements for providers are: minimum of a Master's Degree in a clinical discipline with at least three years post-graduate clinical experience, licensed in the state in which he/she practices, and malpractice insurance in the amount of $1mill occurrence and $3mill aggregate.** **Lifestyle EAP audits providers' files annually as a part of the re-credentialing process with provider contract periods of one year. All EAP clients receive a satisfaction survey within 30 days of the closing of their case. The satisfaction survey asks several quality assurance questions. Lifestyle EAP has a core staff of counselors that are employees of the Cleveland Clinic in addition to our national provider network. These counselors receive regular training on evidenced-based therapy approaches and receive ongoing clinical supervision. Any client complaints are documented and the case is reviewed by the Lifestyle Department Manager.**	5 points
6.A.7 Describe your process for suicide interventions. Detail all methods, i.e. telephonic, in-person, group settings, etc. **When an employee presents to Lifestyle EAP with symptoms of suicidal ideation, a masters level clinician answers the 24-hour line and provides an in-depth risk assessment, crisis services, and creates an action plan. If the client is in need of emergency services the clinician will call the necessary authorities to assist in the emergency. If the caller is not at imminent risk, a safety plan is created and urgent services would be provided to the caller. Emergency cases are handled with priority and seen for face-to-face counseling as soon as possible or within 12 hours if emergency interventions are not necessary as determined by the risk score and action plan.**	5 points
6.A.8 Do your protocols and practices differentiate between worksite death / grief counseling and family-related death / grief counseling? **Lifestyle EAP provides on-site group counseling/Critical Incident Response (CIR) services to support employees in the event that they witness or are involved in a traumatic incident while at work. Traumatic events can have a profound impact on a person's ability function at home and at work. Our team of counselors will provide resources, tools, and ongoing support to help employees return to a healthy and productive level of functioning. The Lifestyle EAP Account Manager works with key leadership to plan onsite interventions, including communications to employees, training of managers, group and one-on-one face-to-face support, and support for the family.**	5 points

Family members dealing with grief have access to face-to-face counseling to address these concerns. In most cases, companies do not request onsite intervention for a family-related death, but should a company make the request, Lifestyle EAP is able to accommodate.	
6.A.9 Describe what resources are available for AR Employees with financial issues / home foreclosures / debt management issues? **Lifestyle EAP understands that employees often face difficult financial challenges, adding to stress and impacting all areas of their lives-especially in these times. We provide unlimited support to employees facing financial challenges. Employees and eligible members can speak with a financial educator about bankruptcy, budgeting, first time home buying, credit card fraud, college fund planning, foreclosure prevention and other major life events such as adoption or saving for a wedding. In addition, seminars and workshops are available on all areas of financial planning.**	5 points
6.A.10 What assistance / advice / material is available for AR Employees dealing with elder / parental home care? **Each day thousands of family members join the care-giving ranks providing assistance to a senior loved one or an adult with special needs. The Lifestyle EAP Eldercare Support Line offers personal and confidential referrals, education, support and follow-up services to help with issues such as: living arrangements, meal preparation, personal care, accessing quality healthcare providers, transportation needs, and caregiver relief. AR Employees and their family members can also take advantage of face-to-face and virtual visit counseling to address caregiver stress and burnout. In addition, Lifestyle EAP offers a host of Caregiver Wellness Seminars.**	5 points
6.A.11 What protocols / practices are in place to assist AR Employees with eating disorders? **Lifestyle EAP offers short-term solution focused counseling. Our specialists can provide an in-depth assessment to determine the appropriate and most cost effective ongoing treatment available to the employee. If it is determined that a short-term model is appropriate, the counselor will continue working with the employee to achieve treatment goals. If long term care is needed, the clinician will provide coordination of care to a higher level of treatment or provide with community resources. As a part of Cleveland Clinic, Lifestyle EAP provides employees access to a large amount of supportive materials and research in all health and wellness categories.**	5 points

6.A.12 Detail issue escalation & resolution practices for issues of child / spousal abuse. At what point are police / authorities involved? **Lifestyle EAP is governed by federal and state statutes that mandate the reporting of certain situations that, in the judgment of a Lifestyle EAP professional, pose risks of serious physical or emotional harm to one or more persons. In situations, including, but not limited to the following situations, if brought to the attention of Lifestyle EAP, will require reporting to a designated authority or otherwise permit breach of confidentiality for purposes of safeguarding persons as described in the internal Cleveland Clinic Child Abuse & Neglect, Elder Abuse/Neglect/Exploitation and Duty to Protect policies, or as otherwise required by law:** • **Probable or imminent risk of homicide or grave physical harm to another person** • **Possible abuse or neglect of a child or vulnerable adult** **Like other mandatory reporters (i.e. teachers, physicians, psychologists, etc.) Lifestyle EAP is required to comply with these provisions. In cases of suspected abuse or neglect of a child or vulnerable adult, Lifestyle EAP will contact the responsible government social service agency and disclose client information as required by law.**	5 points
6.A.13 Describe any processes for facilitating access to legal services. **Under the Lifestyle EAP benefit, employees may access a 30 minute telephonic legal consultation for legal issues with an attorney by contacting our 24-hour 800 line for direction and resources regarding legal issues. Common areas pursued are custody, divorce, adoption, bankruptcy, credit, trust/wills, power of attorney, elder law, Medicare, estate planning, landlord/tenant, real estate, immigration, injury, and criminal. Lifestyle EAP does not cover employment law due to the conflict of interest.**	5 points

6.A.14 Explain what differentiates you from your competitors in the EAP marketplace, in 200 words or less. **Lifestyle EAP differentiates itself from others by being housed within the Cleveland Clinic Wellness Institute. The EAP successfully incorporates wellness components in a variety of ways such as a monthly eNewsletter with all original content by Cleveland Clinic experts, wellness seminars on topics centered around the "Big 4" causes of chronic disease, wellness focused counseling and through health and wellness content on the interactive EAP website. In addition:** **We are committed to providing employers a benefit that contains outpatient mental health costs. 85% of all cases are resolved within our 6 and 8-session EAP models resulting in a hard dollar return on investment for employers.** **Providing employees a meaningful clinical experience separate from their outpatient mental health benefit without co-pays or choosing a provider from a panel breaks down barriers that often prevent employees from seeking help.** **We commit to providing outcome information alongside utilization to demonstrate not only our visibility but our effectiveness.** **We view the EAP as an effective management tool that can help deal with employee performance issues. This is why we offer unlimited sessions for Formal Management Referral clients. We are committed to supporting employees struggling to maintain their work performance for as long as it takes.**	5 points
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? **By implementing the validated measure, the WOS-5, Lifestyle EAP collects pre and post assessment data to provide outcomes on workplace performance. These outcomes demonstrate the effectiveness of the EAP in a quantifiable manner in the areas of absenteeism, presenteeism, work engagement, workplace distress, and life satisfaction. Mental health issues cost employers an estimated $80 to $100 billion annually affecting as many as1 in 2 adults. Research shows that by providing mental health care support, employers realize a decrease in medical costs, absenteeism and presenteeism and an increase in productivity, engagement and well-being. We are committed to providing employers a benefit that contains outpatient mental health costs, and 85% of all cases are resolved within our 6 and 8-session EAP models resulting in a hard dollar return on investment for employers.**	5 points

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?

5 points

By working closely with EBD, trends on chronic disease and medical spend can be extrapolated. The EAP will use this information to create targeted campaigns to promote early detection and treatment of depression, anxiety, and stress, as examples. In addition, Lifestyle EAP is a department of the Cleveland Clinic Wellness Institute. Cleveland Clinic's mission is to make Preventative Healthcare and Wellness a driving force in medicine and society. As one of 26 clinical institutes within the Cleveland Clinic, the Wellness Institute is held to the same standards for delivering clinical outcomes. Research shows that 75% of chronic disease is caused by the following 4 factors, which are the basis for all of the Wellness Institute's Programs: physical inactivity, chronic stress, poor food choices, and tobacco use.

In addition to our external partners, the Cleveland Clinic has transformed its internal culture over the past nine years through eliminating tobacco use at all worksites, enacting an employment restriction to non-smokers only, helping employees manage their stress through coaching, yoga, and other exercise classes, as well as serving healthy foods in all cafeterias and vending areas. The promotion of health at the Cleveland Clinic has been an on-going and successful endeavor, reaching over 50,000 employees and 26 separate Cleveland Clinic workplaces. Our commitment to outcomes is showcased by each program we provide:

Program Title	Scientific Evidence
Stress Free Now	Clinical study: Feasibility of an Online Mindfulness Program for Stress Management—A Randomized, Controlled Trial, *Annals of Behavioral Medicine,* Oct 2013 Clinical study: A Web-Based Mindfulness Stress Management Program in a Corporate Call Center Summary of Findings, *Journal of Occupational and Environmental Medicine*, March 2016
Stress Free Now for Healers	(in Progress) Physician Study and Impact of Coaching. With OPSA leadership. (in Progress) Impact of Stress Free Now with Glickman Urologic and Kidney Institute Caregivers
Go! to Sleep	Clinical study: "Go! to Sleep": A Web-Based Therapy for Insomnia, *Telemedicine and e-Health* Vol 23, Issue 7
eCoaching for Weight Loss	Clinical study: E-Coaching for Weight Loss *International Journal of Business, Humanities and Technology,* Dec 2014
eCoaching for Tobacco	Clinically developed Cleveland Clinic protocols. Medication protocols based on comprehensive assessment and evidence based medication interventions
EAP	(In Progress) Michigan Study on effectiveness in conjunction with Medical Mutual

6.B.3 Provide a description of your approach and methodology for calculating ROI for accounts of our size, including benchmarks used for quantifying. **Lifestyle EAP utilizes the validated measure endorsed by our national governing body, the WOS-5 to measure absenteeism, presenteeism, work engagement, workplace distress, and life satisfaction. In a research study of over 16,000 cases, the WOS-5 has shown statistically significant changes in the expected directions. There was greatest improvement and largest effects in work presenteeism and life satisfaction after use of EAP counseling. Lifestyle EAP collects pre and post assessment data to provide outcomes on improvements in these areas. Lifestyle EAP also utilizes counselor assessed outcomes in the following areas: communication, customer service, anger management, safety, teamwork, presenteeism, resilience, productivity, conflict resolution, work/life balance, and concentration.** **Lifestyle EAP is able to provide an ROI report created by our finance team which includes a Value Summary of Productivity, Employee Turnover, and Short Term Disability; the Total Value of the EAP including the Net Value and Value on Investment, Productivity Costs without an EAP including # of employees, employee distress rate percentage, # of distressed employees, average fully loaded wage, total wages of distressed employees, reduced productivity, and productivity loss; costs with EAP including EAP utilization rate, # of employees contacting EAP, success rate, # of employees who contact EAP and achieve goal, # of employees who contact EAP and do not achieve goal plus those are distressed and do not contact EAP, cost of reduced productivity for those employees, cost of productivity with EAP; EAP Productivity Savings; Employee Turnover including # of employees, EAP utilization rate, # of employees contacting EAP, High Risk EAP percentage, High Risk EAP employees, Success rate in EAP (Percentage of High Risk EAP user who don't leave company), # of high risk EAP users who do not leave company, Replacement cost per employee, Savings on Employee Turnover with EAP, cost of employee turnover with EAP; Net Savings of Productivity; Short Term Disability including # of employees, Percentage at risk to go on short-term disability, # of employees at risk to go on short-term disability, Percent of employees at risk to go on short-term disability who use EAP, # of employees at risk to go on short-term disability who use EAP, Success rate, # of employees "at risk" who reach goal and do not use STD, Average Cost per STD case; and finally, Net Savings Short-Term Disability. Assumption Sources: National Survey on Drug Use and Health (NSUDH), 2017 Actuals, EAP Cases closed without referral outside of EAP, Average across accounts, salary.com, and National Averages.**	5 points
6.B.4 Provide a description of your approach and methodology for monitoring provider compliance related to patient care, including provider incentives. **As part of Cleveland Clinic, safety and compliance is at the forefront of all decision-making and development of processes and procedures. Every institute has its own compliance committee that meets on a monthly basis with each department required to submit a monthly report which includes communication, education and training, enforcement of disciplinary standards, monitoring and auditing, new provider monitoring, new provider orientation, new services, outside agency audits, privacy and security walk through, policy and procedures, response to defected deficiencies, and a risk assessment. All reporting is pulled into a master report and key leaders must present to the Compliance Department once per year. Recommendations are made and turned into yearly monitored plans.**	5 points

6.B.5 Provide an overview of how you intend to engage AR Employees in your services? **Lifestyle EAP ensures employees and managers are fully educated on all the services offered through a variety of training modes, as we understand the unique environment of a multiple employer locations. We are able to successfully support the roll-out of a new program or ongoing services with our employee and manager orientations. Lifestyle EAP will provide coaching to management staff on how to utilize the EAP as a manager tool during the orientation process.** **Employee orientations and manager trainings are conducted in person or via webinar employing a variety of learning tools including videos, PowerPoint and print materials. EAP services and processes are described in detail and time is allotted to answer additional questions in group format and individually. Length of program is flexible. Manager trainings are developed to educate, empower and enrich the development of your leaders and support the use of the EAP as a wellness and management tool.** **Marketing of the program starts with an effective implementation and program roll-out strategy led by Lifestyle EAP's Account Manager. Lifestyle EAP has created a detailed Implementation Manual that is reviewed in depth with key leadership by the dedicated Account Manager. The Account Manager will engage key contacts to design a customized implementation plan based upon the specific needs of the company. The implementation plan ensures that managers, employees and family members receive pertinent information regarding EAP services.** **Lifestyle EAP offers unlimited employee and manager orientations throughout the life of the contract and is dedicated to educating as many employees as possible about the service. To preview Lifestyle EAP videos on specific suite of service offerings, please follow the link below: www.ClevelandClinicWellness.com/LifestyleEAPVideos** **In addition, Lifestyle EAP will work with leadership to leverage any existing wellness programs and/or key contacts (i.e. a Wellness Committee or Wellness Champions) as part of implementation and the Wellness Profile. Also, part of the role of the Intake Counselor is to assess, educate, and develop an action plan for all callers linking to all relevant programs.**	5 points
6.B.6 Describe your experience in dealing with multiple employer locations? **Lifestyle EAP claims 100 companies and organizations as customers nationwide, many of which have multiple locations with unique cultures and needs. We also provide face-to-face counseling to Cleveland Clinic employees. Please note we exclude Cleveland Clinic in our average employer size (Cleveland Clinic has over 50,000 employees).** **In May 2009, Lifestyle EAP officially launched its new approach which integrates solution-oriented counseling with Cleveland Clinic's clinical knowledge related to wellness. This launch has gained national attention as organizations are looking for providers with proven experience integrating health and wellness. We've designed Lifestyle EAP to provide a highly valued employee benefit that delivers solutions-oriented counseling—and stays focused on the key differentiators that have contributed to over twenty successful years in the industry.**	5 points

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. **The Cleveland Clinic has been able to substantially increase its utilization of our own employees by the roll-out of Virtual Visits in 2015 through the Express Care Online application. Both medical and mental health visits are available on the same platform. By reducing the barriers to counseling, we've seen an increase of over 5% in EAP utilization of counseling.** **In addition, Lifestyle EAP has teamed up with the Right Direction, an initiative that gives employers the tools to address depression in the workplace. We are currently taking part in this initiative with 2 employer groups including a national retail store and a college.**	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? **Lifestyle EAP Utilization Reports are available Quarterly, Semi-Annually, and Annually. Reports can be reviewed with your Account Manager over the phone, via GoTo Meeting, or face-to-face. Current and archived reports can be accessed on our interactive website and de-identified data can be extracted by EBD on demographics, primary presenting issue, resolution, and outcome.**	5 points
6.C.2 Detail what services / features / functions are provided to employees through your website/portal? **Lifestyle EAP's website provides access to online articles and streaming audio and video covering interpersonal and workplace topics. Users choose from interactive assessments and online training courses to help evaluate general health and well-being and can sign up for upcoming online seminars and webinars or view past ones. Our content supports striking the critical balance between personal and professional lives.** **http://www.powerflexweb.com/1629/login_LEAP.html** **login: lifestyle** **password: demo** **HR and Managers are tasked with simultaneously handling employee issues and maintaining productivity. We support the development of your organization's leaders through exclusive web-based tools, accessed through a unique HR and Manager login and password. HR and Managers will have immediate access to practical information customized to address a variety of concerns that may arise in the workforce such as substance abuse, managing change, conflict resolution, workplace safety, and many more.**	5 points

6.C.3 Do you offer podcasts / e-books for download? If so, provide a sample list of the available topics. **As a part of Cleveland Clinic Wellness, our client companies have access to the tools and resources of the Cleveland Clinic including the monthly Health Essentials newsletter, Facebook Live discussions with physicians and other caregivers, and a variety of instructional videos and seminars, and healthy recipes. For more information, please see https://my.clevelandclinic.org/departments/wellness**	5 points
6.C.4 List the top 3 accessed topics in the last quarter? Last year? **The top 3 primary presenting problems (accessed topics) in the last quarter and for 2017 year-end were as follows:** **Stress 14%** **Legal 12%** **Family/Marital & Couple 9%**	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? **All selection process is handled both internally by Cleveland Clinic staff members including our Marketing and IT department and by our sister organization, WorkPlace Options.**	5 points
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. **Information and content on lifestyleeap.com is private and only available to our client companies. Each group, employees, managers, and HR have their own unique login and password. Content is tailored to each individual group.**	5 points
6.C.7 Describe an AR Employee's ability to maintain a "profile" on the site. **Maintaining a profile on the site is not a current offering.**	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. **Our wellness programming is offered in the context of a clinical institute. We have a solution for every aspect of evidenced-based population health management including tobacco cessation, building resilience, weight loss, healthy lifestyles, hypertension, healthy pregnancy and diabetes; nutrition services; sleep programs; and cultural assessments.** **EAP also provides a wide array of trainings on health and wellness topics including tobacco cessation, strength training, healthy lifestyles, and nutrition and physical activity. We specialize in developing account specific trainings based on identified need. Grounded in our commitment to the health care industry in particular, we look forward to leveraging our understanding of the unique challenges and opportunities of your environment to support and develop your employees through education and trainings.**	5 points
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. **Lifestyle EAP utilizes the validated measure endorsed by our national governing body, the WOS-5 to measure absenteeism, presenteeism, work engagement, workplace distress, and life satisfaction. In addition, by incorporating the SBIRT model to identify risk for substance use and the WOS-5 to evaluate work-related impact, demographic and presenting problem information is gathered and outcomes are provided back to the organization. Early intervention and treatment show the greatest improvement and largest effects in work presenteeism and life satisfaction after use of EAP counseling.**	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

5 points

Lifestyle EAP operates a 24-hour line answered live by Masters level clinicians for immediate in-the-moment support. Face-to-face counseling is offered to all eligible members seeking services. Lifestyle EAP maintains a national network of providers. The minimum professional requirements for providers are: minimum of a Master's Degree in clinical discipline with at least three (3) years post-graduate clinical experience, licensed in the state in which he/she practices, and malpractice insurance in the amount of $1mill occurrence and $3mill aggregate. All of Lifestyle EAP's virtual visit clinicians are Cleveland Clinic employees counseling in the state in which they reside.

As a general policy, Lifestyle EAP does not disclose the names of its providers. Lifestyle EAP is committed to growing our national provider network to provide the highest accessibility to all employees at all locations. Lifestyle EAP has licensed clinicians in all 50 states and is committed to growing the network per employer need. The number of clinicians in the state of Arkansas, by county are as follows:

Zip	County	Providers
72119	Pulaski	4
72032	Faulkner	1
72207	Pulaski	2
72114	Pulaski	2
72802	Pope	2
72701	Washington	1
72801	Pope	2
72903	Sebastian	1
72401	Craighead	1
72023	Lonoke	2
72756	Benton	1
72315	Blytheville	1
72703	Washington	1

Lifestyle EAP provides provider network guarantees in our contracts assuring that employers have the level of coverage necessary for their population. A sample guarantee is as follows: Provider Access /Coverage: CCWE ensures 80% access within 10 miles and 100% access within 25 miles by July 1, 2013. CCWE performance guarantee is as follows: Should CCWE not meet the provider coverage commitment as stated by July 1, 2013, company will be provided a credit of either six hours of onsite wellness programming or complimentary access to 30 licenses for Cleveland Clinic clinically-developed and proven stress, sleep, and nutrition programs. This credit must be used no later than December 31, 2013. Or Company may choose to be provided a three percent (3%) reduction in their per-employee per -month pricing which will be effective August 1, 2013 and continue through July 31, 2014, at which point per-employee per-month pricing will revert to the pre August 1, 2013 price.	

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.

5 points

HealthSCOPE Benefits ("HealthSCOPE") is committed to HIPAA compliance and the protection of our member's protected health information.

Creating- HealthSCOPE does not routinely create new health information data files. The organization's systems are designed to access existing files as needed to process individual claims. In the event a new data file was necessary, the required information would be input via the HealthAxis system and stored in the organization's cloud hosted systems as detailed below in "accessing" and "storing" respectively.

Accessing- HealthSCOPE's workforce accesses data files and records through a cloud-delivered solution provided by HealthAxis Group, LLC ("HAXS") located in Irving, TX. HAXS is a provider of integrated solutions and services for health benefit administrators and health insurance claim processors. HAXS provides a secure cloud-delivered solution to HealthSCOPE for managing our claims system. HAXS ensure regulatory compliance in all of their processes and for protecting member data. The claims management system is a complete integration of member management and claims processing from claims to claims payment. HAXS provides a redundant data storage that is also located in Blue Hill Data Services' (See "storing" below) data colocation operations. HAXS' level of compliance and testing annually includes providing HealthSCOPE a SSAE 16 Type II SOC1 report.

To ensure the confidentiality, integrity, and availability of its clients' data, HealthSCOPE requires the use of secure transmission channels at all times when accessing health information data files through the HAXS system. The HAXS system offers a secure web application that HealthSCOPE employees and members access via a Citrix-delivered virtual desktop. Security configurations within the Citrix system prevent users from removing PHI from the VDI environment to either their local computer or removable media such as a flash drive. This communication channel is protected via the use of FIPS 140-2 compliant solutions including HTTPS over TLS. Authentication of HealthSCOPE users is managed using role-based access control, and complex passwords.

HAXS' systems enforce the use of electronic data interchange ("EDI") in standardized formats as required by the HIPAA regulation.

Transmitting- Web-based communications are secured utilizing the current industry-standard version of TLS for encrypted communications. The transmission of health information data files and records is done via secured file transfer protocol ("SFTP") and/or the use of PGP encryption. In the event that health information data files or records need to be sent via email, HealthSCOPE utilizes Symantec's MessageLabs service to ensure encryption and secure transmission. Through the use of the HAX solution (detailed above) HealthSCOPE maintains the ability to transmit health information data files and records via EDI as required by the HIPAA regulation.

Storing- HealthSCOPE's core infrastructure and data center operations are provided in a secure data colocation in Pearl River, NY. Blue Hill Data Services ("BHDS") is the organization's trusted partner that provides secure data storage and application hosting. BHDS' data centers implement fault tolerant solutions, with state-of-the-art physical components and redundant network services. Their data center operations are all U.S. based in Pearl River, NY, Branchburg, NJ, and Shelton, CT. All data center operations provide high-availability environments to HealthSCOPE. Data center security operations include card access, a guard station, and video surveillance. HealthSCOPE has a Business Associate Agreement (BAA) with BHDS.

All HealthSCOPE data stored in the BHDS infrastructure is encrypted upon receipt, and throughout storage, using a hardware-based encryption system provided by Pure Storage. The pure storage solution provides 256-bit encryption using an AES-256 cypher. Pure Storage's proprietary system also provides for secure administration and eliminates the need for human-administered key management. This system ensures HealthSCOPE's data is stored securely and always encrypted at rest.	
7.A.2 Detail your disclosure process to patients as well as how protected information will be disclosed with third parties. **We have included our Notice of Privacy Practices for review within Section IV of our response.**	5 points
7.A.3 Provide a detailed description of your policy for records and information management addressing storage, transfer, destruction, accuracy and confidentiality. **HealthSCOPE has a detailed policy for information management as required by the organization's URAC certification. The pertinent details of that policy are described below.** **Storage- Health information data files and records are stored electronically in the secured data storage facility provided by Blue Hill Data Services ("BHDS") as described in item 7.A.1. the information management policy also specifies detailed policy for handling paper records that contain PHI, which are imaged into the electronic storage system within 24 hours, retained on-site for 60 days in secured storage, and then destroyed. The organization's Records Retention Policy requires that all HIPAA-relevant records and associated materials, including policies and procedures, are retained for a minimum of 6 years from the date of last use, access, or enforcement to maintain compliance with the HIPAA regulation.** **Transfer- The information management policy specifies specific details for the electronic exchange of health information. A specific procedure is documented and implemented for analyzing system interoperability and designing secure system interconnections with the organization's clients. As part of this analysis, a risk assessment is conducted to document possible risks in the exchange of information and management decisions on mitigating measures. Interfaces are thoroughly tested before implemented on production systems.** **The only internal system for the exchange of data is from the Healthaxis system (as detailed in item 7.A.1) to the HealthSCOPE Benefits data warehouse. All such transfers are secured with industry standard encryption through secure transmission protocols; typically TLS or SFTP.** **Administrative controls are in place to protect the use and disclosure of PHI as detailed in the Use and Disclosure of PHI Policy, an exhibit of the Information Management Policy. Among other controls, this policy enforces the principle of access to the "minimum necessary" data as defined by the HIPAA regulation.** **Destruction- In addition to the provisions of the Records Retention Policy, as detailed above in "storage," HealthSCOPE has implemented detailed policies and procedures for the destruction of both physical PHI and electronic PHI ("ePHI"). Physical copies of PHI are securely stored in locking containers and destroyed by contracted vendors local to each HealthSCOPE location that regularly engage in the destruction of PHI documents as their course of business. Electronic media containing PHI are destroyed in accordance with the organization's Destruction and Reuse Policy, which provides for means of destruction including magnetic destruction, software overwriting, and physical destruction.**	5 points

Accuracy- The Information Management Policy describes specific provisions for ensuring the accuracy of HealthSCOPE's data. These provisions are further defined in the organization's Alteration and Destruction Policy which enacts appropriate authentication measurements to corroborate that data has not been altered or destroyed in an unauthorized manner. HealthSCOPE conducts regular checks and audits on the integrity of data, the results of which are reportable to the Security Official. **HealthSCOPE also employs a full-spectrum quality management program as defined by the organization's Quality Management Plan. As part of the program, the quality of service as well as workforce data entry is monitored for accuracy and completeness, and specified actions taken by management to improve any data accuracy issues noted.** **Confidentiality- The Information Management Policy includes specified guidance for protecting the confidentiality of information in the care of HealthSCOPE, with particular attention paid to PHI. This guidance is implemented through the Use & Disclosure of Electronic PHI Policy, which provides the workforce with detailed instructions on when, and to whom, PHI may be disclosed, and their responsibilities for protecting the confidentiality of information. This policy is further reinforced through the required HIPAA training the workforce receives at least annually.** **HealthSCOPE's information security program is designed and implemented to protect the confidentiality of data, in addition to its availability and integrity. This program implements a suite of administrative and technical controls designed to control access to information. Some of these controls include a detailed Access Controls Policy, the enforcement of a roles-based access control (RBAC) model which limits access to the "minimum necessary", and technical configurations requiring secure logon means and unique authentication. The security program is further described in item 7.B.4 of this response.**	
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. **In accordance with the HIPAA Privacy and Security rules, the company's URAC accreditation, and the company's SSAE-18 SOC 1 Type II audit requirements, HealthSCOPE Benefits maintains a robust IT Security and Compliance Program overseen by the Security Officer to manage the organization's electronic security policies, processes, and procedures including information management. As part of the Security and Compliance Program, the organization conducts regular reviews and audits of its compliance with applicable State or Federal laws and regulations, and with established company policies. Examples of these reviews include; auditing workforce access to PHI to ensure ethical use and enforce the 'minimum necessary' standard, regular management inspections of HealthSCOPE facilities to ensure employees are properly handling and storing physical PHI, compliance audits of our trusted business partners, and engaging third-parties to conduct external audits of the organizations procedures such as the company's annual SOC 1 Type II attestation.** **All results are reported to the Business Continuity and Corporate Compliance Committees as required by the organization's Continuous Quality Improvement Program. The executive leadership team is made aware of all discovered issues or areas that present an increased risk of future non-compliance through HealthSCOPE's risk management program. Any violations of company policy are addressed in accordance with organization's Sanctions Policy.**	5 points

7.A.5 Describe your HIPAA policies, procedures, and training related to quality and provider data. **HealthSCOPE Benefits' compliance with HIPAA's Privacy, Security, and Administrative Simplification Rules has been independently confirmed through HealthSCOPE Benefits' URAC accreditation, which requires demonstration of compliance of these rules as a necessary part of the accreditation process. Moreover, HealthSCOPE Benefits provides annual HIPAA training to its staff to ensure that its staff is aware of the newest regulatory updates and policy changes to apply during the performance of their duties. In addition to ongoing training, HealthSCOPE Benefits performs complete testing of its policies and procedures as part of its SSAE18 SOC 1 certification.** **At HealthSCOPE Benefits, we believe that compliance with the HIPAA rules is an active process rather than a passive one. While HealthSCOPE Benefits plays a large role in that compliance, we know that compliance with HIPAA rules extends far beyond our reach. For that reason we are committed to helping our clients through our robust initiatives for client, member, and provider education.** **It is also important to note that our legal/compliance department is responsible for drafting and implementing policies concerning privacy/confidentiality with regards to protected client information. In addition to regular consulting in compliance issues, our team is available "on demand" to engage clients with real time issues. Brett Edwards, Senior Vice President Legal and Compliance, leads our team, which consists of plan document and healthcare reform experts.** **All HealthSCOPE Benefits employees adhere to strict HIPAA regulations and guidelines. Benefit Analysts/Claim Examiners complete ongoing training that includes weekly "round table" discussions of procedures, as well as formalized monthly training on topics such as HIPAA privacy and security, fraud, clinical editing, and new procedures. A final element of training includes a briefing on the plans and special requirements of all new clients.** **HealthSCOPE Benefits requires all employees to complete HIPAA and HITECH training on an annual basis. Completion of the training is logged and retained to ensure that each employee remains up-to-date on the current laws and regulations surrounding the electronic security awareness.**	5 points
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? **We have experienced a very small number of inadvertent disclosures of PHI in the last three years commensurate with a company our size. One incident resulted from a programming error, another mailing error, and another, an email error. Each instance affected no more than 10 individuals' data. Our legal and compliance staff worked closely with the plan sponsor to identify the root cause, perform a risk analysis, draft a report on the results of the analysis, and facilitate communication to notify the affected parties. Moreover, our staff worked to have nondisclosure agreements circulated by parties who may have inadvertently viewed PHI to protect the integrity of members' data.**	5 points

7.B Systems and Data Sharing	
7.B.1 Describe your plans for developing and maintaining your management information system(s). **HealthSCOPE Benefits ("HealthSCOPE") develops and maintains its information systems in close coordination with its IT service provider ("ITSP") Blue Hill Data Services ("BHDS"), of Irvine, TX. Within this relationship HealthSCOPE provides strategic direction, governance, and project oversight on all development and maintenance actions carried out by BHDS. The organizations' information systems program is lead by the CIO, with supporting governance provided by the internal directors of security & compliance, service delivery, and technical services. HealthSCOPE takes a risk-based approach to information systems development and change management, wherein the management team assesses the risks with implementing new technologies and improvements to existing systems. Based on these assessments, management develops appropriate controls and defines technical requirements for implementation, testing, and system performance. These requirements are communicated to the organization's third-party service providers via standardized means such as helpdesk tickets, SOWs, SLAs, or formal contract amendments. HealthSCOPE personnel provide governance, or direct management, on all system-altering projects conducted by its ITSPs, and approve the final testing and deployment of changes.** **Day-to-day operations and administration of HealthSCOPE's management information systems is conducted by BHDS. This includes development, demand monitoring, patching, security monitoring, and general system & network administration. As part of this relationship, BHDS provides HealthSCOPE with regular reports on system health, utilization, and security. HealthSCOPE maintains secure, controlled IT admin-level access to the infrastructure systems and applications in BHDS' data center.** **BHDS's architecture provides HealthSCOPE with fault tolerant solutions, with state-of-the-art physical components and redundant network services. Their data center operations are all U.S. based in Pearl River, NY, Branchburg, NJ, and Shelton, CT. All data center operations provide high-availability environments to HealthSCOPE.** **BHDS undergoes an annual AICPA SSAE 18 SOC1 Type II attestation, the results of which are provided to HealthSCOPE to ensure appropriate user entity controls are in place to provide for the security of its customers' data.**	5 points

7.B.2 Describe your plan for interfacing with EBD's systems and any subcontractors. **HealthSCOPE Benefits ("HealthSCOPE") has in place a rigorous procedure for ensuring the security of customer systems' interfaces as defined by the organization's Information Management Policy. As defined by this policy, claims data, eligibility data, provider data, some pricing data, and claims processing logic (Benefit Programming) are all stored on the Healthaxis claims system which also serves as the reporting database. The data is maintained by and in the Healthaxis system itself and by programs that upload data to the system (e.g. eligibility data, provider data, coinsurance, co-pay, and other processing rules/data). All interfaces are thoroughly tested before data is loaded or used in the production system.** **When working with interconnections between external systems the method of transmission of the data is evaluated based on the client's needs and the need to ensure secure communications. Most of the time this is via SFTP and/or PGP encryption for data in transit. Data can be exchanged either by a pull (data picked up by HealthSCOPE Benefits from the senders FTP server) arrangement or a push (data loaded the HealthSCOPE Benefits FTP server) arrangement. In all cases data is sent using secured connections.** **A risk assessment of systems' interfaces is conducted prior to sending claims data and again on an as-needed bases (i.e., technology changes, additional security interfaces added, changes to applicable law/security rule, etc.) as well as prior to integrating data that is used to manage key work processes. This analysis includes a review of, data definitions, information transfer capability, interoperability issues, and information security issues. Additionally, an interoperability analysis is documented and submitted to programming management and the key representatives of the client and their other vendors (as appropriate) for review and sign-off.** **All interfaces are thoroughly tested and are put into production only after all entities are satisfied that the requirements for the interface have been met. The steps taken ensure accurate and secure interoperability between the sending and receiving systems.** **The only internal system for the exchange of data is from the Healthaxis ("HAXS") system to the HealthSCOPE Benefits data warehouse. HAXS ensure regulatory compliance in all of their processes and for protecting member data. The claims management system is a complete integration of member management and claims processing from claims to claims payment. HAXS provides a redundant data storage. The HAXS system offers a secure web application that HealthSCOPE employees and members access via a secured HTTPS/TLS webportal. HAXS' level of compliance and testing annually includes providing HealthSCOPE a SSAE 18 Type II SOC1 report.** **Additional security controls, as defined throughout this response, are applied to the interface of HealthSCOPE and EBD's systems. These measures include the implementation of enterprise-grade firewalls configured to prevent the unauthorized access of shared systems, the use of extensive access and authentication controls, secure communications channels established through VPNs or the use of HTTPS over SSL, and the encryption of all shared data both in transit and at rest on HealthSCOPE managed systems.**	5 points

7.B.3 Describe your plan for screening for excluded or disbarred/debarred entities. **We would review all out of network providers to determine if they are excluded or disbarred/debarred entities.**	5 points
7.B.4 Describe your plan to meet EBD security requirements. **HealthSCOPE Benefits ("HealthSCOPE") is committed to our members on providing secure infrastructure and applications for members protected healthcare information. Our organization trusted partners, and third-party assessors continually test and validate security protocols, policies, procedures, controls, and continuously implement strong IT security best practices that comply with industry standards.** **HealthSCOPE implements and supports a security framework focused on HIPAA compliance to ensure data operations are secure, maintain regulatory compliance for the HIPAA Privacy and Security Rule, and aligns its business model for organization compliance that supports URAC Core 3.0 Accreditation. HealthSCOPE performs a Statement on Standards for Attestation Engagements (SSAE) Service Organization Controls (SOC) report for maintaining internal controls. The SSAE 18 Type II SOC1 report is completed annually by BDO.** **HealthSCOPE Benefits is in the process of working towards our SOC 2 Level II. Please refer to Section I to review our latest SSAE 18 Audit Report.**	5 points

HealthSCOPE recognizes that it needs to recover from disruptive incidents in the minimum possible time and that this necessity to ensure a speedy restoration of services requires a significant level of planning and preparation. HealthSCOPE's business continuity plan has been prepared to assist the organization to manage a severe disruptive crisis in a controlled and structured manner. It contains information on emergency contact details, strategies to mitigate impact, procedures to be implemented and communication processes to be followed in response to a critical business outage.

As part of the security and compliance program, HealthSCOPE provides initial and ongoing HIPAA training to all workforce members. This training includes specific focus on the protection of electronic protected health information (ePHI) and information security best practices.

HealthSCOPE is prepared to meet the specific security needs of EBD including maintaining compliance with the Business Associate Agreement, signing (as required) the System Confidentiality Agreement, and utilizing the Recipient Identification Number as provided from the EBD eligibility system.

The information below provides additional background on the security practices of our trusted partners:

Data Center Operations (Blue Hill Data Services)

HealthSCOPE's core infrastructure and data operations are provided in a secure data colocation in Pearl River, NY. Blue Hill Data Services ("BHDS") is our trusted partner that provides secure controls that demonstrate a commitment to our organization and clients. BHDS level of compliance and testing annually includes providing HealthSCOPE a SSAE 18 Type II SOC1 report. Trustwave, an authorized scanning vendor, performs monthly security assessments on HealthSCOPE's infrastructure. BHDS data centers implement fault tolerant solutions, with state-of-the-art physical components and redundant network services. Their data center operations are all U.S. based in Pearl River, NY, Branchburg, NJ, and Shelton, CT. All data center operations provide high-availability environments to HealthSCOPE. Data center security operations include card access, a guard station, and video surveillance. HealthSCOPE maintains secure controlled IT admin-level access to the infrastructure systems and applications in BHDS data center. Our network and applications provide role-based access controls (RBAC) and enforce the principle of least privilege when accessing member data. HealthSCOPE has a Business Associate Agreement (BAA) with BHDS.

Claims System (HealthAxis)

HealthSCOPE claims management solution is maintained by HealthAxis Group ("HAXS"), located in Irving, TX. HAXS is a provider of integrated solutions and services for health benefit administrators and health insurance claim processors. HAXS provides a secure cloud-delivered solution to HealthSCOPE for managing our claims system. HAXS ensure regulatory compliance in all of their processes and for protecting member data. The claims management system is a complete integration of member management and claims processing from claims to claims payment. HAXS provides a redundant data storage that is also located in BHDS data colocation operations. The HAXS system offers a secure web application that HealthSCOPE employees and members access. HAXS' level of compliance and testing annually includes providing HealthSCOPE a SSAE 18 Type II SOC1 report.

7.B.5 Describe and provide a copy of your Disaster Recovery Plan as applicable to this RFP. **Please refer to Section IV to reference our Business Continuity Plan.** **HealthSCOPE Benefits maintains a comprehensive Business Continuity Plan to assist the organization in managing any serious disruptive crisis in a controlled and structured manner.** **The Business Continuity Plan contains information on emergency contact details, strategies to mitigate impact, procedures to be implemented, and communication processes to be followed in response to a serious disruptive event. Furthermore, HealthSCOPE Benefits' Business Continuity Plan covers all essential and critical business activities. By defining the business processes and timeframes needed for restoration of business activities, HealthSCOPE Benefits is able to maintain the control and structure needed during a crisis event.** **To enhance the effectiveness of our Business Continuity Plan, we have established several key committees, including our Business Continuity Committee and our Security Committee. Our Business Continuity Committee is composed of senior leadership that meets on regular basis to discuss the latest business continuity risks. The Security Committee of HealthSCOPE Benefits is comprised of our Security and Privacy Officers. The Security Committee meets on a monthly basis to discuss the IT-based risks identified throughout the industry. With the help of our committees, we have instituted many new processes to identify latent risks. For example, HealthSCOPE Benefits surveys all employees that are manager-level and above regarding risks to HealthSCOPE Benefits' operations to give us practical insight into risks that may arise on a day-to-day basis. Additionally, we audit our key subcontractors to ensure that, among other things, they have comprehensive disaster policies in place.** **As part of our initiative in developing our Business Continuity Plan, HealthSCOPE Benefits has developed documented policies and procedures in every department to which all employees have access to ensure that operations are continued in the event of a key employee's absence.** **Lastly, to ensure its continued effectiveness, HealthSCOPE Benefits routinely tests its Business Continuity Plan in a simulated environment to ensure that the Business Continuity Plan can be implemented effectively by management and staff in emergency situations.** **<u>Backup policies, procedures and storage:</u>** **Blue Hill Data Services (BHDS) maintains a 7/24/365 day fully managed datacenter. All systems within the HealthSCOPE environment are monitored from hardware, software and services view on the same 7/24/365 day basis.** **Our outsourced network partner has a fully-functional disaster recovery site in a different physical location from the primary hosting site. Nightly backups are sent to this DR site. Complete monthly system backups are archived to tape and stored offsite for a period of seven years. Incremental data backups are also taken periodically during the day so that files that were modified that day can be restored from an earlier version, if necessary.** **Our applications and data are housed in the primary data center of our outsourced networking partner. This data center is located in New York. Backup data is stored at the disaster-recovery site in New Jersey.** **Healthaxis completes back up of all systems using industry-standard backup procedures on all production servers and source code. These backups are rotated off-site daily via a bonded carrier to a secured vault. HealthSCOPE Benefits performs a full backup of its local computer files every night as well as weekly and monthly. All backup files are picked up and delivered to a secure storage vault. HealthSCOPE Benefits has also implemented a high-quality uninterruptable power supply system.**	5 points

HealthSCOPE Benefits has completed a written Disaster Recovery Plan (DRP) that is dependent upon the Healthaxis, Inc. Data Center Disaster Recovery Plan and redundant Operation Centers and the BHDS Disaster Recovery plan. Since HealthSCOPE Benefits uses the Healthaxis claims processing system in an Application Service provider (ASP) arrangement, all hardware and software is at the Healthaxis site. Also, all scanned images of claims are not only stored at the Little Rock HealthSCOPE Benefits site but are also backed up at the Healthaxis site. HealthSCOPE Benefits' Wide Area Network (WAN) is designed such that in the event of communication failure at the HealthSCOPE Benefits site, analysts are still able to access the system.

Disaster Prevention And Recovery

Healthaxis has developed a disaster recovery plan that focuses first on prevention and in the event that the prevention controls fail, or were inadequate, then on recovery. What follows is a description of the preventive steps and recovery actions that Healthaxis has taken or planned for regarding the most likely sources of risk.

The operations center, which includes all computer hardware utilized for claims processing by customers, is in a fully redundant data center located in Pearl River, New York. Blue Hill performs an annual SAS 70 Type II report of its controls and will comply with the new service organization report standards (i.e., SSAE 18 Type II report) going forward.

Fire

The data center uses a dry-pipe double pre-action fire suppression system that requires both smoke detection and sprinkler head detection to activate a flow of water. Sprinkler head detection is driven by temperature in the sprinkler head area. Sprinkler heads are independent, thus just because one sprinkler head goes off doesn't mean that they all go off. This means that water damage is confined to only the area where water was needed. Smoke detection is provided by a VESDA fire detection system that samples the air every five seconds at sensor locations throughout the facility to verify any change of air quality, in parts per million. In addition to the integrated temperature / air quality sprinkler triggers, there are handheld fire extinguishers located throughout the facility.

Power Outage

The datacenter is isolated from problems that may plague the electrical power grid by direct connection to the power plant. Thus even when surrounding areas "go dark," services at the data center will continue uninterrupted. In the unlikely event of electrical power loss, an uninterruptable power supply ("UPS") UPS immediately takes over. The UPS is a large number of special batteries and controllers which will supply needed electrical power for approximately one hour. Data center personnel periodically test the UPS to verify that it will be ready when needed. If electrical power is not restored within a few minutes, a diesel power generator starts and provides needed electrical power and recharges the UPS system. The diesel power generator can supply needed electrical power for 48 hours without refueling. Theoretically, if refueled, the diesel generator can run indefinitely. The facility has diesel fuel contracts with three different suppliers.

Loss of Air Conditioning

The site, by design, has more (n+1) air-conditioning capacity than needed. Air handlers have oversized cartridge filters to keep air as clean as possible. Both temperature and humidity control equipment are protected from electrical failure by generator power.

Loss of Data Communications

The data center facility provides data communications through dual SONET rings ("the working ring and the protection ring") – with different vendors. Failure of the working ring causes automatic ("self-healing") switch-over to the protection ring which duplicates the performance of the working ring.

Physical Access Control

Building security (24/7) and Blue Hill employees have access to the data center. When leaving the facility, items carried out, including briefcases, are subject to search. Anything that leaves the facility is logged out. An electronic fob is required to operate the elevator after hours. Blue Hill operations staff is on-site 24/7. The security manager maintains an access authorization list and must approve changes to the access list. Visitors sign in at the reception area. Access to secured areas is limited to personnel who require access to these areas to function effectively.

Data Backup

Client data is backed-up daily to a virtual tape library ("VTL") and to tape. Tapes are stored offsite at ADS. ADS is approved and certified to accept clients with Payment Card Industry, HIPAA and SOX compliance requirements. ADS also processes a Homeland Security Clearance for clients with this requirement, and their courier employees have received special training related to this clearance. Each ADS employee involved with data tapes undergoes a full background check and drug screen at least once per year. ADS also possesses a four-and-a-half hour fireproof tape storage vault equipped with temperature and humidity sensors and logs, which may be viewed remotely at any time by their clients through their website. Their on-site security system includes more than 60 facility cameras, and a radio security and fire alarm system that operates when electrical power is unavailable.

ADS requires its clients to provide an authorization list of employees who will participate in the tape exchange process. Each client-authorized person has a designated authorization level and is issued an ADS ID card. ADS will exchange tapes with these authorized individuals and no one else. Due to specific arrangements with Blue Hill Data Services (where the data center is located), two Blue Hill Data Services employees are authorized to exchange tapes for Healthaxis.

Currently, no Healthaxis employee is authorized to participate directly in the tape exchange process. However, Healthaxis operations personnel are authorized to send tapes off-site with specified return dates, and to request that tapes be brought back to the data center.

ADS utilizes tape management software, called TapeTrack. It tracks the movement and location of backup tapes. Tapes are assigned to slots in the tape storage vault, and slot assignments are tracked in the TapeTrack software. Healthaxis tapes (and vault slots) are barcode labeled; tapes are barcode scanned by ADS personnel when checked in or out of the tape storage vault. Healthaxis operations personnel and authorized Blue Hill personnel can also monitor the location and movement of tapes using the TapeTrack software.

Production Environment

Healthaxis incorporates redundant systems in its computer equipment to prevent other types of disasters. The internal power supplies, peripheral paths, data lines and many other components have redundancy built-in so that if one of the components fails, operations are not affected. Disk drives are protected by RAID-5 technology. RAID-5 provides protection by spreading data across multiple drives with a capability to rebuild the data on a single drive from the information on the other drives, and therefore, protecting from data loss in the event of a disk drive crash.

Hardware and Software Maintenance Agreements **Healthaxis has maintenance contracts with key vendors to ensure that hardware and software components, and expertise are available on a 24/7/365 basis. Our new IBM servers and SAN are continuously monitored by IBM and we are contacted by IBM in the event of a problem. The backup systems, including the VTL, and tape drives are on contract with their various providers. Software is also on maintenance, including UniData and AIX, the database and operating system of the production systems, respectively.**	
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? **Confirmed, provider networks can be loaded within the system.** **If a provider is not within a network the customer care team would address the plan participant and provider while on the phone.**	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. **1. Name – Patty Kelly** **2. Title – Implementation Manager**	5 points

	3. Experience and credentials **Patty Kelly, Implementation Manager, has been with HealthSCOPE Benefits, Inc. for 13 years. She is responsible for overseeing the entire implementation process of new clients from contract signing through product go-live which requires close coordination among all the designated personnel for this process.** **Prior to this position, Patty served as a Network Services Administrator for HealthSCOPE Benefits, Inc. She was responsible for implementing the PPO Networks and Vendors for all new and existing clients. She also maintained our provider database, updated directories for all contracted organizations, and built fee schedules for our contracted partners.** **Following your initial "kick-off" meeting, your account manager will work with you to determine a day and time for weekly implementation meetings. These meetings are established to continue any topical discussions not resolved during your initial meeting, and to keep you abreast of our progress on implementation tasks. Weekly meetings are held via conference call, and last throughout the implementation period and into the first few weeks after "Go Live."** **As implementation progresses, these meetings should become shorter in length and may even move to a biweekly cadence. In addition to these regularly scheduled meetings, other specific vendor meetings or design meetings may be scheduled periodically as needed.** **Depending on your overall implementation timeline, and soon after most plan design decisions are made, your account manager will provide a summary document outlining the plan design and features for you to review and approve. It is this approval that allows our benefit system programmers to build your plan for claims adjudication. Additionally, the account manager will provide a copy of your Client Profile document which outlines the account structure (for financial and reporting operations) that you have requested.** **The team described within question 2.A.3 would be involved throughout the implementation process. We have also provided these key personnel biographies within Section IV as an attachment, in addition to our proposed implementation timeline for the State also provided within Section IV.**	
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 will assign a dedicated implementation team for The State of Arkansas, and there are typically 20 or more individuals working through the implementation at any given time. These departments include plan programmers, customer service and member experience, finance/banking, client relations, programming/systems, legal/compliance and trainers.** **Your Account Manager would be dedicated to the project throughout the life cycle of the project.**	5 points

	Account Management and our dedicated Implementation Director will lead the team of the internal resources required for the implementation and will be accountable for its success. Included on our team will be plan programmers, customer service and member experience, finance/banking, client relations, programming/systems, legal/compliance, trainers. Beginning with a kick off meeting, and going forward at least weekly, joint meetings/calls with the client will be held where progress against a detailed implementation schedule is measured and any emerging issues are addressed (sample schedule will be sent via email attachment). An extensive Implementation Questionnaire (IQ) for documenting details around the various functions and benefits, very specific service requirements, will be maintained electronically for ease of use. Extensive testing of all system programming (including test claims) to ensure that interfaces, account structure, and plan programming are accurate. We will thoroughly support the client with any employee meetings or training on site or via web. Confident of our ability to provide a positive implementation process, we have included guarantees to that end. **We will work with the prior medical management operation to capture pre-certifications, authorizations and special arrangements that have already been put in place. This will ideally include an electronic file of pre-certifications and full records of all case management activity and negotiation. We will work with the client to establish rules around continuity of care and benefits in the case where the transaction could otherwise cause a disruption. In most cases, there will be a provider that participates in the prior network but not the new one. This can impact scheduled surgeries, rehabilitation, maternity and mental/health/substance abuse. In each case we will want to define whether we continue to offer in-network benefits and for what length of time or number of visits. We will provide employees and family members with confidential means of communicating transition concerns, including e-mail to a designated Transition Representative or use of a Transition Form that can be sent to either HealthSCOPE Benefits or the client for discussion.** **Our detailed implementation plan outlines individual tasks, person(s) responsible for completion of each task and an estimated date of completion for each task. We provide a client specific document based on our initial meeting with the client and our increased knowledge of the client's resources that are able to support the installation. Perhaps the most important tool used to ensure the integrity of the installation is our Implementation Questionnaire (IQ). Each functional area of HealthSCOPE Benefits uses the IQ to complete their task related to the installation.**	
8.A.3	Detail your implementation steps/processes and identify the time requirements for each. **Our implementation resources will be available to you at all times. Please refer to Section IV to reference our detailed sample implementation plan.** **Our account managers proactively manage clients through providing ongoing information about national and local issues that impact service delivery, and meet at least quarterly with each customer to review not just utilization data, but overall service quality and future planning. Account Management and our dedicated Implementation Director will lead the team of the internal resources required for the implementation and will be accountable for its success. Included on our team will be plan programmers, customer service and member experience, finance/banking, client relations, programming/systems, legal/compliance, trainers. Beginning with a kick off meeting, and going forward at least weekly, joint meetings/calls with the client will be held where progress against a detailed implementation schedule is measured and any emerging issues are addressed.**	5 points

An extensive Implementation Questionnaire (IQ) for documenting details around the various functions and benefits, very specific service requirements, will be maintained electronically for ease of use. Extensive testing of all system programming (including test claims) to ensure that interfaces, account structure, plan programming, is accurate. We will thoroughly support the client with any employee meetings or training on site or via web.	
8.A.4 What support, if any, would you require from EBD during implementation? **A key goal during the implementation process is for your HealthSCOPE Benefits' account team to fully understand the intent in regard to plan cost share, benefit design, and plan exclusions. Upon initial notification of sale, the HealthSCOPE Benefits account team will request all of the current plan documents for our review, as well as any plan design changes being considered for the upcoming year. It is critical that plan designs be agreed upon early in the process to ensure that the entire implementation runs smoothly. Your HealthSCOPE Benefits team will load these design details into our systems and perform testing prior to the effective date.** **In order to start the implementation, we would need the following from EBD:** • **Administrative Agreement** • **Prior Plan Documents, where applicable** • **Plan Designs** • **Eligibility Load/Maintenance** • **Billing/Finance Information** • **Vendors utilizing** • **ID Card Requirements** • **Client Communications** • **Customer Service/Telephone IVR Requirements** • **Web Features**	5 points
8.A.5 What support, if any, would you require from EBD throughout the duration of the contract? **Your Account Manager will reach out to you early in the implementation process to schedule a banking call. The banking call is designed to discuss and set up the claim funding and billing processes and timeline. It will be important to have representatives from Finance and Human Resources departments attend this meeting.** **The call will cover:** • **Check run date** • **Claims funding process and ECHO Health** • **Methods of payment / remittance options** • **Methods of approval / payment release rules** • **Monthly Administrative Invoice details** • **Who your funding and billing contacts are** • **Various forms needed to be completed by your team** • **Reports available to you**	5 points

	The Account Manager will work with you to ensure that the appropriate attendees are present, and he or she will share a meeting agenda in advance. **The Client Profile is a road map that is used to set up your group in our Benefits administration system. The profile outlines the subgroups, medical coverages, and medical plan code descriptions.** **To create a Client Profile, HealthSCOPE Benefits will need the following information:** • **Demographic information** • **Subgroup names** • **Fees** • **Types of medical plans selected** • **Networks selected** **The profile is a critical step in the set up process because the coverage set controls Benefits and your network hierarchies. The descriptions are what you will see on your reports. We suggest working closely with your Account Manager to ensure the structure meets all your needs including billing and reporting. The completed Client Profile will require your sign off before the account can be set up in our systems.**	
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. **Risks to implementation anticipated as follows:** o **Timely and accurate collection of all necessary data from EBD.** • **HealthSCOPE Benefits would mitigate this risk by establishing agreed upon timelines for collection of data from the state** • **HealthSCOPE Benefits would also mitigate this risk by completion of data questionnaire's during onsite meetings with the state during established timeframes** o **Tracking of open issues and obstacles to implementation.** • **HealthSCOPE Benefits utilizes an action log of open questions, issues and obstacles during implementation that is used to track and document resolution. This log can be shared with EBD.** o **New Vendor relationships and establishment of requirements and testing.** • **If EBD requires different vendors than HealthSCOPE Benefits has previously used, additional time will be built in the project plan to account for requirements and testing prior to implementation.** o **Plan changes, vendor changes, benefit changes required after established deadlines for implementation.** • **If EBD requires changes to plans, vendors, or benefits after the established timeline, HealthSCOPE Benefits would work to meet original timelines where possible. Any risk to implementation dates resulting from these changes would be discussed with EBD to determine next steps and timeline.**	5 points

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.	5 points

Statistics and detail for State of Oklahoma:

Number of members and dependents: approximately 187,975
Plan benefits implemented: medical, dental, Medicare supplement, life, AD&D, dependent life, supplemental life, pharmacy, case management, utilization management, flexible spending account
Implementation timeline: 6/1/17 – 1/1/18

Goals:

1. **Pay claims on state membership, state benefits and administer state programs beginning 1/1/2018**

2. **Support project implementation through:**

   - **Hands on involvement and support from executive, management, account management, project management teams**
   - **Requirements gathering and data collection based on state plans, benefits, membership, vendors**
   - **Project plan development, tracking and transparency of plan with the state**
   - **Administration of ongoing client, internal and vendor implementation calls**
   - **Onsite representation by HealthSCOPE throughout implementation**

3. **Other goals completed within established timeline based on state plans, benefits and requirements:**

   - **Build plans and benefits**
   - **Setup customer and provider service related functions**
   - **Provider and member website setup**
   - **Customer service, provider and claims training for internal teams**
   - **Eligibility/membership set-up**
   - **Identification (ID) card and welcome packet setup and mailing**
   - **Establishment of client and vendor feeds**
   - **Process setup for medical management and other programs**
   - **Set-up coordination of benefits (COB) administration**
   - **Set-up subrogation administration**
   - **Set-up of Medicare Secondary Payer and CMS requirements**
   - **Claims testing and approval**
   - **Independent auditor review and approval prior to go live**
   - **Set-up of overpayment and recovery process**
   - **Set-up appeals process**
   - **Set-up billing and account reconciliation process**
   - **Establish and set-up reporting requirements**
   - **Client training for website, data analytics and reporting system**