Retiree Health Plan Advisory Board
Modernization Subcommittee Meeting Agenda

Date:	Wednesday July 20, 2022 OnlinePublicNotices
Time:	09:00 am – 12:00 pm
Location:	Video Tele-Conference & Atwood 19th Floor Conference Room
Teleconference:	Phone: (907) 202-7104 ID: 112 808 338 8 Click here to join the meeting
Committee Members:	Cammy Taylor, Nanette Thompson, Mauri Long

09:00 am **Call to Order – Cammy Taylor, Modernization Subcommittee Chair**

- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure

09:10 am **Working Session**

- PreCertification Process
- GCIT Designated Network

11:50 pm **Public Comment**

12:00 pm **Adjourn**

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Thursday, June 23, 2022 9:00 a.m. to 12:00 p.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members		
Cammy Taylor	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Mauri Long	Committee Member (RPEA)	Present
Judy Salo	Board Chair	Present
Paula Harrison	Board Member	Present
Dallas Hargrave	Board Member	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Others Present + Members of the Public		
Dr. Lydia Bartholomew	Aetna (medical third party administrator)	
David Broome	Aetna (medical third party administrator)	
Breeanne Fisher	Aetna (medical third party administrator)	
Jill Fratello	Aetna (medical third party administrator)	
Kimberly Krebs	Aetna (medical third party administrator)	
Andrew Robison	Aetna (medical third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Stephanie Messier	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Randall Burns	Retired Public Employees of Alaska (RPEA)	
Delisa Culpepper	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	

Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- RPEA = Retired Public Employees of Alaska
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the committee meeting to order at 9:04 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 6/23/22 RHPAB Modernization Committee Meeting

1. **Motion** by Mauri Long to approve the agenda as presented. **Second** by Nan Thompson.
    - Cammy proposed adding Public Comment following the work session, no objection.
    - **Result**: No objection to approval of agenda as amended. Agenda is approved.

Ethics Disclosure

Cammy Taylor requested that committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Item 2. Prior Authorization Overview (Aetna)

Materials: Presentation beginning on page 15 of 6/23/22 agenda packet

Emily Ricci introduced the focus for today's meeting: as part of the settlement between the Division and RPEA, there were several areas identified for review and possible changes, one of which is prior authorization / pre-certification. There are other issues related to this as well, such as travel benefits and penalties for not securing prior authorization, so this is part of a larger conversation. Today's meeting will include a presentation from Aetna about their policies and process related to pre-certification.

Kimberly Krebs introduced the presentation, the Aetna team, and today's presentation topic.

- Cammy Taylor requested that Aetna highlight what in the presentation is not part of the AlaskaCare retiree plan, if it is shown in the slides but does not apply to this plan.
    - Kimberly Krebs confirmed the today's slides do specifically apply to the AlaskaCare retiree plan, the materials were updated to remove information that wasn't relevant.

Breanne Fisher presented summary slides: prior authorization is a standard policy in health care plans intended to protect members as well as the plan by requiring review prior to approving a service, procedure, drug or other service for use for that member. Prior authorization considers whether the proposed procedure or service is clinically appropriate, and appropriate for that member (for example, whether their diagnosis and other conditions merit this approach).

Dr. Lydia Bartholomew presented: Aetna maintains a National Precertification List (NPL) which is publicly available, Clinical Policy Guidelines that establish the evidence base for each procedure, drug or other service and when they are appropriate to use, in the form of Clinical Policy Bulletins for each individual procedure, program or drug. These bulletins are updated regularly, as well as a thorough review for newly-approved drugs and procedures. There is an Aetna committee for reviewing the Clinical Policy Guidelines, as well as a separate National Precertification List committee which reviews overall data on these guidelines and precertification process and determines where there are needed changes or

improvements to the list. There may be several reasons to take something off the NPL: if it is no longer used as a treatment, if there are no longer concerns or a need for pre-certification (*e.g.*, if ~100% of pre-certification requests are approved) and it does not need review, and other reasons.

Pre-certification applies to in-network services and providers; Aetna does not review out-of-network care through this process, and there is a separate process for reviewing out-of-network claims by Aetna. Additionally, the AlaskaCare retiree plan requires that providers who are out-of-network seek pre-certification themselves, so there is still oversight of these claims.

- Mauri Long asked the difference between the clinical policy committee and national pre-certification committee? Do they interact?
    - Dr. Bartholomew confirmed they are separate committees. The NPL committee only maintains a subset of overall pre-certification lists, and has a separate method for analysis. Their scope is the larger national list, which does not include all the items specifically on Aetna's pre-certification list. The clinical policy committee reviews all Aetna policies, which may be listed for different reasons.
    - Emily clarified there may be multiple reasons for a procedure or service needing pre-certification: it may be on the list due to the high cost of the service, and/or ensuring it is the appropriate intervention for the member's condition; it may be an emerging technology that is complicated to administer, or has relatively limited evidence to date, so it merits additional review to ensure it is being used appropriately. She gave an example of a provider acquiring a new piece of equipment, using it for many different situations, some of which are not appropriate or effective. In these cases, pre-certification may be denied. However, if a member receives a procedure that is not determined to be medically necessary, they are at risk of having to pay more for the service, if it is not covered by the plan.
- Mauri asked whether there are different procedures for pre-certification? How does this work with non-network providers, which is common in Alaska? Specifically, is there the same guidelines and process for reviewing non-network claims, as network claims?
    - Dr. Bartholomew confirmed the guidelines are the same, regardless of whether it is in network or out of network; the process is similar, but involves reviewing a specific claim to determine medical necessity, not a prior authorization upfront.
    - Kimberly added there are some specific prior authorization policies in the AlaskaCare retiree plan, because of the plan policies, such as authorization for dental implants.
    - Emily added providers, regardless of whether they are in network, need to follow pre-certification requirements in the NPL. If they do not follow their required procedures, they may be liable for those costs. She also noted the plan booklet is separate from these lists, because they are maintained by Aetna.
- Cammy asked about the plan booklet, which includes a shorter list of pre-certification items: this was expanded from 2 items to 2 pages, but does not include all the things on Aetna's list. Is there a plan to update this?
    - Emily noted this policy has been in the plan since 2014. Not including all of the items in the plan booklet is the result of reluctance to update the plan booklet; however, it means this list is out of date, and it would be challenging to keep that list updated and reflect all the pre-certification policies Aetna adopts or changes. Therefore staff have proposed adopting Aetna's policy as part of the plan, similar to how they have handled clinical policy bulletins.

- Cammy asked how often items are added or removed from these lists?
    - Dr. Bartholomew noted the full list is reviewed annually, including items to add or remove, and updates to existing items. They also regularly review individual items and make updates as needed throughout the year, so the list does undergo regular review.
- Cammy asked the rationale for only requiring pre-certification for in-network providers?
    - Dr. Bartholomew responded Aetna only has contracts with in-network providers, so they have a way to hold those providers accountable if they do not follow procedure, or provide a service without getting pre-authorization. There is no clear mechanism for requiring this for out-of-network providers, which is why they focus on claims in those circumstances.
- Cammy asked whether there is a process for granting overall pre-approval for in-network providers for procedures, such as having a strong track record and no issues for performing that service?
    - Dr. Bartholomew responded offering an ongoing approval would be challenging, the process is set up to require review of individual requests. There are other reasons, besides provider quality or performance, why something would need pre-certification every time.
- Mauri asked the process for reviewing an out-of-network provider's request for prior authorization?
    - Bree responded if an out-of-network provider submits a request, Aetna will search for in-network providers are available within a certain radius who also provide that service. The prior authorization may be denied; if so, the denial letter would list those in-network providers as alternatives for getting that procedure.
    - Dr. Bartholomew added the first level of review is whether it is medically necessary, such as whether it's on the NPL or meets the guidelines. If it does not meet that criteria, it would likely be denied. If it is considered medically necessary but is an out-of-network provider, this alone would not be the basis for denial, but there would be work to encourage the member to use a network provider instead. However, if the member still wants to use the out of network provider, the prior authorization would not deny on this basis.
- Mauri asked whether medical necessity is tied in any way to network considerations?
    - Dr. Bartholomew clarified medical necessity is its own determination, whether the procedure is clinically appropriate for the member's situation (diagnosis, other conditions, etc.). Network considerations are part of benefit determination, which is what the plan will cover and at what level. Additionally, there is review of the specific plan policies to determine level of coverage through the specific plan, also separate from medical necessity.
    - Breeanne added an out-of-network provider can also initiate a prior authorization, which is routed to the same group who does clinical review.

Slide 7 in the presentation illustrates the process for an example procedure. The process begins with the provider, who submits information to Aetna for prior authorization. If the clinical team is unable to make a determination, it is sent to the Medical Director for a determination. The Medical Director also reviews all denials before they are issued, if the clinical team recommends denial: the Medical Director makes decisions on denials. The process is the same for in-network and out-of-network, except the member is responsible for coordinating with the provider if they are out-of-network as well.

- Cammy asked how many staff are needed to review cases? She noted the retiree plan covers approximately 70,000 people, what staffing level is required just to service this plan?
    - Breeanne shared there are approximately 100 staff who review pre-certifications; there is no dedicated staff specifically for the AlaskaCare plan.

- Emily added there are dedicated staff for claims processing, but not for this process.

Slide 8 includes typical turnaround times for the AlaskaCare plan's pre-certifications: it is possible to make a determination within 24 or 48 hours if an urgent decision is needed (the additional hours are typically for requesting more information). For non-urgent decisions, it would take approximately 5 business days, if not sooner. This also assumes that a complete request was submitted; if more information is needed from the provider, there may be a longer wait, typically up to 5 additional days. This also depends on the provider sending the information back in a timely manner, and whether there needs to be correspondence about the case before a decision is made.

- Mauri asked whether there are any pre-certification processes required for emergency care?
  - Breeanne responded "urgent" here means "life or death situation," whether not acting immediately would result in serious harm, including whether the individual is in unmanageable pain. This would determine the speed of review and approval.
  - Dr. Bartholomew added their team uses standard medical criteria to determine urgency, and how fast to respond. She also noted emergency care typically happens immediately and are submitted after the fact, rather than seeking authorization in advance. Aetna would typically learn about these situations after care occurred, or when a person is admitted to the hospital.
- Mauri asked what situations would be considered acute but not urgent?
  - Dr. Bartholomew responded some orthopedic procedures may fall in this category, normally they are elective but some are urgent re: timing. There may also be some behavioral health procedures, such as dealing with substance misuse. She noted in general, they follow guidelines regarding urgency and whether the pre-certification process applies, versus review after the fact for a procedure considered immediately necessary.
  - Emily confirmed staff will follow up and provide definitions of "urgent" in the plan.
  - Cammy added the plan booklet does refer to urgent versus non-urgent situations, and having those definitions would be helpful.
- Cammy asked for more details regarding turnaround times: she understands the slide information is sharing a time range, are there more specific statistics for the AlaskaCare plans?
  - Breeanne shared they do keep statistics about their performance, and will follow up with more detailed data for this plan.

Breeanne continued: if a case is denied, the provider can request a peer-to-peer review, which is a discussion between the provider and the Aetna case reviewer. This is done within 14 days of the denial determination. If the provider does not respond within 14 days, or opts not to do peer-to-peer review, the decision is upheld. If a meeting is held, the decision may be reversed, but could also be upheld by the Medical Director, the review does not guarantee a change in decision.

- Mauri asked for summary data of how many cases are still denied, after peer-to-peer review? She also asked whether providers are contacted after a denial, to ask for more information about whether the treatment is medically necessary, or if there is missing information?
  - Breeanne clarified if more information is needed, if there are pieces needed to make the determination, the review team first reaches out for more information; they do not move forward with a denial on this basis alone. If they do have full information and there is a recommended denial, the review team (nurses) elevate the decision to the Medical Director,

who is the person who issues the denial. There are multiple steps in the process, with the goal of having complete information and finding the best service for the member, before a potential denial occurs. There is also opportunity to reverse the denial if the provider still feels it is medically necessary.

- Emily added the Division also encourages peer-to-peer conversations to determine medical necessity, to resolve the issue before a denial would occur if possible.

Slide 11 illustrates the coverage difference between a member getting services from an in-network or out-of-network provider: if a service is provided that is on the NPL but they do not get pre-certified, and not on the NPL, if the provider is in network, the member is still protected from being liable to pay for that care. If the provider is out-of-network, however, and does not get pre-certification when it was required, the member is responsible for more of the cost. The booklet currently says the benefit reduction would be $400, or 50% co-insurance if it is an inpatient mental health treatment. Travel benefits are also not covered in this situation.

Emily noted this policy has not been updated since at least 2003, and should be reviewed: for example, if travel benefits would otherwise be covered, it does not make sense to deny coverage of those travel benefits. This needs review, staff recommend more work on this policy.

Breeanne continued: slide 12 includes links to pre-certification information both on Aetna's website and the Division's plan booklet. Section 3.2 Precertification has details.

- Cammy asked if there are services that require pre-certification in the AlaskaCare plan booklet that are not on the NPL?
  - Breeanne responded there are some specific requirements in the plan beyond the NPL, as well as guidelines Aetna maintains beyond the NPL.
- Paula Harrison asked how Aetna interacts with other coverage, if they are the secondary payer?
  - Breeanne confirmed pre-certification requirements are typically with the primary payer. If Aetna is secondary payer, they would not also use this process if the primary payer determined it will be covered. The exception would be if a service is not covered under the primary payer, but is covered by the plan Aetna is managing, and if that service requires pre-certification per Aetna policies.
- Nan Thompson asked whether Medicare has its own pre-certification process? How does Aetna interact with Medicare coverage?
  - Dr. Bartholomew responded Medicare (CMS) itself only reviews claims after the fact, so there is no pre-certification process for that coverage. However, Medicare Advantage plans do have a pre-certification process, which does not apply to AlaskaCare.
  - Emily added typically Medicare as the primary payer would make the coverage determinations; if the AlaskaCare plan does not cover a service, but Medicare does, Medicare' processes would apply. If Medicare does not cover a service, then AlaskaCare as secondary coverage would apply, and the processes in place would require it.
  - Cammy clarified AlaskaCare would not add a pre-certification requirement if they are the secondary payer, if it is covered by Medicare.
  - Emily clarified if Medicare determines something is not medically necessary, then likely AlaskaCare would also not cover it. But if they determine it is simply not covered by Medicare as a benefit, then the AlaskaCare plan's coverage would apply (if it is covered).

- Judy Salo asked about a situation where something is not covered by Medicare, but is covered by AlaskaCare and requires pre-certification? She is concerned about the additional time and review that may be required, and whether this is an issue.
    - Emily responded staff will follow up and identify more information about how Aetna interacts with Medicare in these situations; she is not aware of problems associated with coverage of services that are not covered by Medicare, but noted that as more members become Medicare eligible and have AlaskaCare as secondary coverage, this is helpful to understand further and identify if there are any issues to address.
- Judy asked whether statistics about pre-certification could be included in the quarterly review meetings? For example, how many denials occur, how many processes took more time than average, how many were out of network, and other statistics that help the Board understand whether members are having problems with this process.
    - Emily responded Aetna does provide some of these statistics, they may not be specific to the AlaskaCare plan but across their full book of business. She recommended monitoring this annually, not quarterly. She also shared the Division looks closely at appeals—how many, what procedures or services, and how many are denied. She recommended this is the best indicator overall for diagnosing problems that need to be addressed.
    - Judy responded this makes sense, but would still like to see the number of pre-certification issues come up, they do hear occasionally from members having problems with this process.
- Cammy asked about potential future improvements, or improvements made by Aetna recently, in the process? She noted the American Medical Association (AMA) has opposed pre-certification in the past, providers feel it adds burden to their practices. Has Aetna made changes in response to these concerns, or their recommended changes?
    - Dr. Bartholomew noted Aetna is aware of these concerns, one of the issues regarding administrative burden is that health plans maintain their own pre-certification lists that vary beyond the national and Aetna overall requirements. She shared Aetna works to have an efficient process, making it easier to submit requirements (such as online submittal and a questionnaire to streamline the process), and regular review of the NPL to remove things that do not require pre-certification (such as a previously-new, now-established procedure that has a strong evidence base). She is aware of provider concerns, many of which are generally about the process rather than specific policies.
    - Cammy also noted having the information publicly online has made this more available to providers, as well as members, so they can understand what's required.

Kimberly confirmed Aetna's follow-up: definition of "urgent"; data about turnaround time; more information about penalties; data regarding denials, appeals and issues regarding pre-certification within the AlaskaCare plan; and providing more information about how Aetna's processes interact with primary payers, specifically Medicare.

The Board took a break at 10:35 a.m., and returned to the meeting at 10:45 a.m.

Chair Taylor called the meeting back to order.

Emily shared the Division would like to identify next steps about addressing pre-certification in the plan. There are some specific areas that need to be updated, as well as other possible updates that may come up as a result of discussion. What are committee members interested in?

- Nan mentioned penalties as an area of interest.
    - Emily noted the Division will want to maintain monetary penalties in some way, because this is a way to incentivize members to seek pre-authorization when needed, and utilize network providers where possible. However, some penalties may not be appropriate, such as not paying for travel benefits, so this needs to be discussed. Additionally, staff would like to review penalties for behavioral health treatment, which is an important area that needs review regarding coverage.
    - Mauri recommended the group should review coverage as well, particularly around mental health coverage, this is an important issue and should be discussed more comprehensively than penalties: if coverage changes, that will also impact penalties.
    - Emily agreed this is an important topic to address, but she is concerned about not being able to quickly address the issue of behavioral health coverage; it would take up to 4 to 6 months to fully address that coverage issue, including research time, talking with Aetna, and multiple committee meetings to discuss possible changes. This would also delay the changes to pre-certification, which is a narrower focus. She recommends the group still proceed with discussing pre-certification penalties now, and not waiting until the behavioral health coverage review is done, so they can implement some changes by January.
- Nan asked whether there are hard deadlines in the settlement regarding pre-certification? What is the Board and Division required to do?
    - The Division is only required to start a discussion with the Board, which they have done as of the April committee meeting, not necessarily to make concrete changes. The Division still plans to move forward with working on these changes, but there is no hard deadline for making changes.
- Cammy noted the urgency could be the disparity in penalties for inpatient behavioral health claims, which is a reduction of coverage to 50% member responsibility, versus only a $400 reduction in coverage for other medical claims. Is it possible to move this forward now, depending on availability of Aetna and the Division, such as another committee meeting on this topic?
    - Aetna confirmed they could pull information together for a meeting in July. Division staff are also able to prepare for another committee meeting in late July or early August, if limited to the discussion about the disparity in penalties for behavioral health pre-certification.
    - The group also discussed the fact the Board meeting, currently scheduled for August 4, may be postponed to allow more time to prepare before votes on potential changes.
    - Staff will follow up about scheduling a meeting when staff and committee members are available, given summer travel plans in July and August.

Item 3. Proposal Review: Gene-Based, Cellular, Other Innovative Therapies (GCIT) Network

Materials: Documents beginning on page 2 of 6/23/22 agenda packet

Cammy invited Division staff to present:

Betsy Wood provided an overview of the updated GCIT network policy proposal, including answers to questions from members brought up in the April committee meeting, and some changes to the proposal in response to feedback. The purpose of this policy is to put guidelines in place for coverage of new GCIT therapies, which are specialized, complex and high-cost treatments for certain conditions, that will

continue to expand as this technology is utilized for more conditions. While these are pharmacy services, they are sophisticated treatments that require administration, monitoring and working with qualified providers for these therapies. The purpose is to ensure prior review of these therapies by the plan to ensure members' safety, that it is medically necessary and administered by a qualified provider.

In response to question about pricing: page 5 outlines the specific cost and dosage for the covered therapies, and who is eligible. For example, Spinraza has an ongoing regimen for treatment, while some other therapies (Luxturna and Zolgensma) are one-time treatments, but with a high cost for the single dose. Prices will change over time, but the current prices are provided for illustration.

In response to question about eligibility and intended uses for each of these therapies proposed for coverage is also covered on page 5. One of the therapies (Zolgensma) is intended for children and youth, while the others (Luxturna and Spinraza) may be utilized by adults as well. However, these are all new treatments, so the Division anticipates guidance may change over time as there is more data long term and more people receive this treatment. At this time, these therapies treat rare conditions and are unlikely to be used by many members in the retiree plan, but this will also put into place a framework for addressing these treatments as more are developed and approved.

In response to question about the number of providers and facilities covered: this list of network facilities will grow over time as more providers become qualified to provide these services, but the current list is provided beginning on page 9. Two of the therapies have lists of approved providers from the manufacturers, while Spinraza does not have a manufacturer-maintained list, but one that Aetna does maintain. Aetna is actively working to expand its network. The proposed coverage requires accessing this treatment at an Aetna-designated facility (meaning in the GCIT network).

- Cammy asked whether the cost listed is average savings to the plan, and takes dosage into account?
    - Betsy confirmed yes, this is based on an annual average based on current costs and the network requirement, and dosage for each therapy. She reiterated the purpose of this policy is to protect the member as well as the plan, not only ensuring it is medically necessary, but also because of the high cost involved in the treatment and if the member does not utilize an in-network provider and becomes responsible for a portion of the overall cost, which can be extremely high.
- Cammy asked whether Medicare covers these GCIT services now? It is unusual to cover these therapies under the medical plan, not the pharmacy plan?
    - Betsy will research whether it is covered under Medicare, but she believes it is considered a medical benefit, and that is typical for many GCIT services at this time.
    - Kimberly commented it is typical for these therapies to be covered in the medical plan, not the pharmacy plan. There are some other therapies covered under the pharmacy plan.
    - Sara Guidry added many plans specifically exclude these therapies in the pharmacy plan, because they typically require a provider visit to administer the therapy. Some can be home administered, but this is not typically. Additionally, the cost of the medication means it is better to ship the medication directly to the provider's office, to avoid loss. She also noted other therapies are currently covered under the retiree pharmacy plan.
    - Emily added so far, there have not been any claims submitted to the retiree pharmacy plan for most therapies on the medical benefit specialty list.

    - Kimberly clarified there are 16 GCIT therapies covered by Aetna; 3 are in the GCIT network because of the complexity of administration. The other 13 are covered by pre-certification.
- Mauri asked whether the decision to cover under the medical plan may change over time, or differ across administrators, and whether the cost was the consideration?
    - Emily responded because these are medically administered therapies, it seems appropriate to cover them as medical services, even though they could also be considered a pharmaceutical product. She believes it is less of an issue of cost, and more about complexity of administration.
- Cammy asked whether the pharmacy plan also covers these products?
    - Sara would need to review the list, but believes they would likely be covered in the pharmacy plan. However, there is an excluded drug list they maintain for coverage, which does not apply to the retiree plan currently, but would be updated to exclude coverage for these 3 therapies to maintain consistently in the plan. The exclusion list is also related to the "vigilant drug list" for other medications that are not covered for other reasons.
    - Emily reiterated that even if these are covered now, they have not been brought to the retiree plan yet, so there are no current claims even if they are covered (coded in the system, not determination of coverage). The purpose of this is to clarify coverage upfront, to ensure consistent policy and utilization of these products.
- Mauri asked whether this is already in the employee plan?
    - Emily responded Aetna's GCIT network is already in place the employee plan.
    - Sara added for the employee plan, these therapies are covered under the medical plan.
- Cammy pointed out the $2 million lifetime maximum for people not covered by Medicare, which could include everyone on the plan if Medicare does not cover this service for anyone. She urged elevating discussion of removing or changing the lifetime cap, given the cost of these services.
    - Emily responded it is still appropriate to put this policy into place soon, to protect members and the plan as these therapies continue to develop.
- Mauri asked whether someone billing the retiree plan as it is now, it could be covered under the pharmacy plan? And it would be excluded from the lifetime maximum?
        - Emily responded yes, the pharmacy plan does not include the lifetime maximum. However, the member would not have the other benefits of this process: going to an approved provider, network terms of coverage, and travel benefits.
    - Mauri asked how additional therapies are added?
        - Kimberly shared Aetna monitors what is FDA approved; this is when Aetna would begin its process to evaluate whether to add it to the GCIT network or determine if they belong on the standard pre-certification list. Determining which network they are covered under depends on what the committee will decide in the future regarding coverage. For example, they anticipate future approval of drugs for hemophilia, which FDA is in process of reviewing.

Betsy continued: the Division has been working with Aetna and OptumRx to determine how these new therapies would be covered. She also reiterated they would be excluded from pharmacy coverage, but still covered by the plan: the purpose is to only cover under the medical plan, through this network. OptumRx's excluded drugs list is defined as those using gene therapy technology, and/or that require medical administration (and not self-administration), making them appropriate for the medical plan.

- Cammy asked if there are other therapies that are medically administered, beyond these GCIT network drugs, and how they are covered?
    - Sara shared there are some medications covered in the pharmacy plan which do require a provider to administer; the member typically orders the drug themselves, but sends the medication to the provider's office directly, and the member goes to the provider. Sometimes the provider will not accept the medication, and the member receives the shipment and takes the drug to the provider to be administered. In this case, it may be that the medication itself is covered under the pharmacy plan, but the service of administration (the doctor's visit and time to administer the treatment) is billed to the medical plan. Even if the medication itself is covered under the medical and pharmacy plans, it would not be billed to both, the service would be billed separately.
- Cammy asked whether these medications are covered in the medical plan also?
    - Sara confirmed these are covered in both the medical and pharmacy plans, but the plans do not communicate directly; they are typically billed under one or the other.

Betsy concluded by reiterating the Division will work with Aetna and OptumRx to determine the lines between medical and pharmacy coverage, and how these GCIT therapies (the 3 listed in this policy so far, and as others are approved in the future) are covered.

- Cammy noted the intent is to bring this to the Board for a recommendation vote at the next meeting. She asked staff to clarify what additional information is required? How would coverage of additional therapies be added in future, would that require a recommendation vote?
    - Betsy responded the Division proposes as a policy, because they are adopting the Aetna GCIT network which currently includes these 3 therapies but will have others over time, to adopt what Aetna maintains as their current network. The Division anticipates following Aetna's guidance about other therapies they plan to include in the plan going forward. This is similar for programs such as the Centers for Excellence, where the Division relies on Aetna's expertise and clinical determinations to cover therapies and services, since they do not have the expertise.
    - Sara clarified the policy also adopts a definition of these therapies, not individual products, so as new therapies are added, they would also be included. Or in OptumRx's case, the list of excluded therapies (covered under medical, not pharmacy, plan) would be expanded automatically to match the plan's current coverage.
- Mauri asked for clarification: what is the Division proposing to adopt, as a policy?
    - Betsy responded the proposal is to implement Aetna's GCIT Designated Network and associated additional travel and care coordination and support benefits as part of the plan. Aetna's GCIT program currently includes 3 therapies but could change over time. The proposal also contemplates implementing OptumRx's medial benefit specialty exclusion list, to clarify that therapies meeting certain criteria are eligible for coverage under the medical plan, not the pharmacy plan.
    - The plan booklet would identify what is covered under the medical plan, and not covered in the pharmacy plan; would clarify what benefits are available under this program, including travel benefits and clinical review; and would also address coverage of future therapies adopted over time, as Aetna adds or changes coverage in this network.

She reiterated this is a process for members to understand what is covered under the medical plan and the pharmacy plan, to ensure they access the therapy in a way that it will be covered, and provide the structure for coverage of other GCIT treatments as they are approved in the future.

- Mauri asked how this policy would be updated in the future - would there be future amendments? How would this be impacted by possible selection of a different third party administrator in the future, if Aetna is not longer the provider?
    - Emily responded there may be additional therapies included in the program in the future, and the possible selection of a different third-party administrator in the future may necessitate a future plan amendment to ensure clarity for members.
- Nan asked whether the cost savings reflect consideration of whether they are covered under the pharmacy plan now? Does it reflect the network savings, or also charges from manufacturers?
    - Emily noted they would rely on Aetna to negotiate rates, since it also depends on whether the hospital qualifies for other rebates, determined on a facility-wide basis.
- Mauri asked if the manufacturer has approved a facility for a therapy, but it is not included in the Aetna network, why would they not be covered? Why not cover the service, but limit the payment to a recognized charge if out of network? She is concerned about not covering some facilities, versus only covering up to a certain charge.
    - Emily noted one issue is negotiated contracts: a facility may be approved by the manufacturer, but charges significantly more (several million dollars) for a service, beyond the negotiated network rate. There is also an administrative cost to having out-of-network coverage for these 3 therapies only, and may be difficult because the charges may change over time. There is also a risk of a member seeking out-of-network care and being responsible for significant additional cost, given how expensive these therapies are.
    - Kimberly added Aetna can also negotiate a single-case agreement, such as a facility that does not typically administer these drugs, and this is what they try to do if dealing with a facility that is not in network who would provide this service.
- Mauri recommended language requiring that the TPA must try to negotiate a rate before treating it as an out-of-network, she sees the main benefit as financial savings to the plan given the cost and potential exposure for covering these services.
    - Emily responded the other provisions of the network are member coordination and travel benefits, which are also protections for the member. There is currently risk of financial exposure now, given the lack of guidelines for these specialty medications. She cautioned against designing policies to address the extremes or unusual situations, and instead having flexibility in the policy where needed. She pointed out some providers also can be incentivized to not participate in the network, if there is sufficient out of network coverage, and she does not want to create that incentive.

Proposed meeting on Wednesday, July 20: topics to discuss include GCIT out-of-network questions, as well as more information about how Aetna evaluates and considers adding facilities to the network. Cammy asked the Division to respond to potential concerns that the purpose of this proposal is primarily related to cost savings. She also asked Betsy to provide OptumRx's current Vigilant Drug Program (exclusion list).

Item 4. Public Comment

Before beginning public comment, the Chair established who was present on the phone or online, and who intended to provide public comments, and reiterated reminders about these comments being part of the public record, and that commenters cannot share protected health information (PHI).

- **Wendy Woolf, RPEA**. Wendy expressed concern about how additional therapies will be added in the future, if there is no opportunity to comment on more therapies being included if Aetna updates their program. While the current list of therapies is limited and not likely to impact many (if any) retirees, there could be many other new therapies that do have direct impact as they are developed. Even with the enhanced travel benefit, she also expressed concern about moving some of the covered drugs out of the pharmacy plan and into the medical plan, given the $2 million coverage maximum, she noted this may be a perceived diminishment (whether or not it is a diminishment is a legal question). She suggested that changing or removing the lifetime maximum could be an enhancement to offset a potential diminishment. She sees value in implementing this policy, including protecting members, but these concerns should be addressed, and ensure the plan is not diminished.

Item 5. Closing Thoughts + Meeting Adjournment

- Mauri commented she has not been involved in the modernization work for the last couple years, but remembers prior discussions about removing the lifetime maximum. Could removing the maximum be considered an offset, if this is a diminishment?
    - Emily responded the Division does not see this as a diminishment, but instead as an enhancement for members because of the other benefits. This would not require an offset. However, she noted there are other options for addressing this concern: one would be revising the out-of-network coverage provision to maintain the network coverage, but also ensure Aetna makes an effort to negotiate a single-case price for an individual member's service, if they wish to or have reason to use an out-of-network facility for a GCIT covered service. Another is to carve out GCIT coverage from the lifetime maximum in the medical plan, since it is a high-cost service and is limited to these specific situations and therapies. Emily noted staff have considered carving out this program, as well as the SurgeryPlus travel and coordination benefit, since they anticipate significant savings from that program that could justify the potential financial exposure from exempting these services from the lifetime maximum. This is something the group can continue discussing in the next meeting.

Staff will prepare the additional information, respond to questions, and draft the proposed revisions to the policy for the next committee meeting on July 20, for a potential vote.

Upcoming meetings:

- The Modernization Subcommittee meet Wednesday, July 20, 2022, 9 a.m. to noon.
- The Regulations Subcommittee will meet on Thursday, July 14, 2022, 1 to 4 p.m.
- The next Retiree Health Plan Advisory Board quarterly meeting was rescheduled from Thursday, August 4 and is now Thursday, September 27, 2022.

1. **Motion** by Mauri Long adjourn the meeting. **Second** by Nan Thompson.
    - **Result**: No objection to adjournment. The meeting was adjourned at 12:12 p.m.

RHPAB Subcommittee Meeting 7/20

Aetna

Precertification Follow-Up

Precertification for AlaskaCare Plans

Definition: is a process used by all medical plan administrators to confirm the medical necessity of care for certain procedures *before* services are rendered. The State of Alaska's AlaskaCare plans have specific requirements related to precertification and Aetna administers the AlaskaCare plans according to these requirements.

AlaskaCare Defined Benefit Retiree Insurance Information Booklet Language: 3.2 Precertification

"Certain services, such as inpatient stays, certain test and procedures, and outpatient surgery require precertification. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to pre-certify services if the plan is secondary to coverage you have from another plan, including Medicare.

You do not need to pre-certify services provided by a network provider. Network providers will be responsible for obtaining the necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to pre-certify services.

When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna for any services or supplies that require precertification as described under *section 3.2.2 Services Requiring Precertification*. If you do not pre-certify, your benefits may be reduced or the medical plan may not pay any benefits."

Types of Precertification

Urgent Definition:

- The member or provider states that the request is urgent due to risk of life or health of the member; or
- The member or provider states that the member would be subject to unmanageable pain without the treatment requested; or,
- In the opinion of a practitioner with knowledge of the member's medical condition, the request is urgent; or
- The request involves an unscheduled inpatient admission (i.e. ER admission).

Routine Definition:

Precertification request received with no request for urgent review.

Precertification Standard Turnaround Times

Urgent Turn Around Times:

- If additional clinical information is **NOT** required to make a decision: Within **24 hours** of initial receipt of the request.
- If additional clinical information IS required to make a decision: Within the earlier of **48 hours** from the receipt of additional clinical information OR 48 hours from the end of the time allotted to provide the clinical information.
- Notes:
  - Initiate request for additional clinical information within 24 hours from receipt of the request.
  - Provide 48 hours from the issuance of the request for information for the member and/or provider to supply the additional clinical information required for decision-making.

Non-Urgent Turnaround Times:

- If additional clinical is **NOT** required to make a decision: Within **5 business days** of initial receipt of the request.
- If additional clinical IS required to make a decision: Within the earlier of 5 business days from the receipt of additional clinical information OR 5 business days from the end of the time allotted to provide the clinical information.
- Notes:
  - Initiate request for additional clinical information within 5 business days from receipt of the request.
  - Provide 48 calendar days from the issuance of the request for information for the member and/or provider to supply the additional clinical information required for decision-making.

AlaskaCare Retiree Turnaround times

AlaskaCare Retiree Specific

	Type (in days)	
Year	**Routine**	**Urgent**
2022 YTD	3.5	0.0
2021	3.6	0.1
2020	3.1	0.5
Average	**3.4**	**0.3**

Precertification when Aetna is Secondary

Primary Insurance covers service

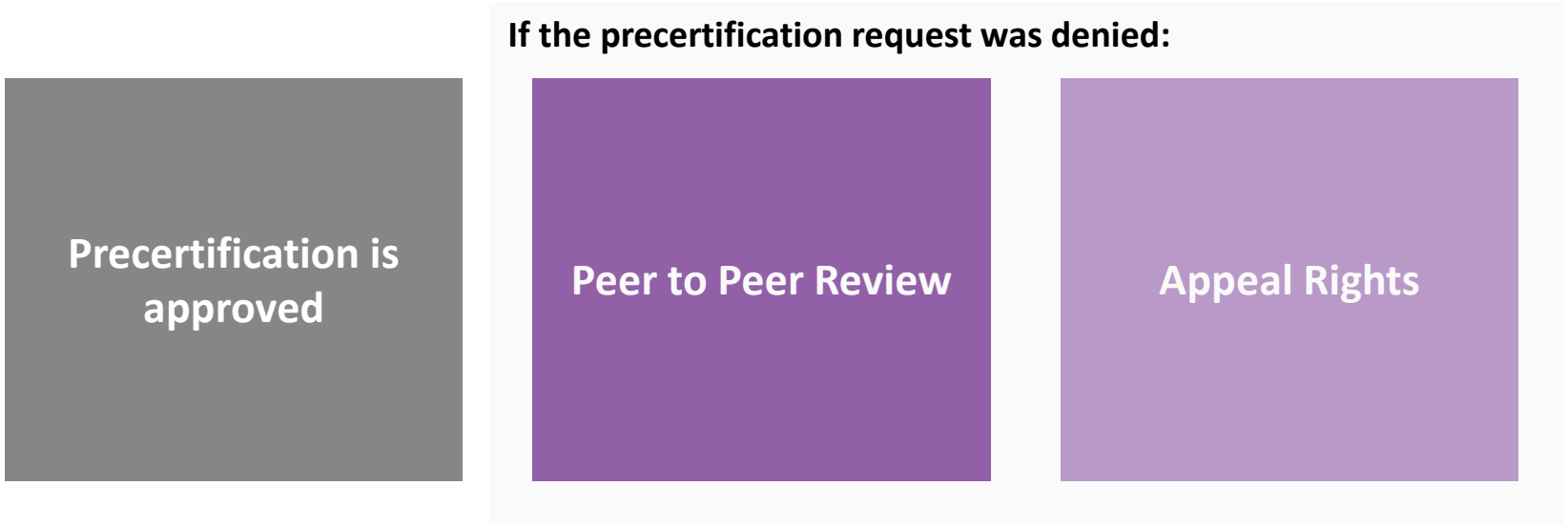
Service Covered by Primary Insurance → Aetna will process the claim with normal COB rules. There will be no denial for no precertification.

Primary Insurance does NOT cover service

Service NOT Covered by Medicare → Aetna will check system for precertification approval. → If no precertification approval is on file, claim will deny. → Member may appeal claim denial.

After Precertification

After precertification, there are multiple possible paths/outcomes:



Peer to Peer Review

What is a Peer to Peer Review?

A Peer to Peer review is a discussion between the requesting provider and an Aetna Medical Director to review the request and relevant clinical information.

Peer to Peer Process

Each precertification denial determination communication to a provider includes information on how to request a Peer to Peer review within 14 days of the date of denial. If requested, Aetna will offer dates and times for the provider to contact an Aetna physician.

Aetna may reverse an initial denial once a Peer to Peer review is complete, if the information shared confirms medical necessity. The Aetna Medical Director may continue to uphold the original denial following a Peer to Peer review.

32%
of offered Peer to Peer reviews result in a discussion.[12]

46%
of completed Peer to Peer discussions resulted in a partial or full overturn. [2]

1 While each adverse determination creates an opportunity for a Peer to Peer discussion, this number is a comparison of the number of providers that were offered specific dates/times for a Peer to Peer to the number that completed a discussion.
2 This data is an average of calendar year 1/1/2020 – 6/30/2022

Appeals

Appeals related to precert denials[1,2]

	Upheld	Overturned	Partially Overturned	Total	% of all appeals
2022 YTD	5	6	3	14	6.4%
Level 1	5	6	3	14	6.4%
Level 2	0	0	0	0	0.0%
2021	21	11	1	33	7.4%
Level 1	20	11	1	32	8.0%
Level 2	1	0	0	1	2.3%
2020	12	7	0	18	3.1%
Level 1	11	7	0	18	3.3%
Level 2	1	0	0	1	1.6%

1 Detail3 codes: Medical necessity; Medical necessity based on clinical review; prior authorization denial; referral/authorization/precert
2 Retiree plan detail only

5.2%
of appeals during this time period were related to a precert denial

36%
of appeals related to a precert denial were either fully or partially overturned

What happens if I fail to precertify?

AlaskaCare Defined Benefit Retiree Insurance Information Booklet Language: 3.2.3 How Failure to Pre-certify Affects Your Benefits

“A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means that Aetna will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of bills.

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however, you should verify with Aetna prior to the procedure that the provider has obtained precertification from Aetna. If your treatment tis not pre-certified by you or your provider, the benefit payable will be reduced as follows:

a) Except as otherwise provided below, Aetna will apply a $400 benefit reduction for failure to obtain precertification for the medical services listed in *section 3.2.2, Services Requiring Precertification*

b) If precertification of inpatient treatment for a mental disorder was not requested, your coinsurance for mental disorder benefits will be 50%

c) If precertification for travel expenses was not requested, no travel benefits will be paid.

Precertification Penalties

AlaskaCare Retiree Penalties applied

Penalty Type	OON Precert	Mental Disorder	Travel	Total
2022 YTD			13	
2021			35	
2020			40	

Data forthcoming

Proposal Title	GCIT Network Benefits - DRAFT
Health Plan Affected	AlaskaCare Retiree Health Plan
Proposed Effective Date	January 1, 2023
Reviewed By	Retiree Health Plan Advisory Board
Review Date	July 20, 2022

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1) Background

Gene-Based, Cellular, and Other Innovative Therapies

Gene-based, Cellular, and other Innovative Therapies (GCIT) are a relatively new and rapidly advancing area of medical treatment that work by replacing or repairing defective genetic material within a cell. GCIT products are distinct in that they are highly specific, engineered using genetic material, and may require harvesting the patient's cells (or a donor cell population) to be modified in a laboratory setting before being used to treat the patient.

GCIT services include:

- Cellular immunotherapy
- Genetically modified viral therapy
- Cell and tissue therapy, and more

GCIT products are U.S. Food and Drug Administration (FDA) approved therapies that are intended to treat or cure previously untreatable or difficult to treat conditions such as hemophilia, spinal muscular atrophy, and retinal disease. However, GCIT therapies are typically extremely expensive ranging in cost from $600,000 to $2.5 million. Because many of these therapies are new to market, many traditional cost controls and network agreements do not apply, leaving the plan and members with little financial protection and oversight.

Current AlaskaCare Coverage

Currently, the Plan covers GCIT services from both network and non-network providers and facilities. However, because these therapies are so new, charges for these services are not contemplated by many standard network agreements, meaning Aetna and most network providers have not previously established an agreed-upon price.

In limited circumstances, some plans may cover portions of GCIT therapies under both medical and pharmacy plans. However, these treatments are typically complex to administer, requiring specialized equipment, clinical expertise, and specific facility capabilities. Because of these requirements, GCIT therapies are most commonly and appropriately billed through medical plans.

The AlaskaCare Plan currently includes an individual lifetime medical benefit maximum of $2 million.[1] As a result, GCIT services that are paid through the medical benefit may move retiree plan members closer to meeting their lifetime maximum. While the AlaskaCare Plan has not experienced prices of this magnitude, Aetna has reported other plans have seen charges nearing $12 million for one course of treatment.

AlaskaCare Gene Therapy Experience

Though conditions treated by GCIT services are usually very rare, the AlaskaCare Employee Plan and the AlaskaCare Retiree Plan have already experienced claims for some of these novel therapies. AlaskaCare has experienced claims for Zolgensma (approximately $2.1 million per dose) and for Spinraza (approximately $128,000 per dose, 3-6 doses per year). Both are gene therapy treatments indicated for spinal muscular atrophy, a hereditary condition that most often affects babies and children and causes muscles to become weak and waste away.

2) Goals and Objectives

Implementing the Aetna GCIT Designated Network and associated patient support program is intended to:

1. Ensure members maintain access to necessary treatments
2. Provide members with appropriate logistical and clinical support
3. Reduce member and plan risk and add cost controls for emerging high-cost treatments.

3) Summary of Proposed Changes

Aetna's GCIT Designated Network

The proposed change ensures eligible therapies are covered through providers participating in Aetna's

[1] 2022 AlaskaCare Retiree Insurance Information Booklet, *Section 1.1 Medical Benefits*, and *Section 3.1.5 Lifetime Maximum*. https://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2022.pdf

GCIT Designated Network. These providers have been manufacturer-approved to administer the drugs and have agreed to contractual pricing terms for the therapies. Members receiving GCIT services from a designated network medical provider would have access to care coordination and support from a dedicated clinical team with specific GCIT experience. The care coordination team will help AlaskaCare members with the pre-certification process, ensure the member seeking treatment finds the most appropriate facility and provider, work directly with hospitals on claims, and provide answers to any questions that arise.

Aetna's GCIT Governance Committee, consisting of representatives from pharmacy, clinical, operational, finance, actuary, legal, network, and product areas, reviews FDA pipeline therapies to determine appropriate classification for inclusion in the GCIT Designated Network program. All drugs in the FDA pipeline are reviewed and identified as GCIT (or not) in advance of FDA approval. The first three GCIT services to be included in the GCIT Designated Network benefit were selected due to cost and administration criteria. Aetna is in the process of identifying criteria for including other GCIT products into the network benefit. Before any additional GCIT products are included in the benefit, appropriate notification will be provided.

Once a therapy has been identified for inclusion in the GCIT Designated Network benefit, Aetna begins contracting conversations with providers that are identified through information provided by the drug manufacturers or through prior authorization requests. Aetna's criteria for provider participation in the GCIT Designated Network is that they are approved by the manufacturer, they become Aetna credentialed, and that they are willing to execute an Aetna GCIT-specific agreement.

Steering utilization to manufacturer-approved providers helps to ensure that member receive GCIT services from providers that have the right skills and capabilities to safely administer these therapies. Given that GCIT services are highly specialized, most manufacturers will certify centers where their product can be administered safely. Some GCIT products require personalization and specialist care available at a select few sites around the country. GCIT product manufacturers provide on-site training and technical assistance with machine use and calibration where applicable. They also confirm that the facility can handle and store the specific GCIT product in accordance with their guidelines (*e.g.*, proper sterilization techniques or cold storage levels).

Because this area of medicine is relatively new, there are not currently any independent GCIT accrediting organizations. As the industry grows, a more formalized accrediting organization may develop.

Plan Coverage for GCIT Services

Under the proposed program, the Plan would only provide medical plan coverage for GCIT services received from a GCIT-designated provider or facility. No medical plan benefit would be provided for GCIT services received from an out-of-network provider. In addition to plan coverage for the GCIT therapy and associated medical charges, covered services would also include travel and lodging expenses (lodging: $50 per night per person) up to $10,000 per course of treatment for the member and a companion if the care must be administered away from the patient's home. Under the current plan benefits only limited travel costs would be reimbursable.

This proposal would clarify that these products are covered under the medical plan, rather than the pharmacy plan. This would align with the current plan language, emerging industry standards, and ensure members are accessing these benefits through a coordinated approach.

This proposal also contemplates excluding the cost of GCIT drugs or products included in the GCIT Designated Network program from accumulating toward a member's lifetime maximum benefit. This exclusion would only apply to the cost of the drug or product and would not apply to the cost of any associated travel expenses or other medical expenses. These other associated expenses (provider, facility, and travel charges) are currently billed through the medical plan and would remain so. GCIT products obtained through the medical benefit that are not part of the GCIT Designated Network program would continue to accrue towards a member's lifetime maximum benefit, as they do today.

To clarify coverage of GCIT services between the medical and pharmacy plans, this proposal contemplates implementing the Pharmacy Benefit Manager's (OptumRx) Medical Benefit Specialty Vigilant Drug Program Exclusion List. This list includes approximately 20 specialty products that meet the following criteria:

1. Designated as an orphan drug[2] and/or exhibits Gene Therapy technology;
2. Annual drug cost is over $500,000;
3. Is **not** self-administered; and
4. The first dose may be administered in an inpatient setting.

Drugs appearing on the Medical Benefit Specialty Drug list would be covered through the medical benefit (as they are today), rather than the pharmacy benefit. As new products enter the market, this list may evolve and be updated over time.[3]

4) Impacts

Member Impact | Minimal

The Retiree Plan has experienced fewer than five claims for the therapies included in the GCIT Designated Network program across all plans. Out of all drugs currently listed on OptumRx's Medical Benefit Specialty Vigilant Drug Program Exclusion List, only one member is utilizing one drug. Current utilizers of any impacted GCIT services on both the medical and pharmacy plan would be able to continue their current course of treatment, and would not be adversely impacted by the addition of the GCIT network program.

Any new utilizers would be connected with the care coordination and member support aspects of the program (described above) when the precertification request for their medication is submitted to Aetna. This includes the additional benefit of travel support beyond what is provided for in the current plan should a member require travel outside of their community to receive treatment.

Future utilizing members would have dedicated support from the GCIT Network program team at Aetna to help with identifying the most appropriate provider and facility, coordinating claims, and obtaining approval for payment of associated travel and lodging claims.

[2] Orphan Drug: A drug or a biological product that prevents, diagnoses, or treats a rare disease or condition. *Designating an Orphan Product: Drugs and Biological Products.* U.S. Food & Drug Administration. https://www.fda.gov/industry/developing-products-rare-diseases-conditions/designating-orphan-product-drugs-and-biological-products

[3] See the attached "OptumRx Medical Benefit Specialty Vigilant Drug Program List" for a current list of products.

The FDA has approved administration of these therapies in very limited circumstances. Many patients who qualify to receive GCIT therapies have underlying genetic defects and therefore may be experiencing many medical needs. Even so, most patients are able to travel to a facility where it is safe and cost-effective to administer the therapy. If patient travel is not possible, Aetna's GCIT Network program team will work with the member and the facility where the patient is admitted to secure an exception so that the appropriate care may be delivered at network rates.

Currently there are no facilities or providers in Alaska participating in Aetna's GCIT network, meaning it is likely members residing in Alaska will travel to receive care.[4] While the manufacturer-approved list of facilities that can administer GCIT services does not perfectly align with Aetna's provider network, there is a great deal of overlap. As of May 2022:

- of the 14 facilities approved by the manufacturer to administer Luxterna, 10 are Aetna GCIT-designated;
- of the 127 facilities approved by the manufacturer to administer Zolgensma, 48 are Aetna GCIT-designated; and
- the manufacturer does not provide a full listing of facilities approved to administer Spinraza, however 43 of the approved facilities are Aetna GCIT-designated.

Aetna works closely with their network facilities approved to administer GCIT services to negotiated specific discounts. To further support members who need to travel to receive care, the GCIT Network program covers travel costs beyond those typically available, providing important financial support for members.

Some members may wish to seek care in state if possible. Aetna has already demonstrated success in negotiating single case agreements for GCIT services to be administered by an Alaska provider at an Alaska facility on an individual basis. Single case rate negotiations are initiated when a pre-authorization request is submitted to Aetna for a GCIT product to be administered at a facility that is not part of the GCIT Network. When this occurs, Aetna reaches out to the facility to discuss capabilities and options. Whenever possible and appropriate, Aetna will continue to pursue negotiation of single case agreements in Alaska.

While members will not experience a change to their out-of-pocket costs for GCIT services obtained through the medical plan, the reduction in the total cost of the services will result in the member using less of their lifetime medical benefit maximum.

Financial Impact to AlaskaCare | Cost Savings

There is no additional administrative cost to the plan associated with implementation of the GCIT network program or the Medical Benefit Specialty Vigilant Drug Program Exclusion List.

Due to the rare nature of the conditions treated by GCIT therapies, it is difficult to estimate how much future utilization (if any) should be expected. However, should any claims be incurred for impacted

[4] See attached "Aetna Institutes ™ Gene Based, Cellular and Other Innovative Therapy (GCIT™) Designated Centers" for current list of providers.

medications, the plan would be protected from artificially inflated prices and would realize cost savings through the discounted rates available through the program.

Use of Aetna's GCIT-designated network is expected to save the plan an average of 17% below the listed Average Wholesale Price (AWP) for applicable drugs and may include drug rebates in eligible circumstances. The plan will have additional cost protection due to Aetna and the GCIT providers having an agreed upon contractual price for services. The GCIT network program would initially apply to three products, though more products will likely be added to the program as it matures, and as new drugs come onto the market. Initial products include:

Zolgensma

- Approved by the FDA to treat children less than two years of age with spinal muscular atrophy.[5]
- One time infusion.
- Infusions administered sooner (closer to birth) have better outcomes.
- AWP: $2.5 million
- Average savings: $425,000

Luxturna

- Approved by the FDA to treat children and adult patients with an inherited form of vision loss that may result in blindness.[6]
- Only available at a few sites across the country.
- A pre-treatment visit is required, including a treatment and examination. After the product is administered (one dose per eye), the patient must return within a specified time frame for a post-dose visit.
- AWP: $510,000 per dose; $1.02 million total
- Average savings: $170,000

Spinraza

- Approved by the FDA for children and adults with spinal muscular atrophy.[7]
- Administered via four initial loading doses over a 60-day period, and then one dose every four months for life or as long as a benefit from the product is demonstrated. Six doses are administered in the first 12 months of treatment, followed by three doses in each 12-month period thereafter.
- AWP: $153,000 per dose
- Average savings: $100,000

Operational Impact (DRB)| Minimal

The Division anticipates minimal operational impacts associated with implementation and member communication as follows:

[5] https://www.fda.gov/news-events/press-announcements/fda-approves-innovative-gene-therapy-treat-pediatric-patients-spinal-muscular-atrophy-rare-disease

[6] https://www.fda.gov/news-events/press-announcements/fda-approves-novel-gene-therapy-treat-patients-rare-form-inherited-vision-loss#:~:text=The%20U.S.%20Food%20and%20Drug,that%20may%20result%20in%20blindness.

[7] https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-spinal-muscular-atrophy

- Staff will need to review and distribute communications to educate and increase awareness of the GCIT Network program.
- Staff will need to update the Plan Booklet to ensure the benefit is appropriately described.
- Staff will need to coordinate and oversee implementation of the changes with Aetna.

After implementation, the ongoing operational impacts are anticipated to be minimal, and will include reporting, program monitoring, and updates to the booklet language and communication materials as appropriate.

Operational Impact (TPA) | Minimal

The initial impact to the Third-Party Administrator (TPA), Aetna, is anticipated to be minimal, primarily because Aetna already offers this program for their fully-insured book of business and for other self-insured customers who elect to participate:

- Aetna will update, code, and test their system to ensure that the changes associated with the program have been properly loaded.
- Aetna will ensure that their concierge staff are aware of the change and can properly communicate about and articulate specifics of the programs to members.
- Aetna will ensure internal channels are in place to connect any utilizing members with the appropriate care team as needed.
- Aetna will produce reporting on the utilization, impacts, and any savings associated with the program.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include maintenance of the network and regular updates to the list of drugs included in the program.

The initial impact to the Pharmacy Benefit Manager (PBM), OptumRx, is anticipated to be minimal, primarily because OptumRx already administers the Medical Benefit Specialty Vigilant Drug Program Exclusion List for their fully-insured book of business and for other self-insured customers who elect to participate:

- OptumRx will update, code, and test their system to ensure that the changes associated with the program have been properly loaded.
- OptumRx will ensure that their customer service staff are aware of the change and can properly communicate about and articulate specifics of the change to members.
- OptumRx will ensure continuity of care for any currently utilizing members.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include regular updates to the list of drugs impacted.

5) Considerations

Clinical and Provider Considerations

Ensures patients receive GCIT benefits in facilities committed to cost and quality management. A dedicated clinical team guides the members through the process, from precertification to aftercare.

6) Proposal Recommendations

DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2023.

RHPAB Board Recommendation

Insert the RHPAB recommendation here when final along with any appropriate comments.

Description	Date
Reviewed by Modernization Subcommittee	6/23/2022, 7/20/2022
Reviewed by RHPAB	11/01/2021, 02/10/2022, 05/05/2022

Drug	Indication*
ABECMA INJ	Treatment of adult patients with relapsed or refractory multiple myeloma
AMONDYS 45 INJ 50MG/ML	Treatment of Duchenne muscular dystrophy (DMD)
BREYANZI INJ	Treatment of adult patients with large B-cell lymphoma
BRINEURA KIT 150/5ML	Treatment for a specific form of Batten disease; approved to slow loss of walking ability in symptomatic pediatric patients three years of age and older
CARVYKTI INJ	Treatment of adult patients with relapsed or refractory multiple myeloma
ELZONRIS SOL 1000MCG	Treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients, two years of age and older
EXONDYS 51 SOL 100/2ML	Treatment of Duchenne muscular dystrophy (DMD)
EXONDYS 51 SOL 500/10ML	Treatment of Duchenne muscular dystrophy (DMD)
GIVLAARI INJ 189MG/ML	Treatment of adult patients with acute hepatic porphyria, a genetic disorder resulting in the buildup of toxic porphyrin molecules which are formed during the production of heme (which helps bind oxygen in the blood)
IMLYGIC INJ	Local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery
KRYSTEXXA INJ 8MG/ML	Treatment of chronic gout in adult patients refractory to conventional therapy
KYMRIAH SUS	Treatment of adult patients with relapsed or refractory follicular lymphoma after two or more lines of therapy
LUXTURNA SUS	Treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy
PROVENGE INJ	Treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer
RETHYMIC IMP	Immune reconstitution in pediatric patients with congenital athymia
SPINRAZA INJ 12MG/5ML	Treatment of children and adults with spinal muscular atrophy (SMA)
TECARTUS SUS	Treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL); adult patients with relapsed or refractory (r/r) B-cell precursor acute lymphoblastic leukemia (ALL)
VILTEPSO SOL	Treatment of Duchenne muscular dystrophy (DMD)
VYONDYS 53 INJ 100/2ML	Treatment of Duchenne muscular dystrophy (DMD)
YESCARTA INJ	Treatment of adult patients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.
ZOLGENSMA INJ	Treatment of Spinal Muscular Atropy (Type I)

**Indications summarized from www.FDA.gov*

Aetna Institutes ™ Gene Based, Cellular and Other Innovative Therapy (GCIT™) Designated Centers

Gene Based, Cellular and Other Innovative Therapy (GCIT) services are gene-based, cellular and/or innovative therapies that have a basis in genetic/molecular medicine. GCIT products and services, as determined by Aetna, are FDA approved therapies that have the potential to cure previously untreatable, often fatal, conditions.

All GCIT services will be authorized in accordance with Aetna's Drug Infusion Site of Care Policy and with the Aetna Member's specific benefit plan. Preauthorization is required for coverage to be effective for all GCIT services.

Providers that offer GCIT services and have met our criteria are designated to participate in the Aetna Institutes™ GCIT designated network ("Designated GCIT Providers"). Designated GCIT Providers have demonstrated a commitment to providing value for our members.

For the following GCIT therapies, Designated GCIT Providers are listed below:

Luxturna (Voretigene Neparvovec-rzyl):

Provider Name	City	State	Zip	Phone
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Massachusetts Eye and Ear Infirmary	Boston	MA	02114	(617) 523-7900
University of Michigan - Kellogg Eye Center	Ann Arbor	MI	48109	(877) 475-6688
Cincinnati Children's Hospital & Medical Center	Cincinnati	OH	45229	(513) 636-4200
Oregon Health & Sciences University Hospital - Casey Eye Institute	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Penn Presbyterian Medical Center (Scheie Eye Institute)	Philadelphia	PA	19104	(215) 662-8000
St. Luke's Health Baylor College of Medicine Medical Center	Houston	TX	77030	(713) 785-8537

Spinraza (Nusinersen):

Provider Name	City	State	Zip	Phone
Banner University Medical Center Tucson Campus	Tucson	AZ	85719	(520) 694-0111
Banner University Medical Center Phoenix Campus	Phoenix	AZ	85006	(602) 839-2000
Diamond Children's Hospital, part of Banner University Tucson Campus	Tucson	AZ	85719	(520) 694-5437
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
Lucile Packard Children's Hospital	Palo Alto	CA	94304	(650) 497-8000
Rady Children's Hospital San Diego	San Diego	CA	92123	(858) 576-1700
Stanford Medical Center	Stanford	CA	94305	(650) 723-4000
Children's Hospital Colorado	Aurora	CO	80045	(720) 777-0123
Connecticut Children's Medical Center	Farmington	CT	06032	(860) 545-9000
Children's National Medical Center	Washington	DC	20010	(888) 884-2327
MedStar Georgetown University Hospital	Washington	DC	20007	(202) 444-2000
Nemours Children's Hospital Delaware	Wilmington	DE	19803	(302) 651-4000
Joe DiMaggio Children's Hospital	Hollywood	FL	33021	(954) 265-5324
Nemours Children's Hospital	Orlando	FL	32827	(407) 567-4000
Nicklaus Children's Hospital	Miami	FL	33155	(305) 666-6511
St. Josephs Woman's Hospital (Baycare)	Tampa	FL	33607	(813) 879-4730
Memorial Regional Hospital	Hollywood	FL	33021	(954) 966-4500
Children's Healthcare Of Atlanta – Scottish Rite Hospital/Egleston Children's Hospital	Atlanta	GA	30342	(404) 785-1285
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Ann and Robert H Lurie Children's Hospital of Chicago	Chicago	IL	60611	(312) 227-4000
University of Kansas Medical Center	Kansas City	KS	66160	(913) 588-1227
Boston Children's Hospital	Boston	MA	02115	(617) 355-6000
Children's Hospital of Michigan	Detroit	MI	48201	(313) 745-KIDS
Children's Hospital of Michigan	Grand Blanc	MI	48439	(313) 745-KIDS
University Of Michigan Medical Center	Ann Arbor	MI	48109	(734) 936-6641
C S Mott Children's Hospital	Ann Arbor	MI	48109	(877) 475-6688
Gillette Children's Specialty Healthcare	Saint Paul	MN	55101	(651) 291-2848

Provider Name	City	State	Zip	Phone
The Children's Mercy Hospital	Kansas City	MO	64108	(816) 234-3000
Children's Hospital and Medical Center	Omaha	NE	68114	(402) 955-5400
Goryeb Children's Hospital at Morristown Medical Center	Morristown	NJ	07960	(973) 971-5200
Cincinnati Children's Hospital and Medical Center	Cincinnati	OH	45229	(513) 636-4200
Nationwide Children's Hospital	Columbus	OH	43205	(614) 722-2000
Ohio State University – Arthur James Cancer Center	Columbus	OH	43210	(614) 293-3300
The Children's Hospital at Oklahoma University Medical Center	Oklahoma City	OK	73104	(405) 271-5437
Oregon Health & Sciences University Hospital – Doernbecher Children's	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Milton Hershey Medical Center Pennsylvania State University	Hershey	PA	17033	(800) 243-1455
Hospital of The University of Pennsylvania Health System	Philadelphia	PA	19104	(800) 789-7366
Cook Children's Medical Center	Fort Worth	TX	76104	(682) 885-4000
Children's Medical Center of Dallas	Dallas	TX	75235	(214) 456-7000
Children's Hospital of The King's Daughters	Norfolk	VA	23507	(757) 668-7000
Seattle Children's Hospital	Seattle	WA	98105	(206) 987-2000
University of Wisconsin Hospital and Clinics	Madison	WI	53792	(608) 263-6400

Zolgensma (Onasemnogene abeparvovec-xioi):

Provider Name	City	State	Zip	Phone
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
Lucile Packard Children's Hospital	Palo Alto	CA	94304	(650) 497-8000
Rady Children's Hospital San Diego	San Diego	CA	92123	(858) 576-1700
Ronald Reagan UCLA Medical Center	Los Angeles	CA	90095	(310) 267-8000
Stanford Medical Center	Stanford	CA	94305	(650) 723-4000
Children's Hospital Colorado	Aurora	CO	80045	(720) 777-0123
Connecticut Children's Medical Center	Farmington	CT	06032	(860) 545-9000
Children's National Medical Center	Washington	DC	20010	(888) 884-2327
Nemours Children's Hospital Delaware	Wilmington	DE	19803	(302) 651-4000
Jackson Memorial Hospital	Miami	FL	33136	(305) 585-1111
Joe DiMaggio Children's Hospital	Hollywood	FL	33021	(954) 265-5324
Nemours Children's Hospital	Orlando	FL	32827	(407) 567-4000
Nicklaus Children's Hospital	Miami	FL	33155	(305) 666-6511
St. Josephs Woman's Hospital (Baycare)	Tampa	FL	33607	(813) 879-4730
Memorial Regional Hospital	Hollywood	FL	33021	(954) 966-4500
Children's Healthcare of Atlanta – Scottish Rite Hospital/Egleston Children's Hospital	Atlanta	GA	30342	(404) 785-1285
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Ann and Robert H Lurie Children's Hospital of Chicago	Chicago	IL	60611	(312) 227-4000
University of Kansas Medical Center	Kansas City	KS	66160	(913) 588-1227
University of Kentucky Hospital	Lexington	KY	40536	(859) 257-1000
Children's Hospital New Orleans	New Orleans	LA	70118	(504) 899-9511
Massachusetts General Brigham	Boston	MA	02114	(617) 726-2000
Boston Children's Hospital	Boston	MA	02115	(617) 355-6000
Children's Hospital of Michigan	Detroit	MI	48201	(313) 745-KIDS
Children's Hospital of Michigan	Grand Blanc	MI	48439	(313) 745-KIDS
University of Michigan Medical Center	Ann Arbor	MI	48109	(734) 936-6641
C S Mott Children's Hospital	Ann Arbor	MI	48109	(877) 475-6688
Gillette Children's Specialty Healthcare	Saint Paul	MN	55101	(651) 291-2848
The Children's Mercy Hospital	Kansas City	MO	64108	(816) 234-3000
Children's Hospital and Medical Center	Omaha	NE	68114	(402) 955-5400
Goryeb Children's Hospital at Morristown Medical Center	Morristown	NJ	07960	(973) 971-5200
Columbia University Medical Center	New York	NY	10032	(212) 305-2862

Provider Name	City	State	Zip	Phone
University of Rochester Medical Center Health System – Strong Memorial Hospital	Rochester	NY	14642	(585) 275-2182
Cincinnati Children's Hospital and Medical Center	Cincinnati	OH	45229	(513) 636-4200
Nationwide Children's Hospital	Columbus	OH	43205	(614) 722-2000
Akron Children's Hospital	Akron	OH	44308	(330) 543-1000
Integris Southwest Medical Center	Oklahoma City	OK	73109	(405) 636-7000
The Children's Hospital at Oklahoma University Medical Center	Oklahoma City	OK	73104	(405) 271-5437
Oregon Health & Sciences University Hospital - Doernbecher Children's	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Milton Hershey Medical Center Pennsylvania State University	Hershey	PA	17033	(800) 243-1455
Cook Children's Medical Center	Fort Worth	TX	76104	(682) 885-4000
Texas Children's Hospital	Houston	TX	77030	(832) 824-1000
Children's Medical Center of Dallas	Dallas	TX	75235	(214) 456-7000
Children's Hospital of The King's Daughters	Norfolk	VA	23507	(757) 668-7000
Seattle Children's Hospital	Seattle	WA	98105	(206) 987-2000
University of Wisconsin Hospital and Clinics	Madison	WI	53792	(608) 263-6400

Your plan may include additional Designated GCIT Providers that are not listed above. Your health care provider can call Aetna to obtain information regarding Aetna's GCIT program and the requirements for becoming a Designated GCIT Provider.

Note: Some GCIT Designated Providers may not be part of your plan's network. Please confirm the provider is participating in your plan before obtaining services.

The following services are administered primarily in a home health setting and may be directed to a designated home health care provider, in accordance with Aetna's Drug Infusion Site of Care Policy and your specific benefit plan.

Amondys 45 (Casimersen)
Exondys 51 (Eteplirsen)
Viltepso (Viltolarsen)
Vyondys 53 (Golodirsen)

For the following other GCIT services, refer to Aetna.com and utilize the online provider search to find an Aetna provider in your area that participates in your plan. Not all providers offer GCIT services. Your health care provider can call Aetna to obtain information regarding Aetna's GCIT program and the requirements for becoming a Designated GCIT Provider.

Givlaari (Givosiran)
Imlygic (Talimogene Laherparepvec)
Onpattro (Patisiran)
Oxlumo (Lumasiran)

The lists of GCIT services above are subject to change.

Note: Some GCIT Designated Providers may not be part of your plan's network. Please confirm the provider is participating in your plan before obtaining services.